

**A Report to the  
US Senate Special Committee on Aging  
April 2003**



**the  
Assisted  
Living  
Workgroup**

**Assuring Quality in Assisted Living:  
Guidelines for Federal and State Policy,  
State Regulation, and Operations**



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State Regulations,  
and Operations***

**A Report  
To The  
U.S. Senate Special Committee On Aging  
From The  
Assisted Living Workgroup**

**April 2003**

## ***Acknowledgements***

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Cover artwork, titled "*All American*," was done by Lamberto Hechanova a resident of a long term care residence in Jamaica, New York.

# ***Assisted Living Workgroup Participating Organizations***

## **ACCREDITING ORGANIZATIONS**

CARF-CCAC  
Joint Commission on Accreditation of  
Healthcare Organizations

## **AGING/LONG TERM CARE ORGANIZATIONS**

American Geriatrics Society  
National Academy of Elder Law Attorneys  
National Adult Family Care Organization  
National Association of Professional Geriatric  
Care Managers  
National Council on Aging  
Pioneer Network

## **CONSUMER ADVOCATES**

AARP  
American Bar Association Commission on Law  
and Aging  
Alzheimer's Association  
Consumer Consortium on Assisted Living  
Center for Medicare Advocacy  
National Association of Local Long Term Care  
Ombudsmen  
National Association of State Ombudsman  
Programs  
National Association for Continence  
National Citizens' Coalition for Nursing Home  
Reform  
National Committee for the Prevention of Elder  
Abuse  
National Committee to Preserve Social Security  
and Medicare  
National Senior Citizens Law Center  
NCB Development Corporation, The Coming  
Home Program

## **DISABILITY COMMUNITY**

National Multiple Sclerosis Society  
Paralyzed Veterans of America  
United Cerebral Palsy

## **HEALTH CARE PROFESSIONALS**

American Academy of Home Care Physicians  
American Assisted Living Nurses Association  
American College of Health Care Administrators  
American Medical Directors Association  
American Occupational Therapy Association  
American Physical Therapy Association  
American Society of Consultant Pharmacists  
Consultant Dietitians in Health Care Facilities  
National Association of Activity Professionals  
National Association of Social Workers  
National Network of Career Nursing Assistants  
National Conference of Gerontological Nurse  
Practitioners  
National Hospice and Palliative Care  
Organization

## **PROVIDER ASSOCIATIONS**

American Association of Homes and Services for  
the Aging  
American Association of Service Coordinators  
American Seniors Housing Association  
Assisted Living Federation of America  
Catholic Health Association of the United States  
National Association for Home Care  
National Center for Assisted Living

## **REGULATOR ASSOCIATIONS**

Association of Health Facility Survey Agencies  
National Association for Regulatory  
Administration

## **STATE/LOCAL GOVERNMENT**

National Association of State Units on Aging

## **OTHER**

American Institute of Architects

***Assisted Living Workgroup  
Steering Committee***

AARP

American Assisted Living Nurses Association

American Association of Homes and Services for the Aging

American Medical Directors Association

American Seniors Housing Association

Assisted Living Federation of America

Association of Health Facility Survey Agencies

Consumer Consortium on Assisted Living

National Association of State Ombudsmen Programs

National Center for Assisted Living

National Citizens' Coalition for Nursing Home Reform

The NCB Development Corporation/Coming Home Project

Pioneer Network

*Assuring Quality in Assisted Living:  
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## ***Introduction***

As a result of the April 2001 hearing held by the U.S. Senate Special Committee on Aging, committee staff members asked assisted living stakeholders to develop recommendations designed to ensure more consistent quality in assisted living services nationwide. The primary directive was to be inclusive and permit any interested national organization to participate in the endeavor. Shortly thereafter, a core group of assisted living stakeholders extended invitations to numerous national organizations. Subsequently, the Assisted Living Workgroup formed with nearly 50 organizations representing providers, consumers, long term care and health care professionals, regulators and accrediting bodies. Meetings on assisted living and the development of recommendations began in Fall 2001.

The ALW identified overarching interests or principles that all topic groups were to consider. Those interests were:

- Quality Indicators
- Dementia Care
- Outcome Measures
- Accountability
- Regulations & Legislation
- Facility Size
- Research
- Best Practices
- Affordability

Much of the ALW's early work focused on developing the rules and processes under which the ALW would operate, including a four-stage approval process for recommendations. After much discussion, it was decided that a two-thirds majority vote of the participating organizations present (or through written proxy) at a full ALW meeting was necessary to move a recommendation forward to the next stage of the ALW's four-stage approval process. Many recommendations were significantly modified as they moved through the development stages. Each approved recommendation was voted on at least three times by the organizational representatives present at the full monthly ALW meetings.

The chapters in this report are organized by ALW topic group. In each chapter, both recommendations that received a two-thirds majority vote of the ALW participating organizations voting at the meeting and those that did not are included. Recommendations receiving two-thirds majority support appear first in each chapter; recommendations that did not receive two-thirds majority support follow.

Voting records are included for all approved recommendations and for those that failed in the last stage of the ALW voting process (on the third and final vote). Recommendations that failed earlier in the ALW process are included but do not have voting records. Finally, it should be noted that an organization was allowed to change its initial vote on a recommendation after the full report was compiled. However, the ALW determined that such vote changes would not affect whether the recommendation is listed as receiving a two-thirds majority.

The ALW also allowed participating organizations to submit supplemental positions on any recommendation published in this report. Supplemental positions were limited to 500 words and required a minimum of two organizational signatories.

Finally, the appendices at the end of the report include three additional resources. Many topic groups made recommendations for operational models or best practices that have been included as Appendix A. These recommendations were not voted on by the full ALW, but are included for the reader's information. Appendix B is a list of recommendations by topic group. Appendix C is a glossary of terms used in the report.

This report was requested by the U.S. Senate Special Committee on Aging, but is intended to be useful to a broad range of stakeholders, including:

- policymakers at the federal and state levels;
- agencies at the federal and state levels that are involved in service delivery, regulation, quality monitoring and enforcement, and providing public subsidies;
- consumers and their families;
- assisted living providers;
- health and long term care professionals, such as nurses, medical directors, pharmacists, social workers, activity directors, nutritionists, etc.;
- insurers, both public and private;
- financiers, both public and private; and
- public policy researchers.

#### **Contact Information**

For further information about the ALW, please check the Web site, [alworkgroup.org](http://alworkgroup.org), or send an e-mail with questions to [info@alworkgroup.org](mailto:info@alworkgroup.org). Written inquiries can be addressed to Assisted Living Workgroup, 2519 Connecticut Avenue, NW, Washington, DC 20008.



## ***Topic Group Recommendations***

### **Definition and Core Principles**

In its August 15, 2002 letter to the ALW Steering Committee, the Senate Special Committee on Aging emphasized the importance of the ALW developing a uniform definition of assisted living that would “provide consumers a clear understanding of what kinds of services they should expect in assisted living.” The letter reiterated that the “Committee members’ primary goal is that the consumer knows what he/she is getting when signing a contract to enter an assisted living facility. Further, the letter specified: “the Committee expects the definition the Workgroup ultimately chooses to have sufficient detail to ensure that those facilities that are not providing a minimal level of service do not receive the classification ‘assisted living.’”

With the Senate Committee on Aging letter as a guide, the ALW focused its attention on agreeing to a consumer-oriented, consumer-friendly definition of assisted living, rather than a more technical definition targeted to an audience of state regulatory or licensing agencies.

The challenge to the ALW in crafting a consumer-friendly definition was this: how to incorporate into the consumer-friendly definition elements that many in the ALW felt were important to assuring quality and raising the bar in assisted living. Such elements ranged from issues around private rooms to issues of levels of service and requirements for state licensing. The ALW was unable to craft a single definition that was supported in full by 2/3 of the participating organizations

To address this challenge, the ALW chose to develop a multi-faceted definition of assisted living, targeted to the consumer that includes supplemental elements that some in the ALW felt were critical to a definition that would ensure quality in assisted living. The ALW participating organizations were then offered the option of approving each of the elements separately or in various combinations.

## **Definition of Assisted Living**

### **Part A: Services and Regulation**

Assisted living is a state regulated and monitored residential long-term care option. Assisted living provides or coordinates oversight and services to meet the residents' individualized scheduled needs, based on the residents' assessments and service plans and their unscheduled needs as they arise.

Services that are required by state law and regulation to be provided or coordinated must include but are not limited to:

- 24-hour awake staff to provide oversight and meet scheduled and unscheduled needs
- Provision and oversight of personal and supportive services (assistance with activities of daily living and instrumental activities of daily living)
- Health related services (e.g. medication management services)
- Social services
- Recreational activities
- Meals
- Housekeeping and laundry
- Transportation

A resident has the right to make choices and receive services in a way that will promote the resident's dignity, autonomy, independence, and quality of life. These services are disclosed and agreed to in the contract between the provider and resident. Assisted living does not generally provide ongoing, 24-hour skilled nursing.

### **Rationale**

Assisted living is distinguished from other residential long term care options by the types of services that it is licensed to perform in accordance with a philosophy of service delivery that is designed to maximize individual choice, dignity, autonomy, independence, and quality of life. The definition includes core services that must be offered by any assisted living residence. Many of the recommendations that follow provide more specificity as to what services should be offered and how they should be monitored by state regulatory agencies.

Within the range of what residences are licensed to provide and state regulations regarding what services must be provided, providers and residents\* must agree on individual service packages. The recommendations that follow also provide more specificity about how contracts and service plans should be developed with residents\* in a manner that is respectful of their preferences and fully discloses the terms, costs, and implications of the residents'\* (see definition in Appendix C, Glossary) choices with regard to services.

### **Voting Record for Part A**

#### **1) Organizations Supporting Part A Without Qualification**

Alzheimer's Association, American Academy of Home Care Physicians, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association, Consultant Dieticians in Healthcare Facilities, Consumer

Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Coming Home Program, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Social Workers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Multiple Sclerosis Association, Pioneer Network

- 2) **Organizations Supporting Part A Only With Part B**  
AARP, National Association of Professional Geriatric Care Managers
- 3) **Organizations Supporting Part A Only With Part C**  
American Medical Directors Association
- 4) **Organizations Supporting Part A Only With Parts B & C**  
National Academy of Elder Law Attorneys
- 5) **Organizations Opposed to Part A**  
Assisted Living Federation of America, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center
- 6) **Organizations Abstaining From Voting on Part A**  
American Occupational Therapy Association

## **Part B: Private Units**

Assisted living units are private occupancy and shared only by the choice of residents (for example, by spouses, partners, or friends).

## **Rationale**

The requirement for private occupancy units is essential to operationalizing the assisted living philosophy. Dignity, autonomy and independence will not be achievable without private personal space that is controlled by the resident. Quality of life in assisted living will be greatly diminished without dignity, autonomy, and independence. Assisted living (a residential setting for person with physical and cognitive disabilities) should mirror the current environmental standards for subsidized independent senior housing; i.e., people should not give up the right to privacy simply because they need services for a disability.

## **Voting Record for Part B**

- 1) **Organizations Supporting Part B Without Qualification**  
AARP, American Academy of Home Care Physicians, NCB Coming Home Program, National Association of Activity Professionals, National Association of Social Workers, Consultant Dietitians in Healthcare Facilities, National Senior Citizens Law Center
- 2) **Organizations Supporting Part B Only With Part A**  
American Association of Homes and Services for the Aging, Consumer Consortium on Assisted Living, National Adult Family Care Organization, National Association of Professional Geriatric Care Managers, National Center for Assisted Living
- 3) **Organizations Supporting Part B Only With Part C**  
Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsman, National Association of State Ombudsman Programs, National Citizens' Coalition for

Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants

**4) Organizations Supporting Part B Only With Parts A & C**

National Academy of Elder Law Attorneys

**5) Organizations Opposed to Part B**

American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Association for Regulatory Administration, Catholic Health Association, National Hospice and Palliative Care Organization

**6) Organizations Abstaining From Voting on Part B**

Alzheimer's Association, American Assisted Living Nurses Association, American Occupational Therapy Association, Joint Commission on Accreditation of Health Care Organizations, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Multiple Sclerosis Association, Pioneer Network

**Part C: Levels of Care**

A state must establish at least two assisted living licensure categories, based on the types and severity of the physical and mental conditions of residents that the assisted living residence is prepared to accommodate. The licensure category shall determine licensure requirements relating to important concerns such as staffing levels and qualifications, special care or services, participation by health care professionals, and fire safety.

**Rationale**

Licensure categories are necessary because currently there is great divergence in the level of services available within assisted living residences. Some assisted living residences provide no more than limited assistance with routine activities of daily living. At the other end of the continuum, some assisted living residences serve residents with significant needs and make available health care services that are almost comparable to those found in nursing facilities. If only one category is used, either the licensure standards are too onerous for those assisted living residences providing a relatively low level of service, or more commonly, the licensure standards fall to a lowest common denominator that is inadequate to protect the residents who have significant health care needs.

Licensure categories benefit assisted living residences by allowing them to limit their services by licensing at a lower level, or to offer a full range of services from low to high by licensing at a higher level (which still gives the facilities the capacity to serve residents with fewer needs). Licensure categories benefit consumers by providing them with lower cost options as well as options that can accommodate increased future care needs, and by giving consumers clear information on what a facility is required by law to do or is prohibited by law from doing.

**Voting Record for Part C**

**1) Organizations Supporting Part C Without Qualification**

American Academy of Home Care Physicians, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, Consultant Dietitians in Healthcare Facilities,

National Association of Activity Professionals, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

- 2) **Organizations Supporting Part C Only With Part A**  
American Medical Directors Association
- 3) **Organizations Supporting Part C Only With Part B**  
National Association of Local Long Term Care Ombudsman, National Association of State Ombudsman Programs
- 4) **Organizations Supporting Part C Only With Parts A & B**  
National Academy of Elder Law Attorneys
- 5) **Organizations Opposed to Part C**  
AARP, American Association of Homes and Services for the Aging, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association, Consumer Consortium on Assisted Living, NCB Coming Home Program, National Center for Assisted Living, National Multiple Sclerosis Association
- 6) **Organizations Abstaining From Voting on Part C**  
Alzheimer's Association, American Assisted Living Nurses Association, American Occupational Therapy Association, Joint Commission on Accreditation of Health Care Organizations, National Adult Family Care Organization, National Association of Social Workers, National Hospice and Palliative Care Organization, Pioneer Network

***Voting Summary for Definition of Assisted Living***

Vote	Definition Part		
	Part A	Part B	Part C
Support without qualification	18	7	11
Support only with Part A	n/a	5	1
Support only with Part B	2	n/a	2
Support only with Part C	1	6	n/a
Support only with other two parts	1	1	1
Oppose	10	8	10
Abstain	1	8	8

### **Supplemental Position on Parts A, B, and C**

1) The undersigned strongly support Parts A and B of the definition and support an alternative version of Part C. We feel that Part A, together with the recommendation on the principle of assisted living, describe the unique model of care that assisted living provides, including essential service components as well as focusing on consumer independence and dignity. The requirements in Part A clearly raise the bar for what qualifies as assisted living currently and bring it into alignment with the goal of providing the services consumers need in a way that they can control, to the maximum extent possible.

Part B, the requirement for private occupancy units in assisted living, is critical to realizing the goals of assisted living – resident control, autonomy, and dignity.

Part C, as currently written, requires a state to license two or more assisted living licensure categories. We do not think that licensed levels of care within an assisted living category is helpful to a consumer's understanding of assisted living and may even be detrimental by requiring discharges and transfers from lower to higher levels of care. As an alternative, we recommend that a state develop or maintain the separate categories of care that they likely already have (e.g., board and care, residential care, group adult foster care, skilled nursing) to allow existing and new models of care and housing types to be developed as needed for various groups' needs and preferences. We believe that assisted living should be established as a discrete licensing category, as defined in Parts A & B, with a regulatory system designed to: 1) support its unique philosophy and mission, 2) implement minimum standards, and 3) allow a flexible approach to service levels, within the established parameters, to allow residents and providers to increase and decrease services to meet the needs of their current or target residents. We feel that the recommendations in the report support this approach to licensing assisted living.

*AARP, American Association of Homes and Services for the Aging, NCB Development Corporation, Consumer Consortium on Assisted Living, National Center for Assisted Living, Paralyzed Veterans of America*

### **Supplemental Positions on Part A**

1) We oppose Part A of the assisted living definition. Part A fails to meet the primary request of the U.S. Senate Special Committee on Aging – that a definition “offer consumers a satisfactory understanding of what services they will be guaranteed should they choose to live in an assisted living facility.” (Letter From Senate Special Committee on Aging to Assisted Living Workgroup, August 15, 2002) Although Part A intimates that assisted living provides a comprehensive level of service, Part A and other report recommendations actually guarantee relatively little.

We believe that a regulatory system – including a regulatory definition of “assisted living” -- must set forth clearly the types of services that must be provided. Consumers deserve a definition of “assisted living” that has real meaning.

By contrast, Part A relies on a model in which a resident's right to services is defined almost exclusively by the facility's admission contract. We emphatically reject this model. In almost all instances, an admission contract is a form contract signed by the resident or the resident's representative. For many, entry to assisted living occurs during an unsettled and stressful time.

The pivotal question is whether a resident receives health care services in an assisted living residence. Part A states only that an assisted living residence provides "[h]ealth related services (e.g. medication management services)." But "health related services" is never defined, and "medication management" is a limited service: as defined in the report's glossary, medication management "[i]nvolves storing medication, opening medications for a resident, reminding residents to take medication and other assistance *not involving the administration of medications.*" (Emphasis added.)

Although requiring little or nothing in health care capability, Part A nonetheless defines "assisted living" to include facilities that provide significant levels of health care. The only health care limitation in Part A is a statement that assisted living does not provide "on-going, 24-hour skilled nursing," and even this limitation is accompanied by the qualifier that assisted living "generally" does not provide such care.

The end result of Part A is total confusion as to what kind of health care might be provided in an assisted living residence. Under Part A's definition, an assisted living residence might not be capable of administering medication or, on the other hand, might be prepared to provide extensive nursing care including, on certain occasions, "ongoing, 24-hour skilled nursing."

Part A's reference to "scheduled and unscheduled needs" does not clarify the health care services provided, because an assisted living residence as defined could be unable to meet many resident health care needs, either scheduled or unscheduled. Similarly unhelpful is Part A's reference to a resident's "right to make choices and receive services in a way that will promote the resident's dignity, autonomy, independence, and quality of life." Without specifics, this feel-good language does nothing to inform a consumer as to the services that he or she can rely upon in an assisted living residence.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center*

2) We dissent. The fundamental essence of assisted living is consumer choice. Further, state regulatory scenarios must incorporate the necessary flexibility that addresses these consumer needs and preferences for long-term care. By discussing only specific services and offerings, this component of the proposed definition overlooks one essential—and often overlooked—aspect: Assisted living is a philosophy of care.

This philosophy embraces the need to:

- Foster resident independence,
- Promote the individuality of each resident, and

- Nurture each resident's spirit.

Further, vital resident issues such as the preservation of resident privacy, choice, and dignity cannot be mandated—or even addressed—by specific service requirements. Rather, these key concepts must be recognized at the outset as being an integral part of the consumer-centered nature of assisted living.

*Assisted Living Federation of America, National Association for Home Care*

### **Supplemental Positions on Part B**

1) We concur with Part B of the definition primarily because we strongly support the goal of giving all people requiring residential long-term care services the option of residing in private quarters. However, our concurrence is not free of serious concerns about the difficulties of pursuing that goal through the vehicle of a definition. Definitions steer regulatory policy.

Two competing and contradictory trends that are difficult to reconcile are at play. First, the vast majority of residences being built as assisted living have private units. If private units are the norm for new construction, then non-private units in existing facilities could be grandfathered as assisted living. Second, however, some states have renamed all residential living "assisted living." In these states, private units are not required.

Our primary concern is assuring that regulations are based on the needs of the individuals receiving services and the types of services they are provided. We do not want to encourage different rules for different residential long-term care facilities, based on the wealth of the residents.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants*

2) We dissent. The Assisted Living Workgroup could not reach agreement on whether a definition of assisted living should include a requirement that private units must be required in assisted living settings as part of state minimum standards.

While we agree that residents should have the right to choose whether to share a room or not, that choice is eliminated with regulatory language that requires private units. In effect, such language would require providers to build all private units in case no potential residents choose to share a room. Regulatory language needs to state that shared units are permissible in order to give providers the flexibility to respond to marketplace factors that gives consumers more options rather than less.

The rationale for the proposed language asserts that resident dignity, autonomy and independence will not be achievable without private personal space that is controlled by the resident. The proponents of the proposed language are making a statement concerning their knowledge of how a resident's quality of care and quality of life is



affected without the benefit of asking residents who currently share units as to whether they agree with the statements that are being made on their behalf.

Quantifying how the values of dignity, independence and autonomy are achieved in the eyes of a resident in assisted living is a multi-faceted and complex undertaking. It is not reducible to a single assertion that the operationalizing of these values in the eyes of a consumer hinges on a requirement for private units. Dignity, independence and autonomy can be operationalized in a variety of choices made each day by the resident, even in ALRs where the resident shares a unit.

*Assisted Living Federation of America, Joint Commission for Accreditation of Health Care Organizations, National Association for Home Care*

### **Supplemental Position on Part C**

1) We dissent. The rationale for why a state must require two levels of assisted living licensure categories has no basis in fact related to improving quality of care in assisted living.

No evidence is offered to support the statement that a state that has only one licensure category that the licensure standards are too onerous for ALRs providing a relatively low level of service or that the licensure standards will be inadequate to protect residents who have significant health care needs.

No evidence is offered to support the statement that levels of licensure offer a more affordable option to consumers. Issues surrounding what makes assisted living more affordable to consumers are considerably more complex and intertwined with public policy decisions affecting housing subsidies and services subsidies than this rationale acknowledges.

Finally, no evidence is offered to support the statement that levels of licensure provides consumers with clearer information on what the ALR is required by law to provide.

*Assisted Living Federation of America, Joint Commission on Accreditation of Health Care Organizations, National Association for Home Care*

## **Core Principles**

These core principles of assisted living should be reflected in the setting's mission statement, culture, policies, and procedures:

- 1) To create a residential environment that actively supports and promotes each resident's quality of life, right to privacy, choice, dignity, and independence as defined by that resident.
- 2) To offer quality supportive services, individualized for each resident and developed collaboratively with the ALR.
- 3) To provide resident-centered services with an emphasis on the particular needs of the individual and his/her choice of lifestyle incorporating creativity, variety, and innovation.
- 4) To support the resident's decision-making control to the maximum extent possible.
- 5) To foster a social climate that allows the resident to develop and maintain relationships within the ALR and in community-at-large.
- 6) To make full consumer disclosure, including what services will be offered and their associated costs, before move in and throughout the resident's stay.
- 7) To minimize the need to move.
- 8) To foster a culture that provides a quality environment for the residents, families, staff, volunteers, and community-at-large.

### **Organizations Supporting the Core Principles**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association, Consultant Dietitians in Health Care Facilities, Consumers Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organizations, National Multiple Sclerosis Society, Pioneer Network

### **Organizations Opposed to the Core Principles**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

### **Organizations Abstaining from a Vote on the Core Principles**

Assisted Living Federation of America, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Network of Career Nursing Assistants

### **Supplemental Position on Core Principles**

1) We dissent. While the core principles adopted may be appropriate to inspire assisted living staff members, the core principles contribute nothing to the discussion in the ALW report. At best, the core principles are aspiration statements. They are marketing principles that do not reflect actual practice in many assisted living residences. Moreover, the core principles do not distinguish assisted living from other health care settings. They describe neither the assisted living industry today, nor the recommendations that follow in this document.

The core principles misleadingly promise more than the recommendations deliver. For example, a purported core principle is "minimize[ing] the need to move." Yet the majority recommendations allow an assisted living residence to force eviction simply by refusing to provide a service that the resident needs, even though the residence could provide that service under its license. (See our dissent to D.04) Also, under the majority recommendations, an assisted living residence can force eviction by refusing to accept Medicaid reimbursement, even though the residence has Medicaid certification, and even though the resident has become Medicaid eligible by spending his or her life savings for care at the assisted living residence. We proposed requiring that a Medicaid-certified assisted living residence accept available Medicaid reimbursement, but our proposal was voted down. (See our opposition to failed recommendation R.20)

We believe the core principles are misleading. They should not have been included in the report.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy,  
National Association for Regulatory Administration, National Citizens'  
Coalition for Nursing Home Reform, National Committee to Preserve Social  
Security and Medicare, National Network of Career Nursing Assistants,  
National Senior Citizens Law Center*

## ***Topic Group Recommendations Adopted by 2/3 Majority of the ALW***

### **Accountability & Oversight**

#### **Purpose**

The Accountability & Oversight Topic Group developed recommendations for regulatory systems designed to provide oversight to assisted living residences.

#### **Issues**

The group worked on two primary issues: 1) developing regulatory system guidelines for states and 2) establishing a mechanism to develop outcome measures and quality improvement methods that can be integrated with traditional systems to provide state-of-the-art measurement systems to ensure consumer safety and satisfaction. Related to the goal of providing guidance regarding current regulatory systems, the topic group made recommendations in the following areas: components of a state accountability and oversight system; state-level assisted living stakeholder groups; consumer reports; licensure of assisted living; supply constraints; pre-licensure review; funding for long-term care ombudsmen; and public access to statutes, regulations, survey and inspection reports.

To develop valid outcome measures and improved quality improvement systems, the topic group made recommendations to create a National Center for Excellence in Assisted Living (CEAL), including the tasks to be undertaken by that entity. CEAL would be an on-going effort at the national level to review, research, evaluate and validate methods that will promote quality in assisted living. An additional recommendation made by the topic group is the creation of state-based assisted living workgroups, comprised of assisted living stakeholders, that evaluates the final recommendations of the national assisted living workgroup from the viewpoint of each particular state.

#### **Participants**

This topic group was co-chaired by Lyn Bentley of the National Center for Assisted Living and Rick Harris of the Association of Health Facility Survey Agencies.

Topic group participants included Doug Pace of the American Association of Homes and Services for the Aging, Paul Willging and Ed Sheehy of the Assisted Living Federation of America, Karen Love and Jackie Pinkowitz of the Consumer Consortium on Assisted Living, Marianna Grachek of the Joint Commission on the Accreditation of Healthcare Organizations, Donna Lenhoff and Christopher Havins of the National Citizens' Coalition for Nursing Home Reform, Dorothy Northrop of the National Multiple Sclerosis Society, Toby Edelman of the Center for Medicare Advocacy, Don Redfoot of AARP, Bill Reynolds of the Pioneer Network, Carolynne H. Stevens of the National Association for Regulatory Administration, Robert Jenkins of the NCB Development Corporation's Coming Home Program, Josh Allen of the American Assisted Living Nurses Association, Janet Kreizman and Meg LaPorte of the American Medical Directors Association, and Nancy Coleman of the American Bar Association's Commission on Law & Aging.

**Accountability and Oversight**

**AO.01 Center for Excellence in Assisted Living**

**Recommendation**

A national Center for Excellence in Assisted Living (CEAL) should be formed and funded to continue the work of the Assisted Living Workgroup and serve as an ongoing information clearinghouse and shall include a governing board comprised of key stakeholders.

The CEAL should foster and develop the following: 1) performance measures, including measures of clinical outcomes, functional outcomes, staff and resident\* satisfaction; 2) updated versions of the ALW recommendations and report; 3) dissemination of these tools that are developed; 4) practice protocols to deal with identified problem areas. The CEAL should also develop capacity to provide technical assistance to states, at their request, for integration of outcome measures and the ALW recommendations; identify and promote areas for research AL; and utilizing objective quality measures and data, provide a regular report to Congress and the nation regarding the state of the assisted living industry.

An additional role of the CEAL is to develop a means of reporting quality information about ALRs in ways that are useful to various constituents.

The governing board of the CEAL should include balanced representation ensuring no one group dominates the board. The groups represented should include: 1) consumers and their advocates, 2) providers, 3) state officials, 4) other professionals working in long term care.

**Implementation**

Guideline for Federal Policy

**Rationale**

Promoting quality in assisted living requires developing better information tools for all constituents—to foster autonomy for consumers, innovation among providers, and informed decision-making among government officials.

**Consumers:** Consumers and their families considering assisted living need information about quality that would allow them to make informed choices among alternatives. Those consumers who live in assisted living need a mechanism to express their satisfaction or dissatisfaction in ways that feed into management practices, state enforcement, and quality reports for other potential consumers.

**Supervisory and Direct Care Staff:** Quality services are a function of able and committed staff. Staff satisfaction and retention of staff are vital to the continuity of services. Supervisory and direct care staff should be consulted on structure and performance measures and process considerations, including staff scheduling, the appropriateness of workload standards, the availability of supplies and equipment, continuing education for staff.

**Providers:** Providers shall focus on quality outcomes in their day to day management and

## Accountability and Oversight

operations. Outcomes measures developed by the CEAL should be useful to providers in evaluating their performance and identifying areas for improvement. Practice protocols could help providers develop more effective interventions in problem areas.

**State Enforcement Agencies:** States have the primary responsibility for overseeing quality and enforcing minimum standards for assisted living. The CEAL would have responsibility for updating the guidelines for states on minimum standards. Over time, the effectiveness of these standards should be measured against outcomes measures validated by the CEAL. Quality indicators may be one type of outcomes measure that the CEAL could validate for use by state regulators to ensure more continuous monitoring of a more timely and effective interventions.

**State and Federal Funding Agencies:** State and federal governments have shown increasing interest in providing public reimbursements to assisted living, especially through the Medicaid program and various housing programs. Outcomes measures and the guidelines for state minimum standards should provide benchmarks to evaluate state efforts to assure quality—making sure that increased federal funding is used appropriately.

**State and Federal Elected Officials:** Members of Congress and state legislators have a responsibility to oversee assisted living and to develop policies affecting the industry. An annual report on the state of quality identifying areas for policy development would help policy decision-makers do their jobs, based on accurate and timely information. The CEAL could serve as an ongoing source of information on quality issues for elected officials as well as other constituents.

**Governing Board:** Broad acceptance of the recommendations of the CEAL will require broad and balanced representation on the governing board. Further, the governing board should be an independent decision-making entity rather than affiliated with a governmental body.

**Funding by Congress:** The independence of the CEAL will be critical to its credibility. Congressional funding of the core operations of the CEAL would enable the organization to begin offering services sooner and would help guarantee the independence of the organization. The CEAL may, with approval of its board, seek other funding to sponsor research, help disseminate information, and carry out other functions that it may identify.

### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Home Care, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Adult Family Care Organization, Pioneer Network

### **Organizations Opposing This Recommendation**

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American Seniors Housing Association, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Senior Citizens Law Center, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

### **Organizations Abstaining From the Vote on This Recommendation**

None

### **Supplemental Positions for AO.01**

1) We dissent. This recommendation would establish a private group to perform many functions that are now tasked to public regulatory agencies. We oppose this recommendation because its full implementation would transfer a government function to a private organization with a nebulous governing structure.

The recommendation also would allow the CEAL to solicit contributions for its work, but has no requirements prohibiting conflicts of interest. The provider community would clearly be in a position to make contributions, thus directing the areas of research and potentially affecting research outcomes.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) The undersigned strongly support Accountability and Oversight A0.1 as written for the following reasons:

- To address the on-going quality of assisted living, a national organization is necessary to research and disseminate information and best practices. The CEAL's role as an objective resource to develop and/or validate outcome measures is especially important if these measure are to assume a significant role in quality monitoring.
- A national resource is necessary to continually update standards as better methods of delivery and quality monitoring (e.g., outcome measures) are developed or problems are identified.
- A national organization is needed to develop and disseminate technical assistance to states regarding best practices in regulation and monitoring and to providers regarding operations.
- The products of the CEAL (e.g., regulatory updates, outcome measures, best practices in operations) will benefit all consumers and providers but will be especially useful to affordable assisted living residents and providers. The replacement of process oriented requirements with outcome measures holds great promise to allow greater flexibility in meeting consumers' needs and preferences while allowing providers to run the most affordable operation possible. Likewise, best practice technical assistance will allow states and providers to deliver high quality affordable assisted living.
- Public funding is necessary and appropriate for this function, especially as more federal funding is directed to ALRs.

*AARP, Alzheimer's Association, American College of Health Care Administrators, NCB Development Corporation, Consumer Consortium on Assisted Living, National*

**Accountability and Oversight**

*Multiple Sclerosis Society, Pioneer Network*

3) The rationale for this recommendation specifies: "States have the primary responsibility for overseeing quality and enforcing minimum standards for assisted living." We support states continuing their current role of overseeing assisted living. We support and encourage the creation of Centers for Excellence in Assisted Living (CEAL) in each state and adopting the goals outlined above.

*American College of Health Care Administrators, American Seniors Housing Association, National Center for Assisted Living*



**Accountability and Oversight**

**AO.02 Increased Funding for Long Term Care Ombudsmen**

**Recommendation**

Congress and the states should provide adequate funding for the Long-Term Care Ombudsman Program to fulfill its responsibilities under the Older Americans Act.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Ombudsmen have legislative authority to resolve complaints and represent resident interests in licensed ALRs. Long-term care ombudsmen have the unique opportunity to negotiate agreements and resolve problems before they become enforcement issues. Equally important, long-term care ombudsmen are resources for consumer education on a wide variety of issues related to assisted living, including resident rights, the difference between nursing-home and assisted-living care, community resources, etc. Providing adequate funding would result in more frequent visits to assisted living residents, increased capacity to provide consumers with much-needed education on assisted-living services, and training to effectively carry out the ombudsman responsibilities in this setting.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for AO.02**

None Submitted

**Accountability and Oversight**

**AO.03 State-level Public Meetings to Review ALW  
Recommendations**

**Recommendation**

States should convene public meetings attended by regulators, consumers, consumer advocates, assisted living provider representatives, and professionals working in the assisted living setting. At these meetings, states should consider the recommendations of the Assisted Living Workgroup, as well as other local issues that are relevant to the assisted living industry. Similarly-constituted groups should be convened from time to time to consider new issues and to evaluate the impact of decisions made previously. Particular care should be taken to assist consumers and consumer advocacy organizations in obtaining the resources necessary to participate in this effort.

**Implementation**

Guideline for State Regulation

**Rationale**

The members of the Assisted Living Workgroup believe that the discussions we have had about various questions are at least as valuable as the conclusions and recommendations that we have reached. We do not expect that states will or should adopt the recommendations of the ALW in wholesale fashion. Decisions involve weighing competing values. Inevitably, states will find balance points that differ from one another and from the ALW. We think it is critically important, however, to articulate the values that underlie decisions, including the values that prevail and those that do not. It is no less important to keep the books open on controversial questions, revisiting from time to time decisions that have been made, evaluating once again the underlying value choices, and determining, to the extent possible, whether adoption of a particular recommendation has had its intended effect.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Home Care, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Association for Regulatory Administration, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

**Accountability and Oversight**

None

**Supplemental Positions for AO.03**

1) We agree that states should seek maximum public input when considering assisted living standards. We fully endorse the concept that care should be taken to include input from consumers and consumer advocates.

We dissent because we believe that most of the recommendations from the Assisted Living Workgroup are not appropriate for adoption by the states. For states that have recently revised their assisted living regulatory approach, adoption of the recommendations in the Assisted Living Workgroup report would in nearly every case be a step backwards, increasing the risk of adverse outcomes to thousands of consumers. Rather than follow the report's recommendations, those states seeking to revise their current assisted living regulations should consider measures adopted by other states in recent years. In several dissents published in this report, and in a separately published paper, we will identify several promising, recently-adopted state regulatory approaches to a number of serious care and safety problems within the assisted living industry.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We support this recommendation. We support the concept of convening state meetings to discuss quality improvements in Assisted Living. We recommend that stakeholder meetings be brought together with a vision statement affirming that consumer-centered perspective will be considered in defining all standards.

A consumer-centered perspective is respected when consideration is given to the consumer's values and experiences, as well as individual preferences into the definition and evaluation of quality of care and quality of life.

It is critical that state level discussions to improve quality not be limited solely to consideration of processes, but rather, give equal weight to alternative approaches that might integrate or substitute measures of results and performance, including consumer satisfaction.

*Assisted Living Federation of America, Consumer Consortium on Assisted Living, National Association for Home Care, National Center for Assisted Living, Joint Commission on Accreditation of Health Care Organizations*

**Accountability and Oversight**

**AO.04 Pre-licensure Review**

**Recommendation**

A state review of applicants prior to licensure shall focus on both provider capacity and past performance in assisted living and related fields. For applicants without a relevant performance history, in addition to the capacity review, states should exercise heightened oversight until the applicant demonstrates the capacity to operate the residence in compliance with the regulations for one year.

**Implementation**

Guideline for State Regulation

**Rationale**

An effective tool for promoting quality in assisted living is a pre-licensure review. State licensure review should include two parts: a capacity review and a performance review. The capacity review would determine the applicant's ability to meet minimum standards and assess its financial soundness. The performance review would focus on a provider's history of providing quality assisted living or similar services. The performance review should include any records of past performance, records of complaints, past business practices, and specific experience a provider brings to serving older persons and persons with disabilities. States should not grant licenses to providers that have unacceptable performance records or show inadequate capacity to provide quality services. States should expedite requested records and reviews of past performance, including information requested by licensing agencies in other states.

New providers are necessary in many locations. States may also want to use provisional licensure for providers with limited experience. Lack of relevant performance histories should not be an obstacle to licensure or limit entry into the assisted living field. Instead an approach combining a rigorous capacity review and heightened oversight should be adopted for applicants new to the assisted living field until a performance record is established.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Accountability and Oversight**

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for AO.04**

None Submitted

**Accountability and Oversight**

**AO.05 Supply Constraints**

**Recommendation**

States should not use certificates of need, license moratoria, or any other means to limit the supply of assisted living residences.

**Implementation**

Guideline for State Regulation

**Rationale**

Constraints on the supply of assisted living (such as certificates of need or license moratoria) can negatively affect the quality of services by keeping marginal performers in business while limiting the entry of new providers. Licensure should be used to improve quality, not to limit the supply of assisted living residences. Because they reduce competition, supply constraints drive up costs and diminish quality and innovation. Therefore, states should not use certificates of need, license moratoria, or any other artificial constraint on the supply of assisted living residences.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Network of Career Nursing Assistants

**Organizations Abstaining From the Vote on This Recommendation**

National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

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**Supplemental Positions for AO.05**

1) We dissent from the majority's recommendation to ban supply constraints and from its view that these inevitably preserve substandard facilities while preventing market entry by other providers.

We believe it is equally true that unrestrained growth can and sometimes does result in over-supply with high vacancy rates that force facilities to divert resources from resident care to pay debt

## Accountability and Oversight

burdens and other fixed costs. We have seen:

- Facilities, stressed by high vacancies, make ill-advised admissions of high-acuity residents they could not adequately serve or residents who would be inappropriately placed in a home for frail elderly people;
- Abrupt closures that displaced residents;
- Reduced staffing, unmet payrolls with real/threatened walk-outs, and real/threatened cut-offs of services and utilities in over-extended facilities during time-consuming appeal proceedings related to regulators' forcible closure actions and lender foreclosures;
- Some areas dangerously over-built while others remain grossly under-supplied.

Thus, consumers can and do suffer as much from over-supply, voracious competition by large chains, and market volatility as from under-supply.

The wiser course is to allow states the flexibility to adopt, or not adopt, methods and tools according to their prevailing conditions. States are responsible for protecting residents and preventing harmful conditions. States should not be hampered in choosing methods to perform this mission.

Regardless of the states' choices, residents would fare better if:

- States streamlined their appeals processes to reduce the time residents are exposed to high-risk conditions during forcible closure actions;
- States and the federal government generated better planning data and offered planning assistance to promote better, more agile decision-making by providers, lending institutions and states;
- States that establish a certificate of need process assured opportunities for public input; and,
- States that employ market-restraint methods avoided creating unduly thin supply margins that can result in a reduction of healthy competition or consumer options.

*Association of Health Facility Survey Agencies, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Network of Career Nurse Assistants*

## Accountability and Oversight

### **AO.06 Components of a State Accountability and Oversight System**

#### **Recommendation**

##### Part I

The regulatory system for assisted living is founded on these principles:

- A regulatory system for assisted living is responsible for abating harm and supporting the resident's decision-making control.
- The regulatory system ensures that there is meaningful assisted living stakeholder participation, especially resident\* participation, when defining regulatory standards.
- The regulatory system specifies that the practices, protocols and methods by which care provided are respectful of, and responsive to individual resident preferences, needs and values and that resident values guide care and service delivery decisions.
- Regulatory requirements should be periodically re-evaluated to determine whether or not they are achieving their intended effect.

##### Part II

Each state shall have adequate survey staff to enforce its assisted living regulations and should have an accountability and oversight system (otherwise referred to as a survey and enforcement system) that includes the following elements:

1. Standards for Licensing – Quality assurance begins with the licensing or certification of the ALR. Standards for licensing should include: documentation of competent management; performance history; criminal background checks; financial soundness; required policies and procedures; compliance with specific building and life safety code requirements; appropriately trained staff, food safety, service planning, dietary oversight
2. A Monitoring Element – Includes a system of no less than annual unannounced inspections, and a responsive complaint investigation process.
3. A Technical Assistance Element – The Technical Assistance Element may be used by a state agency as a third component of its integrated oversight of ALRs; the other two components are surveys and complaint investigations. The state agency may provide technical assistance to ALRs on its own initiative or in response to an ALR's request. The technical assistance includes explanation of regulatory requirements and standards.
4. A Remedy and/or Sanction Element – In the Remedy and/or Sanction Element, a range of remedies and/or sanctions may be employed by the state agency, including: directed plans of corrections; fines, reduced capacity; required training, stipulations on admissions; relief of administrative control of the facility, and license revocation. The remedy and/or sanction component should be based on clear regulatory standards that detail the basis for the licensing sanctions. In some instances the state may require a management consultant to be paid for by the ALR.

Regulatory systems should have systems in place designed to timely identify substandard performers, and to quickly and effectively induce satisfactory performance or closure of the



## Accountability and Oversight

ALR. There are three approaches that regulatory agencies should consider using:

Track 1: A small number of ALRs having regulatory difficulties are in such dire circumstances that any reasonable person would fear for the immediate health and safety of the residents. Examples of this situation include: residents are not being fed; there is no heat in the building during the winter due to non-payment of utility bills; residents are being denied urgently needed medical care; residents are being abused by staff and management of the ALR has failed to take any action. Under these circumstances, the only solution is to bring legal action asking for immediate injunctive relief. In situations where the deficiencies do not indicate a physical plant emergency, the injunction shall request some type of receivership or other court-approved change of management of the facility in order to protect residents and allow them to remain in their homes under new management. Discharge of residents shall be an available remedy, but this remedy should be sought by the state agency when there is a physical plant emergency or when receivership or other court-approved change of management of the facility is not possible. Regulatory agencies should have ample legal authority to get immediate relief where necessary to protect residents.

Track 2: ALR operators who have been identified as substandard operators should be immediately notified of their status, of the regulatory agency's assessment of the nature of their problems, and of the remedies and/or sanctions imposed by the state survey agency. The message conveyed should be that identified problems shall be immediately corrected or the ALR will be the subject of additional remedies and/or sanctions and adverse licensure action. In situations involving no harm to residents, the state may give the ALR an opportunity to correct deficiencies before imposing any remedy and/or sanction. Any opportunity to correct problems, if offered, should be limited to a narrow time frame, such as thirty to forty-five days. If problems are not corrected as agreed, the state survey agency shall impose additional remedies and may require the facility to sell or lease the ALR to an unrelated party acceptable to the regulatory agency or bring in an unrelated management company that is acceptable or publicly defend itself at a license revocation hearing. It may be appropriate to conduct a face-to-face meeting with the ALR administrator or with corporate officials to ensure the message is understood and to ensure that any contemplated corrective measures are adequate.

Track 3: License revocation. When Track 2 fails, regulatory agencies shall be prepared to exercise this option.

5. Administrative Procedures Element – Administrative procedures should be expeditious and not unduly prolong or exacerbate the situation that led to the ALR's or State's decision. Administrative procedures should include:

- a. An opportunity for the ALR (including clinical/direct care staff) to discuss survey problems informally with the state agency both during the survey and at the exit conference and to submit a plan of corrections.
- b. The opportunity for the ALR to have an informal conference with the regulatory agency with notification provided to residents\*, the ombudsman, or other appropriate consumer advocacy representative.
- c. The right of the ALR to a hearing before an impartial agency officer with a clear set of

## Accountability and Oversight

procedural rules. The ALR shall have the right to appeal only deficiencies for which the state agency imposes a sanction.

d. The right of an ALR to appeal the state agency decision to the appropriate state court after a contested case hearing. The ALR shall have the right to appeal only deficiencies for which the state agency imposes a sanction.

The state's rules shall be designed and implemented in a way that:

--Minimizes the time between the identification of deficiencies and final imposition of the remedy(ies); and

--Provides for the imposition of incrementally more severe fines and remedies for repeated or uncorrected deficiencies.

Where the state determines there is an immediate threat to residents' health or safety the state's rules shall authorize the imposition of remedies and/or sanctions during the pendency of an administrative hearing.

### **Implementation**

Guideline for State Regulation

### **Rationale**

This recommendation suggests a framework for an approach to oversight of assisted living. This approach seeks to combine elements of traditional regulatory systems having to do with deterrence and abatement of harm with other modes for monitoring and improving performance and quality of care.

This new approach would align the values associated with assisted living (autonomy, choice, dignity) with the outcomes to be accomplished and the means to evaluate the effectiveness of services within a system that encourages and rewards excellence while retaining traditional state responsibility for vigorous rule enforcement when necessary.

A regulatory system for assisted living serves two primary goals: (1) determining compliance with regulatory standards of care (which include quality of life and residents' rights) and (2) preventing avoidable bad outcomes for residents [California Association of Health Facilities v. Department of Health Services, 16 Cal.4th 284, 940 P.2d 323, 65 Cal.Rptr.2d 872 (1997)].

While it could be beneficial for regulatory agencies to provide technical assistance to facilities to help them provide better care for their residents, that work (1) is not the state's core function and therefore should not be done until the state's core functions are completed; and (2) can be accomplished by other entities (trade associations, private consultants, etc). Facilities engage in quality improvement activities. State survey agencies protect public health and safety. Their roles should not be confused. State agencies should not serve as or become part of an ALR's staff or quality assurance teams.

It should be noted that the sequential listing of the Monitoring, Technical Assistance and Remedy and/or Sanction Components is not meant to imply that the state regulatory

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agency shall follow a linear progression from one component to the next. Instead, each component is a distinct part of the system. A state agency, for example, may take direct enforcement action against a provider without prior technical assistance. Similarly, as part of its monitoring functions, a state agency may provide on-site technical assistance in the way of a suggested best practice or the provider may voluntarily initiate a request for technical assistance.

State oversight programs may consider the clinical staff's medical judgment and decision-making in its examination of care processes. ALR clinicians could have the opportunity to provide adequate clinical pertinent explanations regarding their care decisions as part of collaborative or consultative process.

### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Association of Professional Geriatric Care Managers, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

### **Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, American Seniors Housing Association, Association of Health Facility Survey Agencies, National Association for Regulatory Administration, National Center for Assisted Living, National Committee to Preserve Social Security and Medicare

### **Organizations Abstaining From the Vote on This Recommendation**

National Network of Career Nursing Assistants

### **Supplemental Positions for AO.06**

1) Although we agree with much of this recommendation, we submit this supplemental position to indicate our strong disagreement with #1, the purported principles of a regulatory system. The underlying assumption of the introductory principles is that the most significant problem faced by AL regulators is ensuring that residents have enough decision making control. This assumption reflects the majority's unwillingness to acknowledge significant care and safety problems occurring throughout the assisted living industry-- problems such as abuse and neglect, some resulting in injury or death, elopements resulting in injuries or death, avoidable falls resulting in fractures, and dangerous unplanned weight loss that could be avoided using well-recognized interventions.

The introductory principles, by elevating resident choice above all other concerns would be an impediment to an effective regulatory system. The majority diverts attention from the truly

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important issues. Ignoring the prevalence of care and safety problems in the assisted living setting, it directs regulators merely to make sure that residents have the right to make choices. This is neither useful nor rational as a response to the growing crisis in resident safety and well-being.

*Association of Health Facility Survey Agencies, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) As proposed, this recommendation mirrors the current oversight system for assisted living in some states and the federal oversight system for all certified nursing homes. This type of oversight has not proven to be successful and has shifted the main focus of nursing homes from their customers to their regulators. The ALW has an opportunity to propose a new vision for an oversight system and this recommendation does not reflect a new vision.

The oversight system for assisted living should be designed to embrace the following concepts:

- Partnership among providers, residents and regulators to reach the desired goal of quality assisted living;
- Regulators responsible for assisted living should receive specialty training about assisted living;
- The oversight agency should offer technical assistance to the assisted living residences upon request;
- Resident satisfaction should be an integral component for determining quality; and
- Utilize sanctions and fines only as a last resort (sanctions and fines are punishment and do not necessarily relate to long-term improvement of a situation).

*American Association of Homes and Services for the Aging, National Center for Assisted Living, American Seniors Housing Association*

**Accountability and Oversight**

**AO.07 Public Access to Statutes, Regulations, Survey and Inspection Reports**

**Recommendation**

State regulatory agencies should make available information that is helpful to consumers and others related to assisted living residences. This availability includes electronic access to statutes and regulations impacting assisted living. The state should also maintain as public records all survey and inspection reports and plans of corrections for a period of at least three years. States should take steps to offer low cost access to these reports, such as by posting the reports on their web page.

**Implementation**

Guideline for State Regulation

**Rationale**

Consumers need to have easy access to information that will be useful as they assess assisted living residences.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for AO.07**

None Submitted

## Accountability and Oversight

### **AO.08 Federal Jurisdiction Over Assisted Living**

#### **Recommendation**

The federal government shall exercise its jurisdiction to oversee assisted living and enforce federal law in the following areas:

- To protect consumers from unfair and deceptive acts and practices under the Federal Trade Commission Act;
- Whenever an assisted living provider receives Medicaid funding, the federal government shall adequately enforce its responsibilities for Medicaid waiver for assisted living;
- National abuse registries and criminal background checks;
- Civil rights laws, such as the Americans with Disabilities Act;
- Any other existing federal laws and standards that apply.

This recommendation is not intended to take a position on the need for additional federal authority over assisted living.

#### **Implementation**

Guideline for Federal Policy

#### **Rationale**

The Senate Special Committee on Aging and GAO have identified consumer disclosure and marketing practices as a problem area for assisted living. These issues are particularly important in the context of an industry whose providers offer a whole range of services with different types of billing strategies, admission and retention policies, and subsidy options. Under the circumstances, it would make sense for the Federal Trade Commission (FTC) to focus attention under its existing consumer protection authority to examine practices in this industry and to take action where problems may persist.

Similarly, CMS should enhance its oversight of states that are using Medicaid waivers for state plan services in assisted living. Since waivers require that recipients be eligible for nursing home services, they require AL providers to offer a higher level of services to a more disabled population than is often envisioned by state AL regulations. CMS should make sure that states are doing an adequate job overseeing quality—not only through having regulations that address higher levels of disability, but also sufficient staffing in state monitoring agencies.

There may be other ways that the federal government can play a more active role in seeing that states do an adequate job with quality—e.g., federal housing programs may play a role. The general goal will be to give states adequate tools, adequate resources, and adequate oversight to make sure they can meet their responsibilities for promoting quality in assisted living.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consultant Dietitians on Healthcare

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Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Association of Professional Geriatric Care Managers, National Conference of Gerontological Nurse Practicioners, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, Catholic Health Association of the United States, National Center for Assisted Living

**Organizations Abstaining From the Vote on This Recommendation**

American Seniors Housing Association

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**Supplemental Positions for AO.08**

None Submitted

**Accountability and Oversight**

**AO.09 Licensure of Assisted Living**

**Recommendation**

States shall require assisted living licensing for any entity that meets the state's definition or does the following:

1. Holds itself out as an ALR; OR
2. Offers to provide assisted living services unless licensed under another related category OR
3. Uses the phrase "assisted living" in its name or marketing materials.

**Implementation**

Guideline for State Regulation

**Rationale**

Entities that meet the criteria identified in the above recommendation should be licensed as assisted living. This will provide the states with appropriate regulatory oversight of entities that are providing assisted living. Additionally, it will provide consumers with a broad definition of assisted living and the assurance that there is state regulatory monitoring and oversight.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for AO.09**

- 1) We dissent. This definition essentially says that a business only needs to get licensed as an



## Accountability and Oversight

assisted living residence if it calls itself, "Assisted living," or if it meets the state's definition of assisted living. It avoids making any recommendations to states on how they should define assisted living.

Licensure requirements should be based on the care needs of the residents that a facility houses, rather than based on the services that it provides. Otherwise, assisted living residences are unlimited in which residents they may admit and retain. Moreover, facilities could lawfully escape having to meet licensure requirements merely by not offering one out of a long list of services. We believe a more rigorous legal definition is required, and propose the following as a guideline to states:

"Assisted living residence" means any business entity, including an individual, that offers housing, meals, and care to \_\_\_\_ [insert here a minimum number to be determined by state law or policy] or more adults who require assistance with activities of daily living or more extensive care, unless the facility is subject to licensure as a different entity, such as a nursing home, or unless the entity is specifically excluded by law from the requirement to be licensed.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. This recommendation goes beyond the mandate to the ALW to focus on recommendations to the states to improve quality in assisted living. Rationale says that adoption of this recommendation will provide the states with appropriate regulatory oversight authority. States already have the requisite authority. Therefore this recommendation provides no new guidance to the states that will improve quality in assisted living. Further, the thrust of the recommendation infringes on state authority to set the terms and conditions for licensure.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Accountability and Oversight**

**AO.10 Stakeholder Involvement in Federal Actions**

**Recommendation**

Congress and federal agencies shall, in a public and open manner, consult with a diverse representation of stakeholders, including residents\* in the review, evaluation and formulation of any assisted living law, policy, regulation or program.

**Implementation**

Guideline for Federal Policy

**Rationale**

The development and consideration of any assisted living measure without effective communication with the diverse stakeholders of assisted living will result in outcomes that are not significantly effective.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Social Workers, National Association of Local Long Term Care Ombudsmen, National Center for Assisted Living, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Conference of Gerontological Nurse Practitioners, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, Catholic Health Association of the United States

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for AO.10**

None Submitted

***Topic Group Recommendations  
That Did Not Reach Two-Thirds Majority***

**Accountability and Oversight**

*The following recommendations did not reach a two-thirds majority of the ALW. The recommendations showing a voting record were unable to reach two-thirds majority at the final vote. The recommendations that do not show a voting record were unable to reach the two-thirds majority during the development process.*

**Accountability and Oversight**

**AO.11 Measure of Resident Outcomes**

**2/3 Maj. Not Reached**

**Recommendation**

The CEAL (Center for Excellence in Assisted Living) should research, develop and validate measures of resident outcomes including consumer satisfaction and consumer quality of life. When resident outcome measures are available, states may integrate these measures into their regulations and survey process.

The CEAL's designation of outcome measures shall be preceded by research and analysis to identify a limited number of outcome measures that are most useful in evaluating resident quality of life.

**Implementation**

Guideline for Federal Policy

**Rationale**

Outcome measures are a powerful tool in enhancing the quality of life of residents. Additionally, outcome measures may be used to focus state inspection and survey activities on issues that are of greatest concern, to act as sentinels for potential problems as they develop and to help consumers choose an appropriate ALR.

Information on outcome measures should be provided to consumers. The information about outcome measures will require analyses with risk adjustments for the ALRs involved, the level of services offered, and the characteristics of the residents served. The CEAL should work on the technical issues so that reports made to consumers and providers are accurate and understandable comparisons that are useful to their respective decision-making needs.

There are substantial costs imposed on both providers and on regulatory agencies involved in a data collection effort such as the one envisioned here. Restricting data elements to only those most useful to consumers, providers, and states in their respective decision-making as identified by the preceding efforts should minimize these costs.

Because of the complicated technical issues in validating quality measures, collecting the data, analyzing the data, and reporting the results, the ALW envisions an extended period of time during which these measures are developed and implemented. As measures are validated and tested, they may be introduced a few at a time rather than as a whole. The ALW urges particular attention to consumer satisfaction and quality of life measures as areas too often ignored in evaluating quality performance.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social

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Workers, National Conference of Gerontological Nurse Practitioners, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, American Seniors Housing Association, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for AO.11**

1) We oppose this failed recommendation because it is not appropriate for a private organization structured like the proposed "CEAL" to develop the outcome measures and a minimum data set. Our objections to the CEAL concept are more fully set out in our dissent to recommendation AO-01.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) The undersigned strongly support recommendation AO.11. The ongoing effort to promote quality in assisted living must include research to develop and validate measures of resident outcomes. Particular attention should be paid to measures of consumer satisfaction and quality of life. The CEAL, a national body with representation from a balanced group of stakeholders, is the ideal group to conduct this important work.

The Rationale recognizes the value of outcome measures for consumers, providers, and states. Outcome measures benefit consumers by providing the information needed to develop consumer reports, which provide potential residents and their families with the information they need when choosing an ALR. Outcome measures are useful to providers in their internal quality improvement efforts. Performance-based outcome measures are also valuable for states' survey and monitoring efforts, helping states to focus efforts on improving resident outcomes.

It is the hope of the signatories that as outcome measures are validated, and where determined appropriate and feasible, the outcome measures would replace some of the more prescriptive requirements contained in current ALW recommendations which we support in the interim in the absence of appropriate alternatives.

*AARP, Alzheimer's Association, American Assited Living Nurses Association, Consumer Consortium on Assisted Living, NCB Development Corporation, National Multiple Sclerosis Society, Pioneer Network*

**Accountability and Oversight**

3) We dissent. We support in principle the intent of the recommendation, however this recommendation goes beyond the mandate to the ALW to focus on recommendations to the states to improve quality in assisted living.

CEAL is premised on federal funding. Senate Special Committee on Aging did not request recommendations for spending on new federal programs.

Rationale for CEAL calls for federal regulation of assisted living: i.e. Members of Congress have a responsibility to develop policies affecting the industry.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Accountability and Oversight**

**AO.12 Consumer Reports**

**2/3 Maj. Not Reached**

**Recommendation**

The CEAL should develop models for states to use in producing assisted living consumer reports and a uniform disclosure form that are easy to read and useful. These reports should be developed with input from assisted living stakeholders and the assistance of experts in the field of assessing consumer preferences and information needs when making major decisions affecting consumers' lives.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Using valid scientific research and state of the art marketing research techniques to determine what AL consumers want to know has never been attempted at a national level.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Conference of Gerontological Nurse Practitioners, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for AO.12**

1) We oppose this failed recommendation because it is not appropriate for a private organization structured like the proposed "CEAL" to develop a model consumer report. Our objections to the CEAL concept are more fully set out in our dissent to recommendation AO-01.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to*

**Accountability and Oversight**

*Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) The undersigned strongly support recommendation AO.12. A crucial part of the ongoing effort to promote quality in assisted living is the development of consumer reports that will help consumers be more informed about quality outcomes in ALRs. A national model for these consumer reports would help consumers to compare ALRs across states.

A key problem in assisted living has been that consumers are often not informed about important information they need in choosing an ALR. The development of a useful, easy to read uniform disclosure form would ensure that consumers are consistently provided the information they need to make informed decisions.

The CEAL, a national body with representation from a balanced group of stakeholders, is the ideal group to develop models for consumer reports and uniform disclosure forms for the states to use.

*AARP, Alzheimer's Association, American Assited Living Nurses Association, Consumer Consortium on Assisted Living, NCB Development Corporation, National Multiple Sclerosis Society, Pioneer Network*

3) Oversight for assisted living is and should remain at the state level. Thus, development of assisted living consumer reports should logically be done at the state level.

States are encouraged to research what consumers want to know about an assisted living residence and develop a report that provides that information for use by consumers. Keeping this at the state level will make it possible to create reports that embrace the differences in assisted living from state to state.

*National Center for Assisted Living, American Seniors Housing Association*



## ***Topic Group Recommendations Adopted by Two-Thirds Majority of the ALW***

### **Affordability**

#### **Purpose**

Identify recommendations for federal and state policies that will increase the availability of quality affordable assisted living for Medicaid eligible and moderate-income individuals.

#### **Issues**

Affordability in assisted living was examined for two groups: (1) Medicaid eligible residents and (2) moderate-income residents (individuals with \$25,000/year income or less).

Affordability discussions were prioritized, starting with the lowest income residents (Medicaid eligible). Issues impacting access to good quality assisted living were identified for each group and discussed. Recommendations for federal and state policy change were developed as necessary.

The topic group divided discussion topics into five categories: service subsidies, housing development and rent subsidies, operational/services affordability, outside issues' impact on consumer's ability to pay, and related issues. Issues related to each category were generated by the topic group and expanded as additional issues arose through topic group discussions, recommendations of the full ALW, or suggestions of outside experts. Some discussion topics resulted in a recommendation, while others were put aside due to lack of agreement or the belief that the topic area was outside of the group's scope.

#### **Participants**

The co-chairs were Robert Jenkins, NCB Development Corporation and Joani Latimer, National Association of State Ombudsmen Programs.

Participants included Kathy Angiolillo, Senior Citizens League; Bill Benson and Alice Hedt, National Citizens' Coalition for Nursing Home Reform; Lyn Bentley, National Center for Assisted Living; Colleen Bloom and Doug Pace, American Association of Homes and Services for the Aging; Virginia Dize and Greg Link, National Association for State Units on Aging; Dina Elani, Commission on Affordable Housing and Health Facility Needs for Seniors in the 21<sup>st</sup> Century; Toby Edelman, Center for Medicare Advocacy; Jim Gray, NCB Development Corporation Coming Home Program; Bill Harris and Terri Lynch, Consumer Consortium on Assisted Living; Morris Klein and Brian Lindberg, National Association of Elder Law Attorneys; Diane Lifsey, National Council on Aging; Martha Mohler, National Committee To Preserve Social Security and Medicare; Anne Berman, Lisa Newcomb, Ed Sheehy, Katie Smith, and Beth Singley of the Assisted Living Federation of America; Don Redfoot, AARP; Constance Row, American Academy of Home Care Physicians; Amy Sander, Association of State Medicaid Directors; George Taler, MD, American Academy of Home Care Physicians.

**Affordability**

**A.01 Consumer Directed Long-Term Care Benefit**

**Recommendation**

Create new, consumer directed federal long-term care program that includes assisted living and expands service eligibility to meet the needs of people who are not nursing home eligible.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Consumer-directed federal long-term care program: Federal long-term care policy currently favors institutional care over more residential models of care by providing a benefit entitlement only for nursing home care. Assisted living and other forms of home and community-based programs may be funded at the discretion of the states. The institutional bias in federal funding of long-term care goes against consumers' repeated preferences for home and community-based options.

In light of the various disability statutes and the recent Olmstead decision, the federal government and states should move to a long-term care funding system that provides funding in the least restrictive environment possible. To ensure consumer choice, the system should provide consumers the capacity to direct how and where their funding will be spent. This model of consumer directed care could be similar to the Cash and Counseling demonstration program currently being evaluated by HHS.

Expand service eligibility to meet the needs of people who are not nursing home eligible: Many states define nursing home eligibility at a high level of service need. Often, persons with disabilities do not qualify for nursing home care but require significant services and cannot live independently. These people either suffer without required services or depend on family caregivers to fill in the gaps. The quality of life losses to the person with disabilities who forgo services and the economic and health losses (mental and physical) to family caregivers have substantial negative consequences on our communities. A consumer-directed long-term care program would more effectively lessen these impacts if were targeted to those who have disabilities which are less than those required for nursing home eligibility.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Catholic Health Association of the United States, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Multiple Sclerosis Society, National Adult Family Care Organization, Pioneer Network

**Organizations Opposing This Recommendation**

## Affordability

American Assisted Living Nurses Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, American Medical Directors Association, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

### Organizations Abstaining From the Vote on This Recommendation

American Association of Home Care Physicians, National Network of Career Nursing Assistants

### Supplemental Positions for A.01

1) We dissent. While we support development and implementation of a national long-term care policy that gives individuals with various needs a variety of choices about where and how to receive long-term care services that meet defined standards of care, we object to the mythology about assisted living that pervades the rationale for this recommendation.

We support individuals' right to live in the least restrictive environment possible. We cannot support a statement that implies that all assisted living facilities are always less restrictive than all nursing homes. Without a common and meaningful definition of assisted living, we cannot agree to this conclusion, which is more a statement of faith than a statement of fact.

Moreover, our experience with the Nursing Home Pioneers confirms that many of the features that assisted living proponents claim most fervently for assisted living are in fact features of care that are implemented by Pioneer facilities under standards set by the federal nursing home reform law. We reject the majority's implication that innovation and good practices lie solely with assisted living.

Under current law, individuals have choice about where they will receive their healthcare. Consequently, the second sentence in the second paragraph of the Rationale states nothing unique. The distinction for purposes of these recommendations is that nursing facilities are entitlements under the Medicaid program, while assisted living is not. We also oppose the Cash and Counseling demonstration model, which would convert Medicaid into a "defined contributions" program, rather than a program of "defined benefits."

*Association of Health Facility Survey Agencies , Center for Medicare Advocacy , National Association of Local Long-Term Care Ombudsman Programs, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform , National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center*

**Affordability**

**A.02 Home and Community Based Waiver**

**Recommendation**

Continue to expand funding for the 1915(c) Home and Community Based Services waiver program to provide needed services.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

The 1915(c) Home and Community Based Services waiver is the primary Medicaid funding vehicle for low-income persons requiring assisted living services. However, in most states the waiver funding is quite limited and over-subscribed. As an intermediate strategy to a fully implemented consumer directed long-term care program (see Recommendation A.01) the federal government should encourage states to increase their 1915(c) programs.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for A.02**

1) We dissent. We support individuals' right to remain in their homes and communities. However, expanding Medicaid funding of assisted living through home and community-based waivers is not good public policy in the absence of meaningful quality of care standards. In order to be eligible for home and community-based waivers, Medicaid beneficiaries have sufficiently significant health care needs to require a nursing home level of care. Nursing home-eligible individuals should not be placed in assisted living residences that are neither staffed nor otherwise prepared to meet their needs. The majority recommendations do little to guarantee a high quality of care in assisted living

## Affordability

residences.

The expansion of waiver funding of assisted living services is also objectionable because other recommendations, specifically objected to below (e.g., A10 and A.20), would dismantle statutory and regulatory protections that Medicaid and HUD have had in place for many years.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy ,  
National Association of Local Long Term Care Ombudsman Programs, National  
Association for Regulatory Administration, National Association of State  
Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform,  
National Committee to Preserve Social Security and Medicare, National Senior  
Citizens Law Center*

2) We support this recommendation to provide an immediate, short-term solution for funding needed services for assisted living, but continued band-aid approaches such as this will not help to avert a growing crisis in long term care financing. It is important to understand that our current financing system, rooted in the Medicaid welfare program, will not withstand the huge influx of seniors in the coming decades. Therefore, it is imperative that a permanent comprehensive solution for the funding of the entire spectrum of long term care be developed. Research by the health policy experts at Abt Associates indicates that creation of an insurance-based, public/private program offers a viable alternative to today's unsustainable financing system. Additionally, there must be recognition of the need for personal and family responsibility in the planning for future payment of long term care. State and federal governments, in conjunction with providers of care and services, consumers, researchers, actuaries and other stakeholders should meet and develop a strategy to reach a permanent, multi-faceted solution.

Additional research should be done comparing the cost-effectiveness of in-home care services, assisted living care and services and nursing home care and services taking into account acuity levels and cognitive impairment of individuals.

*Catholic Health Association of the United States, Consumer Consortium on Assisted  
Living, National Center for Assisted Living, American Seniors Housing Association,  
American Association of Homes and Services for the Aging*

**Affordability**

**A.03 Additional Federal and State Funding for Affordable Assisted Living**

**Recommendation**

Additional federal and state funding shall be allocated to meet the needs for affordable assisted living.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Individuals with annual incomes below \$25,000 generally cannot afford to pay for assisted living privately. In fact, in 1997, 40% of all people aged 75 and older had incomes below \$10,000 per year. Nearly two-thirds had incomes below \$15,000 (US Bureau of the Census 1998). Further, demographic projections indicate that by 2035 the number of seniors in this county will nearly double as a share of the population. Demographic factors suggest that the need for affordable assisted living will not only continue but will likely increase. Federal and state funding will need to be increased to meet the need for assisted living for those who are moderate and low-income older seniors. This increased funding will need combine increased subsidies for housing costs as well as costs for services.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for A.03**

- 1) We dissent. The recommendation vaguely calls for additional public funding for assisted living.

**Affordability**

arguing, in support, only that older people cannot afford to pay privately for assisted living. We cannot endorse such a broad recommendation for public financing of assisted living when the quality standards approved by the majority are so general and illusive.

The workgroup was unable to reach consensus on a definition of assisted living. In addition, most of the recommendations provide only minimal standards for quality of care as well as minimal guidance on affordability. Many of the quality of care recommendations offer considerably less protection to residents than many states' current rules and guidelines for assisted living. States such as Colorado and Maryland, for example, establish additional staffing standards for facilities that are eligible to receive Medicaid reimbursement.

Without adequate quality standards, we cannot support such broad and open-ended public funding. We are particularly concerned that the recommendation could lead to public payment for a level of care that could essentially be nursing homes without quality of care standards.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy ,  
National Association of Local Long Term Care Ombudsman Programs, National  
Association for Regulatory Administration, National Association of State  
Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform,  
National Committee to Preserve Social Security and Medicare, National Network of  
Career Nursing Assistants, National Senior Citizens Law Center*

## Affordability

### A.04 SSI Payment for Assisted Living

#### Recommendation

State shall create a specific SSI "living arrangement" category that will provide SSI recipients living in assisted living a payment sufficient to cover the average unit and board costs (including overhead and profit) associated with developing and operating good quality assisted living projects.

#### Implementation

Guideline for State Regulation

#### Rationale

While Medicaid can pay for assisted living services for qualified individuals, room and board in assisted living shall be paid out of the individual's income. For many low-income older persons, their income is limited to SSI or an equivalent amount. The unsubsidized development costs for good quality assisted living projects usually exceed what can be supported by rents affordable to an individual at SSI income levels, even in states that offer SSI supplements. Additionally, the development subsidies that can make rents affordable to individuals at an SSI income level (e.g., low-income housing tax credits or other grant programs) are scarce.

In order to allow sufficient affordable assisted living to be developed to serve low-income individuals at SSI income levels, one of two approaches shall be used:

- Increase the development subsidies available to assisted living so rents may be reduced what is affordable at an SSI income level, or
- Increase individuals' capacity to pay the assisted living rent associated with unsubsidized development costs.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

#### Organizations Opposing This Recommendation

None

#### Organizations Abstaining From the Vote on This Recommendation



**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Affordability**

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American College of Health Care Administrators, Assisted Living Federation of America, National Association for Regulatory Administration

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**Supplemental Positions for A.04**

None Submitted

**Affordability**

**A.05 Government Reimbursement for Services and the Cost of Care**

**Recommendation**

Federal and state reimbursement for required and necessary care should meet the cost of care as required by the state defined program and to meet the principles of the Assisted Living Workgroup's definition of assisted living.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Many observers believe that federal and state reimbursements for assisted living services are often lower than the cost of providing high quality care. While the federal government requires that reimbursements be sufficient to provide access to care and to meet the costs of care, the requirement is not implemented forcefully. Rigorous federal and state methodologies should be developed and implemented to test adequacy. Adequacy should be defined as the costs of care and housing as required by the state program where those program requirements meet or exceed the requirements of the ALW. Where state programs do not exceed the standards defined by the Workgroup, the Workgroup's standards should be used to measure adequacy.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for A.05**

**Affordability**

1) We dissent because the recommendation would require public payments to meet "the principles of the Assisted Living Workgroup's definition of assisted living."

A state should pay an appropriate amount to meet the state's definition and requirements for assisted living. It should not make payments to meet an undefined set of "principles" that assisted living residences would not have to meet.

The workgroup did not develop a definition of assisted living and the majority's standards for state regulations are weak. The majority essentially permits each assisted living residence to define for itself which services it will provide and how it will provide them. In the absence of a meaningful definition and standards for assisted living, we cannot support a recommendation requiring full payment to provide unspecified services that would not be required.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsman Programs, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We support this recommendation but would provide the following clarifying and qualifying statements:

- The state and federal government need to be held accountable for assuring that the payments for services rendered are sufficient to cover the care being provided.
- Providers of services need to have the ability to protect and reject participation if the payments are not sufficient to provide the services rendered.

*National Center for Assisted Living, American Association of Homes and Services for the Aging, American Seniors Housing Association*

## Affordability

### **A.06 Medicaid Assisted Living Rate Setting Tool**

#### **Recommendation**

CMS shall create a model state rate-setting tool for assisted living services. The tool should be adaptable to state specific Medicaid programs as well as state regulatory requirements. The tool shall be designed to estimate the costs for delivering quality services in accordance with best practices operational models and include reasonable returns for providers. Inputs into the model should reflect regional costs throughout the state. The model should be used to reassess rates annually.

#### **Implementation**

Guideline for Federal and State Policy

#### **Rationale**

Assisted living cannot be a long-term care service choice for low-income persons with disabilities if there is not a Medicaid or state funded program available to subsidize the cost of those services. Even with a Medicaid or state funded program, quality assisted living services will not be available to low-income persons if the state reimbursement rate for assisted living does not cover reasonable costs and provide some return to providers.

Currently, states do not have a clear and proven methodology to set assisted living reimbursement rates that reflect the costs and incentives required to allow good quality providers to enter. Furthermore, state rates rarely have a mechanism to adjust rates rapidly in the face of an unusual price spike. Without adequate reimbursement and the added danger that cost will rise far more rapidly than state reimbursement, existing providers are very unwilling to take on publicly reimbursed residents and investors and lenders refuse to finance new projects. A fair and rational model needs to be developed to establish, implement, and periodically update required rates.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Home Care, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

#### **Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

#### **Organizations Abstaining From the Vote on This Recommendation**

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Affordability**

Assisted Living Federation of America

**Supplemental Positions for A.06**

1) We dissent. While we support a "model state rate-setting tool for assisted living services," we oppose adjusting Medicaid rates to meet "best practices operational models" because assisted living residences are not required to comply with "best practices operational models." Models are merely suggestions for residence performance. Medicaid rates should be adequate to meet statutory and regulatory requirements. They should not pay for standards that are neither met nor required to be met.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy ,  
National Association of Local Long Term Care Ombudsmen, National Association  
for Regulatory Administration, National Association of State Ombudsman  
Programs, National Citizens' Coalition for Nursing Home Reform, National  
Committee to Preserve Social Security and Medicare, National Network of Career  
Nursing Assistants, National Senior Citizens Law Center*

2) We oppose the specific language in this recommendation and would propose the following:  
A payment mechanism for services provided should be developed specifically for use with each state's Medicaid waiver program. This system should be developed by the state agency responsible for the Medicaid waiver program in collaboration with providers with input from stakeholders. The payment for services must assure the following:

- The payment is sufficient to cover the quality and quantity demanded by the client.
- The payment allows access to a variety of providers in all geographic locations.
- The payment is competitive in the overall marketplace.

*American Association of Homes and Services for the Aging, Catholic Health  
Association of the United States, National Center for Assisted Living, American  
Seniors Housing Association*

**Affordability**

**A.07 Retroactive Medicaid Payments in Assisted Living**

**Recommendation**

Like Medicaid benefits for nursing home care, Medicaid waiver benefits for a resident in assisted living should be retroactive to up to three months prior to the month the applicant submitted an application for Medicaid, provided that the resident was medically and financially qualified to receive services under Medicaid and received allowed Medicaid services. Retroactive coverage is not possible in some cases due to interpretations of Olmstead Letter No. 3, Attachment 3-a. CMS should issue a clarification, providing a procedure that protects the intent of Olmstead Letter No. 3, Attachment 3a, while allowing retroactive Medicaid payments for assisted living residents.

**Implementation**

Guideline for Federal Policy

**Rationale**

Medicaid benefits are offered to applicants in a nursing home who meet eligibility requirements by the first day of the month for which benefits are sought. Benefits may be also be approved for nursing home residents up to three months prior to the month of application, if the beneficiary was eligible during the "retroactive" period. For applicants requesting Medicaid waiver services, however, Medicaid coverage may not be available back to the month application or the three-month retroactive period. This is because under Olmstead letter No. 3, Attachment 3-a, the earliest date that benefits may be provided is the last date in which the following eligibility requirements have been met: basic Medicaid eligibility, medical level of care, determination that the applicant is in the group covered by the waiver, signature of a written document that the applicant chooses to be in the waiver, and the establishment of a written plan of care. These requirements make it difficult for an applicant to receive benefits as of the date of application or for retroactive periods.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Affordability**

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**Organizations Abstaining From the Vote on This Recommendation**

American College of Health Care Administrators

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**Supplemental Positions for A.07**

None Submitted

**Affordability**

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**A.08 Governmental Subsidies and Resident Income Calculation**

**Recommendation**

It should be clarified in all federal and state housing and service programs that when determining an individual's eligibility for federal or state housing and/or services programs, subsidies for one should not be counted as income for the other.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

In order for assisted living to be available to people with low-income, significant subsidies are required from multiple sources, including federal, state, and local governments. Under current regulations, the eligibility criteria for one program often requires counting subsidies from other programs as "income," thereby nullifying the benefits of those other programs, and making it impossible for a person to get the care he or she needs.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Gerontological Society, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, National Association of Home Care, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants

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**Supplemental Positions for A.08**

None Submitted



**Affordability**

**A.09 Tenant Service Payment and Housing Subsidy  
Income Calculations**

**Recommendation**

When an individual seeking admission to a subsidized housing program licensed as assisted living (or its equivalent) will pay privately for services, the amount that he/she will pay for services (e.g., health care, personal care, meals, home maker, transportation, activities) should be deducted from the resident's income before calculating eligibility for federal and state housing subsidy programs (e.g., tax credits, Section 8, HOME) and the resident's contribution toward rent.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Many individuals require services to avoid institutionalization in a nursing home. Often, an individual's income will be greater than what allows him or her to qualify for a housing subsidy program but insufficient to pay for necessary services and housing. In order to assist lower-income individuals to qualify for a residential setting, the service costs to be paid by a resident should be deducted from the resident's income before his/her financial eligibility and rent contribution are calculated.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Gerontological Society, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, National Association for Regulatory Administration, National Association of Home Care, National Committee to Preserve Social Security and Medicare

**Supplemental Positions for A.09**

**Affordability**

**A.10 Medicaid Program Rules: Family Contributions and Room and Board Maximums**

**Recommendation**

When an assisted living resident receives Medicaid support, family or other private contributions paid directly to a provider for additional services or amenities which are not covered by Medicaid should not be counted as income to the resident for the purpose of calculating Medicaid eligibility. A provider shall accept Medicaid payment, plus applicable beneficiary deductibles, as payment in full for all Medicaid covered services provided to those residents the provider has agreed to serve under the program.

States should set the maximum amount that providers participating in the Medicaid program may charge Medicaid residents for room and board. States shall establish maintenance allowances that permit residents to retain sufficient income to pay for room and board and personal expenses. States shall provide room and board subsidies for Medicaid eligible residents whose income is less than what is established by the state as a room and board payment amount.

The maximum room and board amount shall be established with stakeholder input and calculated to cover the reasonable costs of providing room and board as defined by the ALW recommendations without the assumption of housing or other subsidies. In cases where states do not require private rooms as recommended by the ALW, and the resident nonetheless desires a private room, states shall establish a reasonable maximum for such rooms and shall adjust the maintenance allowance to pay for it. Family or other private contributions should be permitted for any reasonable room and board costs not covered by subsidies and should not be counted as income to the resident for the purpose of calculating Medicaid eligibility.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Many residents of assisted living utilizing a Medicaid program may benefit from services or amenities available to them but not covered by Medicaid. These additional services and options are often beyond their ability to afford. In some instances, families of residents (or others) are willing to pay for these additional, non-Medicaid services or amenities. If direct payments from families (or others) to an ALR or other provider are counted as income to the resident, the added income could disqualify the resident for Medicaid. In order to allow a resident to benefit from additional, non-Medicaid reimbursed services or amenities, payments made by a family member, other person, or organization directly to a provider should not be counted as income to the resident for the purpose of Medicaid program eligibility determination.

By definition, Medicaid-eligible residents have almost no savings, and very limited incomes. To assure that all Medicaid recipients can afford room and board, states should set a maximum amount that a provider may charge residents participating in the Medicaid program and should establish a maintenance allowance that permits residents to pay for

## Affordability

room and board and personal expenses. To ensure participation by providers and access services by those residents participating in the Medicaid program, the maximum room and board amount should be based on the fair market costs, including an appropriate profit, of providing room and board services (as defined by the ALW). States should not factor in limited subsidy programs (e.g., low-income tax credits, Housing Choice Vouchers, etc.) when calculating the payment amount if these programs will not be available in sufficient quantity to meet the demand for assisted living by Medicaid eligible residents. States should provide a subsidy program (e.g., a supplemental payment to SSI) to allow individuals eligible for Medicaid assisted living services, but with incomes less than the established room and board payment standard, to pay the room and board charges while retaining an amount established for personal needs.

### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

### Organizations Opposing This Recommendation

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

### Organizations Abstaining From the Vote on This Recommendation

American Seniors Housing Association

### Supplemental Positions for A.10

1) We dissent. Although this recommendation contains several important protections, what is missing is a clear statement that "[t]he amount charged by an assisted living residence for room and board must not exceed the amount of income allocated to the resident by the Medicaid program." We proposed and supported such language, but it was not adopted by the majority.

By definition, Medicaid-eligible residents have almost no savings, and very limited incomes. Medicaid programs allow Medicaid-eligible residents to retain only a certain amount of income each month. For Medicaid-reimbursed assisted living to be affordable to Medicaid-eligible individuals, an assisted living residence's room and board charge must not exceed the resident's income allocation.

Room and board in an assisted living residence is not covered by Medicaid, and thus is not covered by the recommendation's requirement that an assisted living residence accept Medicaid

**Affordability**

reimbursement as payment in full for "Medicaid covered services." For assisted living truly to be affordable for Medicaid beneficiaries, the assisted living residence must be required to set the room and board charge at an amount that is no more than the resident's income allocation set by the Medicaid program.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long-Term Care Ombudsman Programs, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center*

2) When the payment is not sufficient to cover the room and board services, providers must maintain the right to determine whether they are able to accept or retain the residents. Requirements or limitations should not be developed that would limit or restrict family or other private supplementation.

*American College of Health Care Administrators, National Center for Assisted Living, American Seniors Housing Association*

## Affordability

### A.11 Third Party Service Payments and Housing Subsidy Income Calculations

#### Recommendation

When determining an individual's eligibility and rent contribution for a state or federal housing subsidy program, payments made by a private, third party (e.g., family member, charity, or non-governmental entity) to a provider for care services (e.g., health care, personal care, meals, home maker, transportation, activities) should not be considered income to that individual for the purposes of federal and state housing subsidy eligibility determination or rent contribution calculations. (E.g., tax credits, Housing Choice Vouchers/Section 8, HOME).

#### Implementation

Guideline for Federal and State Policy

#### Rationale

Individuals living in government-subsidized housing are low-income. When they need services to avoid institutionalization, they often need financial assistance to pay for those services. Public subsidies for services may be insufficient or unavailable, necessitating family and/or private charitable assistance to pay for services. However, it is not always clear whether family or charitable contributions to a resident's care shall be counted as resident income for the purpose of calculating eligibility for housing subsidy programs. If service payments from family or charities are counted as income, they may have the consequence of raising the resident's rental payments or disqualifying the resident altogether for the housing that they have made their home and hope to remain in through the use of services. Clarification is needed in all federal and state housing programs that service payments from family or other private sources that are paid directly to providers should not be counted as income to the resident for the purpose of calculating that individual's eligibility for the housing program or his/her rent contribution.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Gerontological Society, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Pioneer Network

#### Organizations Opposing This Recommendation

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of

**Affordability**

Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, National Adult Family Care Organization, National Association of Home Care

**Supplemental Positions for A.11**

1) We dissent. We agree that public payments for assisted living must be sufficient to pay for the services or housing that they are intended to cover. However, we strongly oppose allowing supplementation from families or other third parties, which this recommendation would permit.

The language of the recommendation allows payments by third parties for a broad range of services. It does not limit these payments in any way. We infer from the language of the Rationale – that "public subsidies for services may be insufficient or unavailable" [emphasis supplied] – that private payments would be permitted to supplement public payments for covered services. We object to such supplementation. The Medicaid program requires health care providers to accept the Medicaid rate as payment in full for covered services and prohibits facilities from requesting or accepting additional payments (i.e., supplementation) from family members or other third parties. Individuals choosing assisted living should not have to give up financial protections for residents and their families that the Medicaid program provides for any other Medicaid-funded service, including nursing home care.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

## Affordability

### A.12 Medicare & Medicaid Physician House Call Payments in Assisted Living

#### Recommendation

CMS and State Medicaid agencies should increase access to house calls by physicians for assisted living residents by updating their definition of assisted living and raising payments for house calls to assisted living residents.

#### Implementation

Guideline for Federal and State Policy

#### Rationale

Physician house calls to ALR residents are beneficial for many reasons, among them:

1. Allowing physicians to observe the resident in their home environment
2. Ease and cost to ALR and residents
3. Improving lines of communication between physician and ALR staff
4. Decreasing risk to cognitively impaired residents by not moving them from their structured environment

Assisted living residents may enter an assisted living residence with, or develop, functional impairments and chronic diseases that require active medical care management. It is difficult for many residents to travel to physicians' offices. Medicare and Medicaid house call reimbursements are currently inadequate to enable physicians to make house calls in assisted living.

Medicare residents living in their private homes have access to physician house call services. This is because of changes made to the Medicare fee schedule in 1998 that made provision of service economically feasible. To facilitate access to appropriate medical care in assisted living residences, Medicare and Medicaid should establish adequate definition and reimbursement rates for assisted living. Assisted living currently falls under the Medicare definition for domiciliary care, CPT codes 99321-99333. For similar services in private homes, physicians can bill under Medicare house call codes 99341-99350.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

#### Organizations Opposing This Recommendation

**Affordability**

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Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Committee to Preserve Social Security and Medicare

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**Supplemental Positions for A.12**

None Submitted



## **Affordability**

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### **A.13 Transportation**

#### **Recommendation**

Federal and state programs subsidizing assisted living services shall include accessible transportation services for personal and medical needs as a required service within the basic rate. Providers may provide or contract for transportation services.

#### **Implementation**

Guideline for Federal and State Policy

#### **Rationale**

Transportation is a critical need in affordable assisted living. Without transportation services, residents can not get to medical appointments, shop for personal needs, or maintain community or cultural contacts. Transportation costs are often not included in publicly subsidized service packages in assisted living and may not be available through other subsidies. Including them in basic assisted living packages, with appropriate reimbursement, will assure that publicly subsidized residents have access to transportation for medical, personal, and social needs.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

#### **Organizations Opposing This Recommendation**

None

#### **Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, American Seniors Housing Association, National Association for Regulatory Administration

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#### **Supplemental Positions for A.13**

None Submitted

**Affordability**

**A.14 HUD and HHS Collaboration to Deliver Affordable Assisted Living**

**Recommendation**

HUD and HHS should collaborate to craft and fund specific programs to blend housing and service subsidies to enable low-income persons to have access to high quality, affordable assisted living projects.

**Implementation**

Guideline for Federal Policy

**Rationale**

Assisted living is a unique model of residentially based long-term care services for frail and cognitively impaired persons. Assisted living requires a distinct combination of physical amenities and service programs to operate successfully. To serve low-income older persons, an affordable assisted living project will typically combine a variety of federally funded housing and services programs. Negotiating these programs is complex and there are areas where they either do not work together well or one is insufficient. Collaboration by HUD and HHS to enable programs within their respective jurisdictions to work better to fund assisted living would remove obstacles, encourage provider participation in affordable assisted living programs, and maximize the efficiency of limited public resources. Among the issues discussed by HUD and HHS should be income and asset related eligibility standards.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of State Ombudsman Programs

**Organizations Abstaining From the Vote on This Recommendation**

National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Affordability**

**Supplemental Positions for A.14**

1) We support collaboration by HUD and HHS to develop and fund programs that combine housing and services for low-income people. We object to the first two sentences of the Rationale. The assisted living workgroup was unable to reach consensus on a definition of assisted living and the majority's recommendations do little to explain what assisted living facilities can and cannot do. As a consequence, it is inaccurate and misleading to say, as these sentences do, that assisted living is a "unique" type of residential living or long-term care or that there is any "distinct combination" of amenities and services that defines assisted living.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy ,  
National Association for Regulatory Administration, National Citizens' Coalition for  
Nursing Home Reform , National Committee to Preserve Social Security and  
Medicare , National Senior Citizens Law Center*

**Affordability**

**A.15 Federal Housing Subsidy Programs and Assisted Living**

**Recommendation**

Federal housing subsidy programs, both tenant based and project based, should not change their occupancy standards or requirements for amenities when they are used for assisted living.

**Implementation**

Guideline for Federal Policy

**Rationale**

This recommendation seeks to clarify the principle that occupancy standards governing federal housing programs should not be waived simply because the person receiving the housing subsidy has a disability. Occupancy standards for housing subsidy programs, including those administered by HUD, the Rural Housing Administration, and the Internal Revenue Service (the tax credit program) generally require that housing units under their jurisdictions provide units that are shared only by choice. Often, shared units are for married couples or siblings. Rules already clarify that a caregiver may also share the unit. Further clarification will be needed in circumstances where couples are same sex, unmarried, or the resident desires a roommate.

Similarly, occupancy standards also cover the amenities, such as kitchens and bathrooms required for the recipients of housing subsidies. The recommendation clarifies that these requirements should not be waived in those housing projects offering assisted living services. These agencies may need to issue further clarification regarding circumstances under which stoves or other equipment may be disconnected for safety reasons.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Affordability**

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Assisted Living Federation of America

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**Supplemental Positions for A.15**

None Submitted

## Affordability

### **A.16 Federal Housing Subsidies and the Cost of Common Facilities in Assisted Living**

#### **Recommendation**

Federal housing assistance programs, both tenant and project based, should recognize the cost of common areas and service delivery support areas for assisted living. Subsidy amounts (e.g., HUD vouchers payment standards/fair market rents, operational subsidies etc.) available to assisted living projects should be adjusted to reflect these additional costs.

#### **Implementation**

Guideline for Federal Policy

#### **Rationale**

Assisted living programs provide long-term supportive services to frail and cognitively impaired individuals in a residential environment. In order to provide these services (including socialization for isolated persons) in a safe, effective, and economical way, assisted living projects require certain common areas, support spaces, and security systems that exceed those required in independent living projects. Often these requirements are state mandated. These additional requirements may include an activity room(s), dining room, commercial kitchen, bathing room, medication storage room, clinics staff offices, housekeeping room, interior circulation, resident wandering prevention systems, added life safety systems and standards, etc.

All of these additional elements add to the cost of construction and operations. However federal housing assistance programs currently available to assisted living residents are designed primarily for independent housing and are not structured to factor in these additional costs. The lack of specific housing programs, or specific rates within housing programs, designed to meet assisted living's cost structure often makes affordable assisted living projects infeasible to develop or operate. Federal housing subsidy rates should be adjusted for assisted living in order to make affordable assisted living a readily available option for persons needing residentially based long-term care.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association for Regulatory Administration, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, Pioneer Network

#### **Organizations Opposing This Recommendation**

Center for Medicare Advocacy

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Affordability**

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**Organizations Abstaining From the Vote on This Recommendation**

National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

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**Supplemental Positions for A.16**

None Submitted

## Affordability

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### A.17 HUD Assisted Living Conversion Program

#### Recommendation

Continue HUD assisted living conversion program (ALCP). Continue to provide federal funding to pay for structural conversion costs within the HUD budget. However, provide line item for conversion costs separate from the 202 budget line item to eliminate confusion regarding increases/decreases in 202 construction funding.

#### Implementation

Guideline for Federal Policy

#### Rationale

The HUD ALCP program offers tremendous promise to bring needed services and physical amenities to existing projects where residents have aged-in-place and are in jeopardy of having to move to institutional care. It has gotten off to a slow start because of the complexity of combining services and housing programs, but it is now building momentum. The program should be continued at current funding levels to provide it a full opportunity to demonstrate its value.

The funding for the program should, however, be provided in a separate line item from the HUD Section 202 budget line item in order to avoid confusion about the relative increases or decreases in the Section 202 construction funding budget.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Committee to Preserve Social Security and Medicare, National Adult Family Care Organization, National Conference of Gerontological Nurse Practitioners, Pioneer Network

#### Organizations Opposing This Recommendation

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

#### Organizations Abstaining From the Vote on This Recommendation

None

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#### Supplemental Positions for A.17



**Affordability**

1) We dissent. The HUD assisted living conversion program should not be continued in the absence of meaningful and enforceable standards for assisted living residences that HUD conversions would support. Federal money should be restricted to residences that meet specific standards that address, at a minimum, staffing ratios and qualifications, participation by health care professionals, and life safety code. Federal money should also be limited to private units, as described in the defeated recommendation A.27 (private units, including, at a minimum, a private toilet with lavatory and shower or tub, and a kitchenette with sink).

The majority's recommendations inadequately describe standards of care for assisted living residences. They do little more than identify areas where guidance for regulatory standards is important; they frequently fail to provide any specific guidance. The result is many recommendations that are meaningless and content-free (e.g., O.02 (National Fire Protection Association Requirements), O.06 (Food and Nutrition), M.07 (Medication Assistive Personnel job description), D.07 (Hospice Care)).

*Association of Health Facility Survey Agencies , Center for Medicare Advocacy , National Association of Local Long-Term Care Ombudsman Programs, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center*

**Affordability**

**A.18 Assisted Living Conversion Program for Public Housing**

**Recommendation**

Congress should enact a comprehensive program for funding the conversion of public housing projects for older persons to assisted living. Such a program should include: a) capital funds for construction, modernization, and modifications; b) service coordinators and other management and maintenance personnel; and c) enhanced congregate housing funds for services in public and federally assisted housing not usually funded under Medicaid and other services programs.

**Implementation**

Guideline for Federal Policy

**Rationale**

Public housing provides shelter to more older persons than any other federal project-based housing program. In addition, many public housing projects for the elderly also house large numbers of younger persons with disabilities. The residents in public housing projects tend to have lower incomes than other housing programs. Many of the buildings have large numbers of efficiency units that have been difficult to rent as regular apartments. Such projects can be good candidates for conversion to assisted living, either in whole or in part.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Association of Health Facility Survey Agencies, National Adult Family Care Organization, National Association of Local Long Term Care Ombudsmen, National Committee to Preserve Social Security and Medicare

**Supplemental Positions for A.18**

## **Affordability**

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### **A.19 Affordable Assisted Living Demonstrations in Subsidized Housing**

#### **Recommendation**

Create affordable assisted living demonstrations in subsidized housing for residents who can no longer reside safely in their current living environment, meet Medicaid financial eligibility standards, but do not meet Medicaid nursing home level of care criteria.

#### **Implementation**

Guideline for Federal and State Policy

#### **Rationale**

Many people living in subsidized housing have aged-in-place. Often these residents are just barely hanging onto their independence through a combination of self-denial, formal, and informal care. The subsidized housing communities are often ideal candidates for full or partial conversion to affordable assisted living due to their populations' care and economic needs, the concentration of need, and the adaptable environments they offer.

While many or most of the residents meet Medicaid financial eligibility standards, some do not meet the state's Medicaid nursing home level of care criteria. For disabled residents, both those who do and do not meet Medicaid care eligibility standards, the lack of an assisted living program often means displacement. An assisted living demonstration would collect valuable information to inform the discussion regarding what programs are required to avoid displacement, the individual and community benefits of preventing displacement, and the costs and cost savings associated with preventing displacement for both Medicaid eligible and service needy, but ineligible, residents.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, Paralyzed Veterans of America, National Adult Family Care Organization, Pioneer Network

#### **Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

#### **Organizations Abstaining From the Vote on This Recommendation**

National Network of Career Nursing Assistants

**Affordability**

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**Supplemental Positions for A.19**

1) We dissent. Many programs already bring additional services to tenants of subsidized housing. In the absence of a meaningful definition of assisted living, it is not clear what "assisted living" services are contemplated by this recommendation that are not already and otherwise available.

As stated earlier in our dissent to A.01, we, of course, support development and implementation of a national long-term care policy that gives individuals (with various needs) a variety of choices about where and how to receive long-term care services that meet defined standards of care commensurate with assessed level of need.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsman Programs, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

**Affordability**

**A.20 HUD Housing Choice Voucher Rules in Assisted Living**

**Recommendation**

HUD shall modify existing program requirements of Section 8 Housing Choice Vouchers in order for them to become more compatible for use in assisted living residences. Specifically, HUD needs to:

a. HAP Contract and Services: Amend the HAP contract to allow assisted living providers to require service participation and service payment (as required for other residents in the ALR), outside of the rent contract, as a condition of tenancy by modifying Part C Section 6

b. Maximum Resident Contribution: For residents receiving Medicaid waiver funding, immediately amend the Section 8 rule that limits a resident's payment for rent from a maximum of 40% to 65% of his/her income.

c. Resident Contribution Study: Conduct a study within the next two years to determine what the appropriate maximum resident contribution for rent should be in assisted living and adjust the Section 8 rules as appropriate when that percentage of income is determined. Residents who use Section 8 to rent an assisted living unit under the temporary 65% rule may continue to pay the percentage of their income established under that temporary rule as long as they continue to reside in the unit or program where they lived at the time of a new maximum contribution rule was established by HUD.

d. Third Party Contributions: For purposes of facilitating use of vouchers in assisted living settings, HUD should issue a formal position and/or policy clarification stating that financial contributions toward Assisted Living services from family members and other third parties are not considered as income.

e. Section 8 Assisted Living Designation: States and local housing authorities should be encouraged to designate a portion of Housing Choice Vouchers specifically to assisted living, including project based vouchers and/or a set aside for emergency use.

**Implementation**

Guideline for Federal Policy

**Rationale**

HAP Contract and Services

The Housing Choice Voucher Program (formerly known as Section 8 Tenant Based Rental Assistance) provides eligible low-income Americans with a method of obtaining affordable housing. It helps families lease privately owned rental units from participating landlords. The vouchers are generally administered by the local public housing authority or other public entity.

The Housing Assistance Payments (HAP) Contract is a mandatory agreement between the public housing agency and the owner of a unit occupied by an assisted family when the Housing Choice Voucher is utilized. Part C, the Tenancy Addendum to the HAP Contract

## Affordability

contains language that has caused some assisted living homes to decline to participate in the Housing Choice Voucher program. Part C, Section 6b reads as follows: "The owner may not require the tenant or family members to pay charges for any meals or supportive services or furniture which may be provided by the owner. Nonpayment of any such charges is not grounds for termination of tenancy." Similar language is included in a HUD Notice issued in 2000 to address the use of Housing Choice vouchers in assisted living. This policy may have arisen to discourage mandatory meal programs in independent senior housing, a common practice in the 1980's.

Some assisted living home administrators fear that if they accept somebody using a Housing Choice Voucher, the person could refuse to pay for their meals or services, which may be required by state statutes and/or regulations or required to maintain the viability of an assisted living service program. This could potentially create a financial and regulatory challenge for the administrator.

Vouchers are not yet widely used in assisted living, however it is a worthy part of the puzzle for providers attempting to cobble together assisted living programs affordable to very low-income persons. Voucher holders are required to spend a portion of their income on rent; services and meals cannot be paid for using Section 8 funds.

### Maximum Resident Contribution

The HUD Housing Choice Voucher (Section 8) currently requires eligible recipients to contribute thirty percent of their income to their rent payment, with the HUD Housing Choice Voucher (Section 8) paying the difference between their contribution and HUD's established Fair Market Rent (FMR) for their unit type and location. If the FMR payment rate is insufficient to pay for a unit, the resident may currently supplement the voucher payment with up to an additional ten percent of his/her income. To maximize a resident's choice in selecting an assisted living residence in the next two years, HUD should temporarily raise the Section 8 forty percent rule for assisted living residents to sixty-five percent. This is the percentage of income that is allowed for rent (and any services included in the rent) under the Senator Dodd's proposed assisted living tax credit bill S1886.

### Resident Contribution Study

During the two year temporary increase, HUD shall study how much income a resident in assisted living needs to maintain for other needs and establish a revised maximum rent contribution for residents in assisted living as necessary. In order to allow residents and providers to make informed decisions during the temporary 65% rule, any new cap implemented by HUD shall grandfather the 65% Section 8 voucher rules for those residents and providers enrolled during the temporary contribution period.

### Family Contributions

Assisted living services are required to support the needs of many low-income residents eligible for Section 8. Some of these eligible residents will receive family support to pay for assisted living services as allowed by Medicaid or when they cannot access or utilize Medicaid funding. Family contributions together with the Section 8 subsidy often allow a resident to piece together enough resources to cover the room, board, and services charges.

## Affordability

in assisted living. If the family contribution for services counts as income, the resident's income available for service and food payments will be reduced, and in the worst case, their Section 8 subsidy will be revoked. This works against the public's and the resident's interests by making assisted living more difficult to afford, potentially eliminating a residential alternative to institutional care for these residents.

### Section 8 Assisted Living Designation

Due to governmental subsidy structures, persons with low-incomes may require a Section 8 voucher to afford the rental component of assisted living charges. To prevent persons from going without needed services or from being placed in a nursing home unnecessarily Section 8 certificates shall be available when the person's need arises. Because this need often develops from an unpredictable crisis, Section 8 vouchers shall be available without waiting list. To accomplish this, a Section 8 set aside should be established for individual who need assisted living services.

### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Home Care, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

### **Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

### **Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, National Adult Family Care Organization, National Association of Social Workers

### **Supplemental Positions for A.20**

1) We dissent. This recommendation dismantles protections that HUD has had in place for tenants for many years, particularly in its discussion of the Maximum Rental Contribution (#b and #c). The recommendation immediately increases the amount of income that a tenant could be required to pay for a housing subsidy from 40% of his/her income to 65%. The recommendation then calls for a study to determine the appropriate percentage of income to be contributed to rent but says that if the study finds that a percentage lower than 65% is found to be appropriate, tenants admitted under the 65% rule would nevertheless be required to continue paying the 65%. We object to (1) raising the percentage ceiling from 40% to 65% before conducting a study; and (2) continuing the 65% contribution rate for tenants admitted under the 65% rule if the HUD study determines that a lower

**Affordability**

percentage would be appropriate.

We also strongly object to the family contributions (#d) authorized by this recommendation. The recommendation calls for modification of the HAP contract to permit housing providers to require service participation as a condition of tenancy. Residents without sufficient income to pay for services, and ineligible for Medicaid or unable to use Medicaid, would have no choice but to use family contributions. The recommendation recognizes residents' need to rely on family supplementation and provides that family contributions would not count as income to the resident. We support having public payment be sufficient to pay for assisted living. We do not support government subsidies to programs and entities that rely on family supplementation.

By way of contrast to this recommendation, the Medicaid program requires health care providers to accept the Medicaid rate as payment in full for covered services and prohibits facilities from requesting or accepting additional payments (i.e., supplementation) from family members or other third parties. Individuals choosing assisted living should not have to give up financial protections for residents and their families that the Medicaid program provides for residents of other residential long term care settings such as nursing homes.

While we do not oppose some revisions to the HAP Contract and Services, the recommendation (#a) includes no limitations on what level of participation and payment a HUD provider could demand with respect to services. Although we understand the majority to argue that a hallmark of assisted living is residents' ability to pick and choose the services they want and will purchase, the language of the recommendation appears to give unlimited control to the assisted living residence.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsman Programs, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center*



## **Affordability**

### **A.21 LIHTC QAP & Set Aside for Affordable Assisted Living**

#### **Recommendation**

State agencies administering the current 9% low-income housing tax credit program (LIHTC) should review their qualified allocation plan and eliminate any barriers it contains that will prevent AL from achieving a competitive score. To promote the development of affordable assisted living serving the lowest-income, state agencies should create a set-aside for affordable assisted living programs serving Medicaid eligible residents. The amount of the tax credit set-aside should be designed to meet the identified needs for affordable assisted living. Non-profit assisted living projects that do not receive funding under the assisted living set aside should be allowed to compete in the general non-profit set-aside.

#### **Implementation**

Guideline for State Policy

#### **Rationale**

LIHTCs are a primary resource in creating affordable assisted living, providing substantial and difficult to obtain capital investment. LIHTCs allow a project to reduce or eliminate project debt, providing a project subsidy that reduces rent to a level affordable to persons with low-incomes. Without access to LIHTC, it is very difficult to develop a project to serve persons with income at or near SSI payments.

Assisted Living programs often have difficulty competing for LIHTC due to state qualified allocation plan (QAP) scoring systems. States revise their QAPs each year and may choose to recalibrate the scoring system. The QAP in each state should be reviewed and modified to allow assisted living to score in a competitive range with all other projects. Moreover, to encourage the development of assisted living that serves residents with the lowest incomes, state agencies should provide a LIHTC set-aside for assisted living. A set-aside establishes a pool of tax credits that may only be awarded to a project meeting the set aside guidelines. Set-asides encourage people to submit applications for projects conforming to the guidelines because competition is reduced and is limited to like project eliminating scoring advantages of particular project types. Set-aside funds that are not utilized are returned to the general LIHTC pool.

In at least one state that created an assisted living set-aside, the QAP provided that assisted living projects (non-profit and for-profit) would compete against each other in for the set-aside and those not chosen would automatically compete in the more competitive for-profit category. This effectively limited assisted living tax credit funding for non-profits to one project per year. Because of the great need for assisted living that is affordable to those with the lowest-incomes, non-profits should be allowed to compete in the less competitive assisted living and non-profit set-asides.

#### **Organizations Supporting This Recommendation**

**Affordability**

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AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Association of Health Facility Survey Agencies, National Adult Family Care Organization, National Association of Local Long Term Care Ombudsmen, National Committee to Preserve Social Security and Medicare

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**Supplemental Positions for A.21**

None Submitted

## Affordability

### **A.22 Assisted Living Tax Credit**

#### **Recommendation**

Create a special low-income housing tax credit (LIHTC) for assisted living. Incorporate the following provisions:

- Create program guidelines that specifically acknowledge and allow for the health care and service component of assisted living.
- Create a higher credit amount for assisted living (providing a higher tax credit calculated on the qualified basis).
- Provide for a shorter-term compliance period for investors to mitigate the long-term Medicaid and market risks.

Allocate tax credits outside of the current caps in order to avoid competition with other housing options and provide sufficient credits to develop the volume of affordable assisted living required to serve the demand. New tax credit allocations could be set based on projected budget savings from nursing home diversions.

#### **Implementation**

Guideline for Federal Policy

#### **Rationale**

The current LIHTC program does not fit assisted living well. Investors and underwriters are uncertain about program compliance due to health care services provided. They are also concerned about the stability of Medicaid funding source and the long-term business risks Medicaid funding creates. Both of these issues raise the risk of a project default, potentially resulting in severe financial consequences for investors. For the LIHTC program to attract investors to assisted living credits, a new program needs to be structured to account for the qualities and risks of assisted living. These changes are required in order to attract investors to assisted living and deliver adequate subsidy to the project after investors discount the credits for assisted living's operational risk.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

#### **Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform.

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**Affordability**

National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for A.22**

1) We dissent. This recommendation is focused on making affordable assisted living as risk-free and financially advantageous for developers as possible. While we recognize that affordable assisted living will not be built unless developers are willing to build it, we cannot support a recommendation that focuses exclusively on developers' desire to avoid financial risk and that puts developers' interests in safe profits over Medicaid beneficiaries' need for housing and health care.

This recommendation creates an enhanced tax credit for developers of assisted living (second bullet) and shortens the time period for developers' obligation to provide housing to poor people (third bullet). Specifically, this recommendation would allow developers of assisted living to get more financial benefit, while providing less service, than developers of other types of low-income housing. Consequently, the enhanced tax credits supported by this recommendation would not result in the development of a meaningful amount of affordable assisted living. Assisted living developers would essentially be receiving higher tax credits for providing less service.

In addition, there would be no quality control over the assisted living built with this enhanced tax credit. The majority's general recommendations for quality standards for assisted living residences are weak and minimal. This recommendation includes no additional or more specific quality standards that assisted living residences would be required to meet in order to qualify for enhanced low-income housing tax credits. As a result, this recommendation would encourage the development of assisted living residences of dubious quality.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy ,  
National Association of Local Long Term Care Ombudsman Programs, National  
Association for Regulatory Administration, National Association of State Long-Term  
Care Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform,  
National Committee to Preserve Social Security and Medicare, National Senior  
Citizens Law Center*

**Affordability**

**A.23 Advisory Boards for Government Initiative in Affordable Assisted Living**

**Recommendation**

State or Federal Agencies should place priority on designing affordable assisted living initiatives. Governments shall have an inclusive advisory board (e.g., consumers, advocates, providers, and related professionals) working with the agency throughout the process. Affordable assisted living initiatives include, but are not limited to, regulations, waiver programs, and state plan services.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

State and federal programs impacting or providing assisted living are often constructed without consumer, provider, and advocate input throughout the process. The programs often meet with significant opposition when released for public comment due to the lack of public input during the design period. The late stage modifications brought about during the public comment period often lead to awkward compromises, providing convoluted or imperfect remedies to a program's structural deficits. State and federal programs would benefit from consumer, provider, and advocates input from the start of program design in order to craft rational systems meeting all stakeholders' needs.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Association for Regulatory Administration, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for A.23**

## Affordability

### A.24 Aging Network Funding for Training

#### Recommendation

Provide federal and state funding to develop and support ongoing training for staff of the Aging Network who provide information and assistance to consumers about choices and decisions regarding assisted living and other long-term care options. At a minimum, training should include: information about what housing and services options are available, eligibility requirements for programs available to assist with the costs of assisted living, the assistance available to pay for services, and other referral resources available in the community that can assist with decision-making.

#### Implementation

Guideline for Federal and State Policy

#### Rationale

Assisted Living is an important component of the long-term care system and may become an option or necessity for many consumers during their lifetime. It is imperative, therefore, that potential consumers seeking information about long-term care including assisted living, obtain it from persons or entities that are knowledgeable about what options are available to consumers, the basic eligibility requirements of the programs that are in existence to offer assistance with the costs of assisted living, and the possible avenues a consumer may explore when considering assisted living.

Staff who receive training and regular updates on this information will be a valuable resource to both consumers and their representatives as well as to the network of assisted living programs and services in the state or community in which they are located. Trained staff can help prevent misconceptions about what programs are available and the eligibility requirements of those programs and can also assure that programs and services are represented accurately to consumers and their families.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Social Workers, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

#### Organizations Opposing This Recommendation

None

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**Affordability**

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**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, National Adult Family Care Organization,

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**Supplemental Positions for A.24**

None Submitted

**Affordability**

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**A.25 Paper Work Burden of Governmental Programs in Assisted Living**

**Recommendation**

Governmental agencies providing support to affordable assisted living projects should develop unified reporting documents and procedures where appropriate to reduce the paperwork burden on projects.

**Implementation**

Guideline for Federal and State Policy

**Rationale**

Governmental programs, whether state or federal, providing financial assistance to assisted living facilities and for services provided, frequently require separate and often duplicative paperwork and reporting requirements. Because of the burden of completing multiple reports and multiple monitoring requirements, assisted living projects are often reluctant to participate in programs that promote affordable assisted living.

All programs should work together to develop and require uniform and streamlined reporting and monitoring processes so as to eliminate duplication and promote information sharing to the extent permissible.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Gerontological Society, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, National Association for Regulatory Administration, National Association of Home Care, Association of Health Facility Survey Agencies

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**Supplemental Positions for A.25**



**Affordability**

**A.26 Food Stamps Usage in Assisted Living**

**Recommendation**

USDA should provide clarification and guidance to their field offices stating that food stamps may be used by income eligible households residing in assisted living to purchase meals prepared by the assisted living residence and served in a communal area. If a change in the Food Stamp Act is required to provide this guidance, Congress should amend the Act as required.

**Implementation**

Guideline for Federal Policy

**Rationale**

Assisted living is housing with services. Low-income residents in assisted living often do not have sufficient income to pay the operator for rent and prepared meals, yet they need the prepared meals to maintain their health and functioning. Food stamps can and do play a critical role in subsidizing meals for low-income assisted living residents in some states. Unfortunately, USDA field office interpretations vary on whether income eligible assisted living residents are eligible "households" and if they are, whether they may use food stamps to purchase meals prepared by the residence. USDA should clarify at the national level that income eligible assisted living residents qualify to receive food stamps and that the food stamps may be used to purchase meal prepared by the ALR and served in a communal setting. If USDA feels that a change in the Act is required to allow food stamp to be used by income qualified assisted living residents, USDA should seek the required changes to the Act.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Affordability**

**Supplemental Positions for A.26**

1) We oppose this recommendation. In general, people who live in nursing homes and similar facilities where meals are provided by the facility are not eligible to participate in the food stamp program. 7 C.F.R. §273.1(b)(6). We do not support creating an exception in federal law for assisted living, particularly given the nebulous definition and weak recommendations set forth in the report.

We do support assisted living residents being able to use Food Stamps to purchase food that they cook and consume in their private units. However, assisted living residences should not deny residents congregate meals or discourage residents from eating congregate meals or pressure residents into using Food Stamps and preparing their own food when they can no longer do so.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long-Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) The undersigned strongly support Affordability Recommendation A.06 as written for the following reasons:

- Many states have programs that will pay for assisted living services. However, the state subsidies generally do not cover raw food costs or rent (e.g., Medicaid waiver programs).
- Rent and food costs for low-income people must generally be covered out of a resident's SSI payment. SSI payments are almost always insufficient to pay rent costs alone unless a project has received very substantial development subsidies, subsidies that are available to very few projects.
- Even with very substantial development subsidies, rent charges necessary to support the project's debt and on-going costs (e.g., utilities, maintenance) often leave the residents with less income than is required to pay for the raw food costs.
- Food stamps can play an important role in subsidizing the raw food costs for residents without sufficient income to meet rent and food costs.
- Clarification is needed for the current USDA interpretation of assisted living as an "institutional" setting (residents of institutions are not eligible for food stamps) and whether certain categorical eligibility provisions for food stamp recipients override the institutional prohibition.

USDA clarification of current assisted living residents' eligibility for food stamps and, as required, rule or legislative changes to allow assisted living residents to qualify for food stamp assistance would provide much needed assistance to low-income residents and put assisted living on the same footing as other residential options for older persons.

*AARP, Consumer Consortium on Assisted Living, NCB Development Corporation, National Center for Assisted Living, National Multiple Sclerosis Society*

***Topic Group Recommendations  
That Did Not Reach Two-Thirds Majority***

***Affordability***

*The following recommendations did not reach a two-thirds majority of the ALW. The recommendations showing a voting record were unable to reach two-thirds majority at the final vote. The recommendations that do not show a voting record were unable to reach two-thirds majority during the development process:*

**Affordability**

**A.27 Federal Development Subsidies and Private Units 2/3 Maj. Not Reached**

**Recommendation**

Federal programs subsidizing assisted living new construction or conversion should require private units, including, at a minimum, a private toilet with lavatory and shower or tub, and a kitchenette with sink. Subsidy amounts should be sufficient to pay for the private unit requirement.

**Implementation**

Guideline for Federal Policy

**Rationale**

Federal housing programs serving older persons require the provision of full private apartments with private toilets, bathing capacity, and kitchen or kitchenettes with cooking capacity. Older persons should not have to forego those basic amenities simply because they have a disability.

At the same time, the Assisted Living Workgroup recognizes that subsidized housing that is built as assisted living or converted to that purpose will have to make accommodations and adaptations to serve persons with disabilities. For example, more common space may be required to offer services. A kitchenette should include, at a minimum, a sink, a food preparation and storage area, a small refrigerator, and a microwave oven. For residents who cannot operate such appliances safely, the housing provider should have a policy and procedure for disconnecting them.

Similarly, individual units may have to be adapted to allow for different living arrangements. While individuals should not be forced to share rooms with a stranger, some may prefer to share an apartment for various reasons—for example, sharing with a spouse, a friend, a domestic partner, or a caregiver. When requested by the resident, sharing accommodations should be permitted and facilitated.

**Organizations Supporting This Recommendation**

No Vote Recorded

**Organizations Opposing This Recommendation**

**Organizations Abstaining From the Vote on This Recommendation**

**Supplemental Positions for A.27**

1) We support this failed recommendation as written.

*AARP, American College of Health Care Administrators, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social*

**Affordability**

*Security and Medicare, National Network of Career Nursing Assistants, National Association of Social Workers, National Senior Citizens Law Center*

2) The substance of this recommendation is dealt with in Recommendation A.15, "Federal Housing Subsidy Programs and Assisted Living." The occupancy standard in federal housing programs is that units are shared only by choice. Most units of subsidized housing occupied by older persons are single person occupancy. The organizations listed below believe these occupancy standards should not be waived when assisted living services are offered in subsidized housing. A person should not be forced to share a housing unit with a stranger simply because they have a disability.

*AARP, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

**Affordability**

**A.28 Affordable Assisted Living Liability Insurance**

**2/3 Maj. Not Reached**

**Recommendation**

State and federal governments in conjunction with relevant stakeholders shall research the causes for the increased cost of liability insurance in AL to determine appropriate solutions to ensure that assisted living is affordable and appropriate insurance is accessible.

**Implementation**

Further research followed by state and federal policy change.

**Rationale**

The increased cost of general and professional liability insurance is directly impacting the availability of affordable assisted living services. Possible areas to investigate for solutions include but should not be limited to the following:

1. Develop an experience-based rating for ALRs. That is, rates should be reflective of both ALR vs. nursing home experience and rates should be experience-based by ALR. In other words, those ALRs with good claim histories would pay a lower premium than ALRs with poor claim histories.
2. States and insurance commissioners should work creatively with providers and insurers to develop alternate models of general and professional liability insurance.
3. Developing and implementing comprehensive quality improvement and risk management protocols.

The cost of general and professional liability insurance for assisted living residences has increased dramatically during the past several years. These increases have two direct impacts on assisted living:

1. In private pay assisted living residences, the increased costs are passed to the resident. This may have the effect of making previously moderately priced assisted living too costly for some individuals.
2. In assisted living residences (ALR) that participate in the Medicaid-waiver program, reimbursement has not increased to reflect increased costs related to liability insurance. The provider shall absorb those costs and the net effect may be that the ALR will choose to cease providing services under the Medicaid waiver program. An additional factor is the availability of insurance. In one state the highest licensure level was required of ALRs who chose to participate in the Medicaid waiver program. Providers with that highest license level (which had increased requirements and also allowed for increased services to be offered) have been either unable to obtain liability insurance or the cost is prohibitive. That state has been forced to lower the licensure level for Medicaid waiver providers to ensure access for Medicaid waiver residents.

This recommendation is not intended to take a position on tort reform.

**Organizations Supporting This Recommendation**

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**Affordability**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for A.28**

1) We oppose this failed recommendation. We oppose this recommendation because of the highly politicized discussion at the present time as to the causes of the increased costs of premiums for liability insurance. Although we appreciate the final sentence of the rationale – that the recommendation “is not intended to take a position on tort reform” – we cannot support a recommendation that singles out the high costs of insurance as a threat to affordable assisted living. This recommendation is beyond the scope of expertise of the Assisted Living Workgroup.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsman Programs, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center*

**Affordability**

**A.29 Unit Hold**

2/3 Maj. Not Reached

**Recommendation**

Resident's units in an ALRs are their home. As such, their unit shall be held for them during temporary absences as long as the ALR fees continue to be paid. To make this possible for residents whose room, board, or services are paid by a government entity, the following government payment policies shall be integrated into reimbursement programs

Housing and board fees: The resident and any government entity that subsidizes the resident's rental payment, continue to pay his/her full share. The ALR may initiate discharge proceedings in instances of nonpayment.

Health or personal care fees: Because the ALR cannot reduce its staffing and operating costs when a resident is absent from the ALR for short terms, the government entity subsidizing the care costs needs to provide funding during the absence to provide for a viable program. For medically necessary absences, the government entity will continue to pay 100% of the rate (less any resident share of cost payment made to the ALR during the absence) for up to 24 consecutive days per medical episode. For a non-medical absences, the government entity will continue to pay 100% of the rate (less any resident share of cost payment made to the ALR during the absence) for up to 14 days per year to allow the resident the opportunity to leave the ALR for personal reasons. If a resident's absence exceeds the government funding period in either instance, the resident or his/her family shall either pay the fees privately to retain the unit or relinquish the unit to the provider unless at the provider's discretion, the provider is willing to reserve the unit at reduced or no cost for the remainder of the resident's absence. The ALR may initiate discharge proceedings in instances of nonpayment. [Please note: The ALW believes that in the case of non-medical absences, an allowance of 14 cumulative days should be the minimum allowed under government programs. Providing larger allowances for non-medical absences further benefits the residents' options.]

Decisions about terminating residency in the ALR: If the resident decides not to return to the ALR, he/she shall notify the ALR in a manner consistent with law. (The admissions contract shall disclose to residents what these requirements are.) If the ALR claims that under relevant law it is entitled, based on an increase in the resident's care needs, to have the resident transfer or move out, the ALR shall provide the resident (and any designated representative) with a discharge notice. The resident has the right to appeal the discharge in the state administrative process.

**Implementation**

Federal and State Policy

**Rationale**

Assisted living residents who are temporarily absent from their ALR want to be able to return to their homes following their temporary absence. The rule shall assure the resident's right to return. In addition, there need to be provisions that address payment during the resident's absence and terminating the residency. Payments during a temporary absence shall be equal to the payments during occupancy because a provider



**Affordability**

may not be able to modify operations (e.g., staff down, forego debt payments, reduce utility costs, modify food orders) during a temporary absence.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Association for Regulatory Administration

**Organizations Abstaining From the Vote on This Recommendation**

American Assisted Living Nurses Association, American College of Health Care Administrators, American Seniors Housing Association, Joint Commission on Accreditation of Health Care Organizations

**Supplemental Positions for A.29**

- 1) The undersigned strongly support Affordability Recommendation A.29 as written for the following reasons:
- Without unit hold provisions and continued state service payments during absences, residents risk losing their home if they go into the hospital or leave to visit family.
  - ALR's providing affordable assisted living services under governmental programs cannot typically afford to forego service payment during a resident's absences because they do not have the operational flexibility to scale back staff and fixed expenses on a fractional basis.
  - If states do not compensate ALRs for services during a resident's absence, mission-driven providers may be unable to afford to participate in state programs and good quality for-profit providers will likely avoid taking state-reimbursed residents due to their absences' negative impact on the ALR's effective reimbursement rate.

Without the unit hold and reimbursement policies described in A.29, residents may face two unacceptable possibilities: 1) that an absences for medical reasons or to visit family (e.g., funeral, baptism, celebration, vacation) will cause them to forfeit their unit or 2) residents will be pressured by providers not to leave the ALR.

*AARP, Consumer Consortium on Assisted Living, NCB Development Corporation, National Center for Assisted Living, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

- 2) We oppose this failed recommendation. We support R.13, a residents' rights recommendation that addresses unit hold.

**Affordability**

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We oppose A.29 because it focuses on assisted living residences' interest in 100% funding during residents' temporary absences rather than on assuring residents' ability to retain their homes during temporary absences.

We also oppose A.29 because it makes no provision for prorating residents' fees for services that residents do not use while they are absent from the assisted living residence. For example, residents who are away on vacation or in the hospital will not eat meals or use housekeeping services. Assisted living residences should be required to give credit for unused services, prorated on a daily basis.

*Center for Medicare Advocacy, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants*

## ***Topic Group Recommendations Adopted by Two-Thirds Majority of the ALW***

### **Direct Care Services**

#### **Purpose**

The Direct Care Services Topic Group focused its efforts on the wellness and healthcare needs of ALR residents.

#### **Issues**

The main focus of the topic group was in the areas of assessment, resident move-in and transfers, end-of-life and palliative care, dementia care, and wellness.

#### **Participants**

The topic group was co-chaired by Doug Pace of the American Association of Homes and Services for the Aging and Jonathan Musher of the American Medical Directors Association.

Topic group participants included Linda Aufderhaar, National Association of Professional Geriatric Care Managers; Fred Cowell, Paralyzed Veterans of America; Marianna Grachek, Joint Commission on Accreditation of Health Care Organizations; Marsha Greenfield, American Association of Homes and Services for the Aging; Meg LaPorte, American Medical Directors Association; Karen Love, Consumers Consortium on Assisted Living; Katie Maslow, Alzheimer's Association; Cherry Meier, National Hospice and Palliative Care Organization; Constance Rowe, National Association of Home Care Physicians; Shelley Sabo, National Center on Assisted Living; Beth Singley, Assisted Living Federation of America; Bradley Schurman, American Assoc. of Homes and Services for the Aging; Ed Sheehy, Assisted Living Federation of America; Lisa Yagoda, National Association of Social Workers.

**Direct Care**

**D.01 Pre-Move In Screening Process**

**Recommendation**

Elements of the Pre-Move In Screening Process

This is to be completed by appropriately qualified and trained individuals with active participation of the prospective resident\*.

1. Information and discussion of assisted living residence contract including resident and family expectations and resident rights, responsibilities and move in/move out criteria.
2. Information and discussion regarding the assisted living residence rate structure with full disclosure of rate charges and changes and third party payer information (e.g., Medicaid, LTC Insurance, and other Subsidies).
3. Written information regarding Advance Directives (e.g. Living Will, Durable Power of Attorney, and/or DNR).
4. History and Physical (including diagnoses, a list of current medications, and a TB screen). [These elements should be completed by the prospective resident's primary licensed healthcare provider (M.D., D.O., P.A., N.P.) who has seen the individual within the last 60 days prior to move in. The assisted living residence should obtain a signed release form from the resident to authorize the ALR to access the medical records of the prospective resident.]
5. Evaluation of the prospective resident's ability to self-administer medications or need medication reminders, or medication administration.
6. Evaluation of ADL's, IADL's, and risk factors (e.g. – falls, weight loss, elopement, self-neglect, abuse, exploitation).
7. Assessment of cognitive abilities and behavioral issues unless included in the prospective residents medical history. When indicated, a structured evaluation should be conducted (e.g. Folstein mini-mental health exam).

**Implementation**

Guideline for State Regulation

**Rationale**

To best assure that an assisted living residence can meet a prospective resident's needs and expectations, the residence will initiate a pre-move in screening. This process is initiated once a prospective resident requests admission into an assisted living residence and is concluded prior to admission.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of

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**Direct Care**

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Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Adult Family Care Organization, National Center for Assisted Living, National Hospice and Palliative Care Organization, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

National Network of Career Nursing Assistants

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**Supplemental Positions for D.01**

1) We dissent. Pre-admission screenings are extremely important in determining whether an individual's needs can be met in an assisted living residence. Unfortunately, however, this recommendation has little content. Although the recommendation lists topic areas to be addressed, it does not specify how those areas are to be addressed, and contains no indication as to when a facility employee would be considered "appropriately qualified and trained" to conduct the screening.

Existing state laws do more to assure that screenings are meaningful. Virginia, for example, requires use of a Uniform Assessment Instrument to determine the appropriate level of care, based on the state's two-tier licensing system. The Uniform Assessment Instrument must be completed by a physician, a case manager, or a facility employee "with documented training in the completion of the UAI and appropriate application of level of care criteria." (Virginia Administrative Code, Title 22, §§ 40-71-10, 40-71-170(A)(1))

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We support this recommendation. States should retain the flexibility to decide how to meet the intent of an appropriate recommendation in equally effective alternative ways.

We note the following points:

· Prescreening of a potential is generally not the point at which to conduct what amounts to a full assessment. What should be monitored is whether accurate, complete, and easy to understand information has been given to the prospective resident for the purpose of making an informed decision.

· No reference in the recommendation is made to obtaining any information about the prospective resident's lifestyle, preferences or desires, or even inquiring as to the reason(s) prompting the

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decision to move into the ALR.

· The pre-move in screening process is triggered when a resident requests admission into an ALR. There is nothing intrinsic to a resident's request to move-in that would necessitate an immediate discussion of advance directives or DNR orders. Indeed, some residents may find the timing of such a discussion as insensitive when all parties are working to ensure the consumer's transition into the ALR setting is a positive and welcoming experience.

· No rationale is offered as to why states must require assessments to be completed within 14 days of admission as opposed to another interval already specified in state regulation.

· No rationale is offered as to why states must require the pre-move-in screening process and initial assessment to be conducted as a two-step process.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.02 Initial Assessment**

**Recommendation**

Elements of the Initial Assessment

When applicable, information from the Pre-Move In Screening Process may be used to complete the Initial Assessment. Initial Assessment should be completed by appropriate qualified and trained individuals with active participation of the prospective resident\*.

1. Physical history/exam (to be completed by a M.D., D.O., P.A., N.P.)
2. A Mental Health assessment, if appropriate (to be completed by a qualified, licensed, and/or certified professional based on observation, history and physical, or upon request)
3. Functionality: a) Assessment of ADLs; b) Assessment of IADLs; c) Assessment of risk factors (e.g. - falls, weight loss, elopement, self-neglect, abuse, exploitation).
4. Social Environment Factors (may be completed by a licensed and/or certified social worker or a trained staff member): a) Identify social interaction network (e.g.- cultural, spiritual, activities); b) Identify support resources (family, friends, etc.) and special needs c) Identify lifestyle preferences.
5. Obtain Advance Directives from resident if applicable.

Time Frame for Assessment to be Completed

Assessing medication requirements and information regarding advance directives and risk factors shall be completed immediately upon admission. All other components of the initial assessment shall be completed within 14 days of admission.

**Implementation**

Guideline for State Regulation

**Rationale**

The process of understanding, defining and measuring a resident's needs to ensure capable, comprehensive services is an on-going process in assisted living. After the pre-move in screening process, a more complete assessment process takes place upon admission. The purpose is to identify the resident's current needs and areas where support services may be needed as the Assisted Living Residence develops the resident's service plan.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Association of Home Care Physicians, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care

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Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Adult Family Care Organization, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for D.02**

1) We support this recommendation. Although the recommendation gives an adequate description of the medical, functional and social components of an assessment, it does not adequately discuss that the focus of the assessment should be on using or identifying triggers or indicators to pursue additional information from the resident or as a cue to provide the resident with more information in a certain area.

*American College of Health Care Administrators, Assisted Living Federation of America, National Association for Home Care, National Association for Regulatory Administration, Joint Commission on Accreditation of Health Care Organizations*



**Direct Care**

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**D.03 Service Plan**

**Recommendation**

1. The assisted living residence shall develop a service plan for each resident. The service plan shall be customized to the needs and preferences of the resident (including flexibility in scheduling, delivery method, social activities, etc.) The resident shall actively participate in the creation of the service plan if they are able to do so.
2. The service plan shall be developed by appropriately trained and qualified staff, with input of direct care staff, in partnership with the resident\*. When appropriate, the resident's physician and outside healthcare and service providers shall assist in the development of the service plan. The resident's family will be invited to participate at the request of the resident.
3. The service plan shall be developed using information from the pre-move in screening process, initial assessment, and ongoing assessments.
4. The initial service plan shall be completed within 30 days of admission and signed by the assisted living residence and the resident\*. The ALR shall review the service plan 30-60 days after the completion of the initial service plan. The resident\* shall receive a copy of the initial and all subsequent service plans upon completion.
5. The service plan shall include both the services provided by or contracted by the assisted living residence and identify services contracted by the resident from outside agencies and health care providers.
6. When services are provided, a service plan should include the following: scope of services; the frequency of services; monitoring of the services being delivered; a review of the resident's goals/outcomes; and who is responsible for the delivery of service, including coordination responsibility between on-site and 3rd party service providers.
7. The service plan shall be reviewed semi-annually, and/or on significant change, and/or revised as the resident's needs or desires change. There shall be a system in place to identify significant change. The service plan is available to, discussed with, and implemented by the appropriate ALR staff.
8. With respect to services provided by third parties, who are contracted by the ALR, the assisted living residence shall have written policies and procedures addressing their charges, notification procedures, provider and/or resident selection and the monitoring of the services provided. The assisted living residence shall coordinate and monitor the services provided by all third parties contracted by the assisted living residence.

**Implementation**

Guideline for State Regulation

**Rationale**

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Resident assessments and service plans are two of the cornerstones of assisted living that help assure quality service and care. The preparation of an accurate resident assessment and individualized service plan is the first step in providing quality care in an ALR. Ongoing assessment of each resident's service and care needs, along with updating each resident's service plan when service and care needs/preferences change, is essential to providing continuous care.

A service plan is a document developed that identifies the needs and preferences of the resident and outlines how they will be achieved. The plan is developed through an organized collaboration between the ALR and the resident\*. The goal of the service plan is to promote positive outcomes.

Staff providing resident personal care is assigned primary responsibility for carrying out the service plan and performs the majority of the tasks outlined.

Because the resident's needs and wishes may change, the service plan is monitored on an ongoing basis to ensure that the services being provided as specified in the plan and the plan is adequate to meet the resident's needs.

ALR staff is responsible for observing and reporting changes in the resident's condition, with significant changes reported immediately.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Gerontological Society, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Social Workers, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Conference of Gerontological Nurse Practitioners, National Network of Career Nursing Assistants, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

National Center for Assisted Living

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**Supplemental Positions for D.03**

- 1) We support this recommendation, although we note that states retain the flexibility to decide how

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it will meet the intent of an appropriate recommendation.

*Assisted Living Federation of America, National Association for Home Care, Joint  
Commission on Accreditation of Health Care Organizations,*

**Direct Care**

**D.04 Reasons for Resident Transfer or Move-out from an Assisted Living Residence**

**Recommendation**

The following reasons may be given for transfer or move-out by the resident or ALR:

1. The resident desires to move.
2. Following a documented assessment, ALR is no longer able to care for the resident due to his/her physical, or mental/cognitive status or behavioral issues based on the scope of services offered or coordinated by the ALR as disclosed to the resident upon move-in and as required by, state licensing requirements; and, wherever practical and except in an emergency, the ALR has attempted to work with the resident\* so that move-out or transfer would be unnecessary and this attempt has been unsuccessful.
3. The resident fails to pay or arrange payments for services rendered or other material breaches of contract, after reasonable and appropriate notice to the resident\* by the ALR of the nonpayment or material breach.
4. The resident's behavior or conditions presents a direct and serious threat to the well-being or safety of the resident or other residents or staff.
5. The ALR has the right to make a temporary emergency transfer of a resident in the event of imminent and serious danger to the life or safety of the resident or to other residents. In the event of an emergency, the ALR may conduct such transfer without advance notification, although the ALR should make a good faith effort to contact the family or responsible party at the earliest opportunity.
6. The ALR ceases to operate.

**Implementation**

Guideline for State Regulation

**Rationale**

When the Assisted Living Residence cannot meet the resident's needs, limitations of its scope of services, or according to law and regulation, the resident may need to move to another setting or a different level of care.

In all such cases, every effort is made to minimize the trauma associated with the move or transfer. The transfer or move-out should be conducted in a manner that is safe and dignified for the resident.

Move-out due to nonpayment should be reserved for instances when rent and/or fees have been unpaid for 30 days or more beyond the due date. The ALR should provide information on government or private subsidies that may be available to help the resident with costs.

The Assisted Living Workgroup recognizes that a resident has certain rights and protections under federal statutes, including the Americans with Disability Act, the Fair Housing Amendments Act, and the Rehabilitation Act of 1973. The applicable provisions of these statutes generally prohibit discrimination against individuals in protected categories and require reasonable accommodation and program accessibility.

In some instances, the ALR may not be required to make an accommodation if the

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modification would impose an undue financial or administrative burden or would require the ALR to fundamentally alter the nature of its program.

A full and complete examination of the circumstances under which these statutes may apply to a specific case involving an involuntary transfer or move-out is beyond the scope of this discussion. However, state agencies and providers should consider how these rights and protections apply to involuntary transfer or move-out requirements, as the federal statutes may take precedence over state regulations permitting an involuntary transfer or move-out.

In some states, involuntary transfer or move-out from an ALR is governed by the state's landlord-tenant laws. In these states, the state agency generally cannot force the resident to move and the resident will have the opportunity to raise any claims regarding the statutes cited above in a Housing Court proceeding.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for D.04**

1) We dissent. This recommendation, in combination with other recommendations, gives an assisted living residence excessive authority to evict a resident when the resident's needs increase, rather than requiring a reasonable effort to accommodate those needs. The recommendation's reference to the scope of services "required by state licensing requirements" is disingenuous, because the recommendations themselves (including all of the "guidelines for state regulation") do not require assisted living residences to provide any particular level of service. Whenever this issue was raised in the Workgroup, provider representatives refused to adopt any required level of service, maintaining that assisted living residences had to retain the "flexibility" to evict residents.

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We recommend that states adopt levels of care within assisted living – for example, Idaho's three-level system of Level I - Minimal Assistance, Level II - Moderate Assistance, and Level III - Extensive Assistance. (Idaho Administrative Code § 16.03.22.010) This type of system lets a resident know what needs can be met.

The majority's recommendation admittedly obligates an assisted living residence to provide the services disclosed at admission. This disclosure is not an adequate safeguard, given that these disclosures can be written in a vague way and, at the time of admission, a resident choosing among assisted living residences has little ability to understand disclosures relating to services.

The rationale references a facility's obligations under federal anti-discrimination law, but a resident should not have to file a federal lawsuit in order to obtain needed services. A level-of-care system would address this problem so that it could be remedied within a state's regulatory system, in response to a resident's complaint.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. Although we support this recommendation in principle, it goes beyond the mandate to the ALW to specifically address the issue of adequate notice upon discharge.

*Assisted Living Federation of America, National Association of Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.05 Protocols for Resident Transfer or Move-out from an Assisted Living Residence**

**Recommendation**

After the criteria to initiate a move-out of a resident have been met, subject to any appeal rights held by the resident the ALR transfers or moves a resident only after providing the resident with:

1. A meeting will be coordinated with the resident and ALR staff to review the conditions for transfer or move-out. The ALR will assist the resident\* in identifying other appropriate alternative settings.
2. Except in an emergency, advance written notice that includes the reason for the transfer or move-out and the approximate date when the transfer or move-out will occur. A simple and expeditious appeals process should be available to allow the resident and family the opportunity to dispute the transfer/move-out, but does not unduly prolong or exacerbate the situation that led to the ALR's or State's decision;
3. Information on the availability of assistance and support services to help the resident make the transfer or move-out to a setting which is adequate and appropriate for the resident.
4. The ALR shall prepare a move-out summary which includes pertinent information regarding the resident's physical and mental and cognitive status and a list of current medications.
5. A copy of all pertinent resident records, including when an emergency transfer occurs

**Implementation**

Guideline for State Regulation

**Rationale**

The protocols listed in this recommendation are triggered when the ALR initiates the process to transfer or move-out or at the resident\* request.

The protocols are intended to minimize the trauma to a resident as a result of a transfer or move out and to ensure the process is conducted in a manner that is safe and dignified for the resident, balanced with scope of services of the ALR and considers the needs and safety of the other residents and staff.

The Assisted Living Workgroup recognizes that a resident has certain rights and protections under federal statutes, including the Americans with Disability Act, the Fair Housing Amendments Act, and the Rehabilitation Act of 1973. The applicable provisions of these statutes generally prohibit discrimination against individuals in protected categories and require reasonable accommodation and program accessibility.

In some instances, the ALR may not be required to make an accommodation if the modification would impose an undue financial or administrative burden far exceeding what could have been reasonably anticipated upon admission or would require the ALR to fundamentally alter the nature of its program.

A full and complete examination of the circumstances under which these statutes may

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apply to a specific case involving an involuntary transfer or move-out is beyond the scope of this discussion. However, state agencies and providers should consider how these rights and protections apply to involuntary transfer or move-out requirements, as the federal statutes may take precedence over state regulations requiring an involuntary transfer or move-out.

In those states where transfer/move-out is governed by landlord-tenant or other applicable state law, the resident and family may have the opportunity to appeal the ALR's decision. The court or appropriate state agency may require, and the ALR should provide service and discharge planning and information on the availability of services as described above.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for D.05**

1) We dissent. Although we support this recommendation in principle, in our view, it goes beyond the mandate to the Assisted Living Workgroup to provide guidance to the states on matters that will improve quality in assisted living.

*Assisted Living Federation of America, National Association of Home Care, Joint Commission on Accreditation of Health Care Organizations*



**Direct Care**

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**D.06 Palliative Care**

**Recommendation**

1. An ALR will provide, within its scope of services offered, care and support for each resident so that he/she may live as fully and as comfortably as possible within the context of the resident's values and symptoms. These outcomes are accomplished when:
  - The resident\* is provided with accurate and timely information to make treatment decisions.
  - The service plan supports the resident's choices that are consistent with the resident's advance directives, values, spiritual preferences, and life-long living patterns, even though these decisions may involve increased risk or personal harm to the resident.
2. Procedures are in place to assure that the resident receives timely attention to palliative care needs.
3. ALR staff report observations of discomfort, adverse reaction/behaviors to an ALR supervisor or qualified health care professional.
4. ALR staff assists the resident in maximizing independence as the resident's functional capacity changes.

**Implementation**

Guideline for Operations

**Rationale**

Palliative care includes any comfort measure that will prevent, relieve, reduce, or soothe the symptoms of disease or disorder without affecting a cure. As such, palliative care can be provided throughout an individual's life, although it is usually associated with the end of-life or hospice.

Comfort care can become a controversial issue when a resident makes a decision to forego treatment that others judge to be of benefit. For example, a resident decides to stop further chemotherapy, refuses surgery, or decides to terminate dialysis. Quality of life can only be defined by the resident\*. The responsibility of the ALR staff is to direct the resident to resources regarding palliative care. Treatment decisions are driven by the values and preferences of the resident\*. Advance directives, if executed, are a primary source of information.

Studies conducted on end-of-life issues have found that individuals prefer to die at home, surrounded by their loved ones, without pain. The ALR is home and residents may not want to be taken to the hospital or transferred to a nursing facility when they are bedbound or near death. ALR staff may be uncomfortable with death in the facility and feel that they are not capable of meeting the resident's needs. These issues can only be resolved with open communication among the resident, family, and ALR staff. At this point, it may be necessary to consider additional services from outside providers, such as home health agency or hospice.

**Organizations Supporting This Recommendation**

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AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America

**Supplemental Positions for D.06**

1) We dissent. Although we support this recommendation in principle, in our view, it goes beyond the mandate to the Assisted Living Workgroup to provide guidance to the states on matters that will improve quality in assisted living.

Further, it preempts state and ALR flexibility to decide how to will meet the intent of an appropriate recommendation to improve quality in equally effective ways.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.07 Hospice Care**

**Recommendation**

1. If the ALR is able to provide or arrange for the provision of hospice care, the ALR should inform terminally ill residents\* of the availability to receive hospice care at the ALR. The ALR should identify and make available to residents\* information about hospice services and the names and addresses of providers in the geographic vicinity.
2. When a terminally ill resident is receiving hospice care, transfer from the ALR may not be required, if the needs are being met.
3. The ALR and hospice communicate, establish, and agree upon a coordinated service plan that reflects the hospice philosophy and is consistent with regulatory requirements.
4. The service plan identifies the provider/caregiver/family member that is to be held responsible for implementing the service plan.
5. The ALR and hospice determine a process by which information from the hospice interdisciplinary team and the ALR interdisciplinary team will be exchanged when developing, and evaluating outcomes of care and updating the service plan.

**Implementation**

Guideline for Operations

**Rationale**

A person becomes eligible for Hospice Care when a physician certifies that they have a terminal illness. Individuals living over six months are not discharged from the program unless it is determined, by a physician, that the prognosis is greater than six months. The Hospice Benefit is covered under Medicare and Medicaid (in all but a few states). When an individual elects the Hospice Medicare/Medicaid benefit, they elect to receive palliative care. They may still receive curative care if it is unrelated to their terminal illness. At any time, an individual may revoke the Hospice Benefit and return to treatment under Medicare Part A/ Medicaid. The ALR should be aware of the hospice providers in the community and explore potential opportunities to collaborate.

The Conditions of Participation as a hospice provider stipulate that when a Medicare/Medicaid beneficiary elects to receive hospice care, the hospice assumes professional management and financial responsibility for care related to the terminal illness. This care extends across settings from the person's home, personal care home, assisted living residence, nursing facility, or hospital. For this care, the hospice is reimbursed a per diem rate that is all-inclusive of care, without any additional expense to the individual/family. Services included in the hospice benefit are:

- professional care from the interdisciplinary team;
- supplies;
- medications related to the terminal illness;
- durable medical equipment.

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Hospice providers are required to have contracts with hospitals so that if an individual requires more intense care, it can be provided. Hospice providers may also have available staff to provide continuous care at the person's bedside. The intensity and level of care is based on the needs of the individual/family and adjusted as necessary.

Hospice programs provide state-of-the-art palliative care and supportive services to individuals at the end of their lives, their family members and significant others. On-call support is available 24 hours a day, seven days a week, in both the home and facility base settings. Physical, social, spiritual, and emotional care is provided by a clinically-directed interdisciplinary team consisting of physicians, nurses, aides, social workers, clergy, and volunteers. The hospice physician provides guidance to the team and is available for consultation with the primary physician, or in some cases may assume the role as primary physician.

Hospice provides support and care for persons in the last phase of a terminal condition so that they may live as fully and as comfortably as possible. Hospice recognizes that the dying process is a part of the normal process of living and focuses on enhancing the quality of remaining life. Hospice affirms life and neither hastens nor postpones death.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Adult Family Care Organization, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Association of Local Long Term Care Ombudsmen, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for D.07**

1) We dissent. There are no standards in this recommendation. Care for terminally-ill residents is possible "[i]f the ALR is able to provide or arrange for the provision of hospice care."

The recommendation suggests wrongly that the presence of a hospice agency is sufficient, regardless of the staffing and expertise of the assisted living residence. In fact, hospice care is supplemental

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care (generally funded by Medicare) for terminally ill persons. Hospice agency employees are visitors that generally see a patient for only a few hours each day.

This weak recommendation is a step backwards. In many states, an assisted living residence can accommodate a hospice care program only if the facility meets certain statutory or regulatory requirements. In California, for example, an assisted living residence can house terminally ill residents only after the facility has demonstrated its competence to the California Department of Social Services, received the appropriate approval from the Department, and then entered into an agreement with a hospice agency. (California Health & Safety Code § 1569.73)

Terminally-ill individuals often present significant health care problems, and need consistent emotional support. Visitation by a hospice agency is not a panacea and, in any case, a hospice agency may fail to carry out its responsibilities. By failing to even take into account the capabilities and responsibilities of an assisted living residence, this recommendation would jeopardize the quality of care provided to terminally ill residents.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. There are recommendations within the ALW report that we, as individual organizations, helped to develop and continue to support. However, we have come to the conclusion that fundamental differences of principle exist between ALFA and the Assisted Living Workgroup (ALW) in its overall approach to developing recommendations as to how the states might best regulate assisted living. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

Any regulatory guidance to the states should recognize, reflect, and even foster resident-centered care--the unique characteristic that distinguishes assisted living from other forms of long-term care. At the same time, state governments should be granted regulatory flexibility so as not to just promote basic resident safety, but to actually improve quality of care.

While we support the intent of this recommendation, we believe it gives insufficient attention to defining quality standards from the perspective of the consumer, and fails to acknowledge that states and/or ALRs should consider equally effective alternative approaches to meet the intent of an appropriate recommendation.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.08 Advance Directives**

**Recommendation**

Assisted Living providers shall complete the following tasks related to advance directive upon admission and when appropriate.

1. Inquire whether the resident has an advance directive and, if so, request a copy of the advance directive for the ALR's records. If a copy is not provided, the residence shall document whether the resident\* indicates he or she has an advance directive and, if a health care proxy has been appointed, the name and contact information of the proxy. The ALR shall update this information at least annually, again seeking to include a copy of the current directive in the facility's records.
2. Provide the resident\* with an explanation of one's rights under state law to make decisions about medical care, including the right to accept or refuse medical and surgical treatment, and the right to formulate advance medical directives, such as a living will or durable power of attorney for health care, or comfort care only order (DNR order). The explanation approved for hospitals, nursing facilities, hospices and home health agencies by the state's medical assistance program under the federal Patient Self-Determination Act may be used for this purpose.
3. Provide the resident\* with an explanation of ALR's policies regarding the delivery of end-of-life care in the residence, including the delivery of hospice and palliative care (pain management), and the use of comfort care only orders (i.e., do-not-resuscitate orders).
4. Take reasonable steps to ensure transfer of the resident's advance directive, or information regarding its existence, to the hospital or other facility.

**Implementation**

Guideline for Operations

**Rationale**

As part of the ALR's pre-move in screening process, the ALR is obtaining information from the resident\* concerning advance directives. In some instances, the resident\* may not have advance directives, nor understand the benefit/risks of having them. It would be beneficial for the residence to have copies of forms accepted by state law and be able to provide information to the resident\* to make an informed decision.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Academy of Elder Law Attorneys, National Hospice and Palliative Care Organization, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, National Network of Career Nursing Assistants, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

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Assisted Living Federation of America, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Association of Health Facility Survey Agencies.

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**Supplemental Positions for D.08**

1) We dissent. There are recommendations within the ALW report that we, as individual organizations, helped to develop and continue to support. However, we have come to the conclusion that fundamental differences of principle exist between ALFA and the Assisted Living Workgroup (ALW) in its overall approach to developing recommendations as to how the states might best regulate assisted living. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

Any regulatory guidance to the states should recognize, reflect, and even foster resident-centered care--the unique characteristic that distinguishes assisted living from other forms of long-term care. At the same time, state governments should be granted regulatory flexibility so as not to just promote basic resident safety, but to actually improve quality of care.

While we support the intent of this recommendation, we believe it gives insufficient attention to defining quality standards from the perspective of the consumer, and fails to acknowledge that states and/or ALRs should consider equally effective alternative approaches to meet the intent of an appropriate recommendation.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.09 Do Not Resuscitate Orders (DNR)**

**Recommendation**

ALRs should clarify a resident's resuscitation status on admission and with subsequent changes in condition. If the State has regulations regarding out-of-hospital DNR, the ALI should provide the resident\* with information to help assure that their treatment decisions are followed. The ALR should contact the physician to obtain appropriate orders.

**Implementation**

Guideline for Operations

**Rationale**

To provide portability to a DNR order, some states have regulations regarding resuscitation outside the hospital setting. These regulations were developed to assist Emergency Medical Technicians, Emergency Room personnel, and anyone else responding to a code situation, that the individual does not want resuscitation. Some states have designated devices such as a necklace or bracelet; however, this varies among states. This allows the individual to carry on their normal routine without fear of receiving resuscitation.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Adult Family Care Organization, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for D.09**

1) We dissent. This recommendation evades the central issue – can an assisted living residence honor a DNR order or, more specifically, what does an assisted living residence do when a resident with a DNR order needs resuscitation in order to live?



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Currently many assisted living residences do not have licensed health care professionals on staff. As a result, depending on state law, it often is unclear whether these facilities are allowed to honor DNR orders. In many instances, when a resident suffers a heart attack or similar event in a facility, CPR is initiated and/or the paramedics are called, even if the resident and the resident's physician specifically have requested a DNR order.

We recommend that a level of care system be adopted within assisted living, that the highest level require nurse staffing, and that assisted living residences licensed at the highest level be required to honor DNR orders. Such a system would allow residents' health care desires to be honored, and would guarantee that decisions to withhold CPR would be made by qualified health care professionals.

As is noted in other of our dissents, the majority consistently was unwilling to develop levels of care, or to draw distinctions based on a facility's capacity to provide health care services. As a result, this majority recommendation (particularly the rationale) leaves largely to paramedics the job of deciding whether and to what extent to honor a resident's DNR order. We dissent because we believe that residents deserves an assisted living residence that is qualified to do more than just call 9-1-1.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. There are recommendations within the ALW report that we, as individual organizations, helped to develop and continue to support. However, we have come to the conclusion that fundamental differences of principle exist between ALFA and the Assisted Living Workgroup (ALW) in its overall approach to developing recommendations as to how the states might best regulate assisted living. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

Any regulatory guidance to the states should recognize, reflect, and even foster resident-centered care--the unique characteristic that distinguishes assisted living from other forms of long-term care. At the same time, state governments should be granted regulatory flexibility so as not to just promote basic resident safety, but to actually improve quality of care.

While we support the intent of this recommendation, we believe it gives insufficient attention to defining quality standards from the perspective of the consumer, and fails to acknowledge that states and/or ALRs should consider equally effective alternative approaches to meet the intent of an appropriate recommendation.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.10 Identification of Cognitive Impairment/Dementia**

**Recommendation**

The assisted living residence shall have in place procedures to 1) increase staff awareness of signs and symptoms of cognitive impairment/dementia in a resident, 2) evaluate or obtain an evaluation of the resident's cognitive status as it relates to the resident's ability to manage his/her own affairs and direct his/her own care, and 3) adapt the resident's service plan to meet his/her needs, given the resident's cognitive status.

These procedures should include:

1. Training for all staff members shall include information about the signs and symptoms of cognitive impairment/dementia.
2. When cognitive impairment is identified, staff should strongly encourage the resident and his/her family to obtain a diagnostic assessment by an appropriately trained and qualified professional in order to determine the cause of the cognitive impairment.
3. When cognitive impairment is identified, whether or not the resident has received a formal diagnosis of Alzheimer's disease, another dementing disease or condition, or another condition that causes cognitive impairment, staff shall evaluate the impact of the cognitive impairment on the resident's ability to manage his/her own affairs and direct his/her own care; issues of physical safety, ability to manage medications, and need for a surrogate decisionmaker shall be addressed in this evaluation; the resident and his/her family should be included in this evaluation as much as possible.
4. The resident's service plan should be revised to incorporate any changes needed because of his/her cognitive impairment. Since many diseases and conditions that cause cognitive impairment in elderly people are progressive, the resident's service plan should include a timetable for reevaluation.

**Implementation**

Guideline for State Regulation

**Rationale**

Available data indicate that 27-64% of assisted living residents have cognitive impairment but the condition often is not recognized and may not be considered important by assisted living staff. Hawes and Phillip, in their study of assisted living residences, found that 88 percent of staff members who provided or supervised direct resident care believed that memory loss and confusion are part of normal aging. Even in the case of sudden onset of these conditions, 9 percent of staff members believed nothing should be done because the conditions are part of normal aging. These beliefs jeopardize resident safety, interfere with timely identification of serious medical conditions that can cause sudden onset of cognitive impairment, and deprive staff of information they need to provide appropriate care.

In the case of sudden onset of cognitive impairment, diagnosis of the condition causing the change is critical. In the case of more gradual onset and progression, diagnosis is also

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important; however, a diagnosis of Alzheimer's disease or another dementing disease or condition does not establish the level of cognitive impairment or the person's self-care capacity.; in this case, for the purposes of assisted living providers, diagnosis of the cause of cognitive impairment/dementia is less important than the evaluation of its impact on the person's self-care capacity and ability to manage their own affairs.

Some people will be admitted to the assisted living facility with cognitive impairment. Others will become cognitively impaired as time passes. Assisted living staff members can be trained to recognize common signs and symptoms of cognitive impairment in residents. All staff should receive this training, even if the assisted living facility has a special dementia care unit, since some residents who are not in that unit are very likely to have to develop cognitive impairment over time.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Association for Regulatory Administration, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, American Seniors Housing Association

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**Supplemental Positions for D.10**

1) We respect the fact that many states have set additional requirements for ALRs that seek a special designation to serve people with cognitive impairments. However, we do not attempt to prescribe the specific procedures that a state must regulate.

Residents with mild to moderate dementia can still participate in care decisions and express life long values and wishes regarding the care they are currently receiving. Therefore, our recommended guidance to the states and ALRs is to consider a quality monitoring component that focuses on the perspective of the resident and other responsible parties to look beyond the procedures, and to see if the resident and other affected parties feel that their choices are being respected, their needs are being met, and their opinion is sought as to the quality of the services provided.

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Examples of suggested areas for quality monitoring could include:

- Does the resident acknowledge having opportunities to exercise lifestyle preferences (dining, receiving visitors, activities, directing provision of services)
- Does the resident acknowledge being consulted as to his/her satisfaction with the quality of care and services provided;
- Does the staff have the willingness and the ability to communicate with, and respond to, resident's preferences;
- Does the surrogate decision-maker acknowledge that he/she is encouraged to be involved in the development and implementation of the resident's service plan.
- Do family members report having opportunities for involvement in resident's care.
- Does the resident acknowledge being able to make decisions regarding services to be provided to the extent possible and involvement of his or her family as appropriate.

*Assisted Living Federation of America, National Association for Home Care , Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.11 Care for People with Cognitive Impairment/Dementia and Dementia Special Care Units and Facilities**

**Recommendation**

Part 1: Care for People with Cognitive Impairment/Dementia

ALRs shall have in place procedures and services that 1) meet the needs of residents with cognitive impairment/dementia, 2) accommodate and balance concerns about safety and autonomy, 3) recognize and build on strengths, capacities, choices, and values of the resident, and 4) reflect the likelihood that the cognitive status of many of these people will change and deteriorate over time. Such procedures and services include:

1. Staff training about cognitive impairment, dementia, and dementia care;
2. Procedures for assessing and reassessing the resident's cognitive status, abilities, and related care needs;
3. Procedures, including supervision, to help direct care staff understand and respond effectively to residents' behavioral symptoms;
4. Specialized activities that are appropriate for residents with cognitive impairment/dementia;
5. Procedures for working with the resident and the resident's family to define and clarify responsibilities of the resident, the family, and the facility;
6. Procedures for designating and working with a surrogate decision maker, if the resident is not capable of making decisions for him/herself;
7. Policies and procedures to protect residents who wander and/or are at risk of physical harm;
8. Regular monitoring to assure resident safety and health care status, consistent with impairment; and
9. Policies and procedures for involving and supporting family members.

Resident needs related to cognitive impairment/dementia differ depending on the severity of the cognitive impairment. An ALR should have in place procedures and services that are appropriate for the severity of cognitive impairment of its residents.

Part 2: Dementia Special Care Units and Facilities

ALRs that choose to serve only individuals with cognitive impairment/dementia or to establish a special dementia unit or units(s) should define precisely the purpose of the unit(s) and develop admission and discharge criteria, staff training activity programs, and physical design features that are consistent with that purpose.

**Implementation**

Guideline for State Regulation; Operations

**Rationale**

Part 1: Care for People with Cognitive Impairment/Dementia

Diseases and conditions that cause cognitive impairment/dementia result in problems with memory, judgment, reasoning, communication, orientation, awareness, and other cognitive abilities. Assisted living residents with cognitive impairment/dementia generally need the same services and help as those who are cognitively intact and some additional services

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that are directly related to these problems. The list of needed services and procedures above is intended to include only those additional services.

Residents with cognitive impairment/dementia are likely to need help with decision making because of condition-related problems with memory, judgment, and reasoning. Some residents with cognitive impairment/dementia have a court-appointed guardian who can make decisions for them, but many do not. For those residents, state laws designate certain relatives and others who can function as surrogate decision makers for people who are not capable of their own decisions. ALRs should be aware of the relevant state laws. At the same time, it is important to note that many individuals with cognitive impairment/dementia are capable to make some or all of their own decisions.

### Part 2: Dementia Special Care Units and Facilities

Available data show that 27-64 percent of assisted living residents have cognitive impairment/dementia. Some assisted living residences serve only individuals with cognitive impairment/dementia; some have one or more physically separate, dementia special care units; and many do not have dementia special care units. In a 1997/98 study of 2,078 residents of a stratified random sample of 233 assisted living residences in four states, Zimmerman et al. found that 8 percent of small facilities (4-16 beds), 8 percent of large, traditional model facilities (16+ beds), and 25 percent of large, new model facilities (16+ beds and built after 1987) had physically separate care areas for residents with cognitive impairment/dementia. Of all residents with moderate or severe cognitive impairment/dementia in the 233 facilities, 11-32 percent were in these physically separate areas; thus 68-89 percent of residents with moderate or severe cognitive impairment/dementia were not in physically separate areas.<sup>1</sup>

Since it is likely that most assisted living residents with cognitive impairment/dementia will not be in a dementia special care unit or an ALR that serves only individuals with cognitive impairment/dementia, the existence of these units and facilities does not eliminate the need for appropriate procedures and services, as described in Part 1 above, for residents with cognitive impairment/dementia in other units and facilities. State regulations for dementia special care units and facilities generally do not apply to the care of residents with cognitive impairment/dementia who are not in dementia special care units and facilities.

ALRs that choose to serve only residents with cognitive impairment/dementia or to establish one or more dementia special care units should define precisely their policies, procedures, and services in the following areas:

1. Purpose of the unit(s): the ALR could, for example, establish a special care unit that provides special supervision or monitoring, a secured unit to deter elopement, or a unit intended to serve residents with particular behavioral symptoms;
2. Admission criteria: the ALR could, for example, create criteria that admit individuals at a particular stage or stages of a dementing illness, or anyone with a diagnosis of a dementing illness, or individuals with particular behavioral symptoms.
3. Discharge criteria: the ALR could, for example, create criteria that discharge individuals who reach a particular stage of their dementing illness, or individuals whose behavioral symptoms have mitigated sufficiently that they can return to a regular unit.

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4. Staffing ratios and staff training requirements: the ARL could, for example, provide more staff on all shifts or certain shifts in the special care unit; the ARL could also create training requirements that go beyond the dementia care training provided for all direct care staff or that focus on particular behavior management approaches.
5. Activities: the ARL could, for example, provide specialized group activity programs or special dining arrangements in the special care unit.
6. Physical design or environmental features: the ARL could, for example, create a special care unit with physical design features that assist residents to find their way and identify their own room and other rooms (such as the bathroom), and/or a protected area for wandering.

This recommendation applies to activities of the ALR that shall occur before disclosure. Once an ALR has defined the purpose of its special care unit and created policies and procedures that fit the purpose, then it should disclose the relevant information to prospective residents\*.

1. Sloane, P.D. Zimmerman, S, and Ory, M.G., "Care for Persons With Dementia," in Assisted Living: Needs, Practices, and Policies in Residential Care for the Elderly, S. Zimmerman, P.D. Sloane, and K Eckert (eds.) (Baltimore, MD: Johns Hopkins University Press, 2001).

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Association of Professional Geriatric Care Managers, National Conference of Gerontological Nurse Practitioners, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants Center for Medicare Advocacy, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

National Citizens' Coalition on Nursing Home Reform, National Academy of Elder Law Attorneys

**Supplemental Positions for D.11**

- 1) We dissent. The gist of the recommendation is that a facility is required to develop policies related to dementia care, and those policies must address certain areas. We dissent because there is

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no specificity as to what those policies might be. What type of staff training is appropriate for assisted living residences caring for residents with dementia? To what extent is the participation of a physician or nurse required? The recommendation takes no position on these and many other important questions.

Part 2 of the recommendation, pertaining to "Dementia Special Care Units and Facilities," is particularly without content. For example, according to the rationale, a unit could be considered "special care" if it had criteria that allowed for discharge of residents whose dementia reached a specific level. This anything-goes definition of "special care" is wholly unfair to consumers, who would assume reasonably – but mistakenly – that "special care" would be some indication of quality or expertise.

Existing state law has done a better job of establishing meaningful standards for the care of residents with dementia. In Alabama, for example, a "Specialty Care Assisted Living Facility" provides specialized care for residents with dementia. A physician must act as a medical director, and a registered nurse must perform assessments. Regulatory minimums are set for staff training, staff levels, and other important matters. (Alabama Administrative Code r. 420-5-20-.04, 420-5-20-.06, 420-5-20-.08)

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy,  
National Association for Regulatory Administration, National Committee to Preserve  
Social Security and Medicare, National Network of Career Nursing Assistants,  
National Senior Citizens Law Center*

2) We dissent. There are recommendations within the ALW report that we, as individual organizations, helped to develop and continue to support. However, we have come to the conclusion that fundamental differences of principle exist between ALFA and the Assisted Living Workgroup (ALW) in its overall approach to developing recommendations as to how the states might best regulate assisted living. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

Any regulatory guidance to the states should recognize, reflect, and even foster resident-centered care--the unique characteristic that distinguishes assisted living from other forms of long-term care. Resident-centered care involves incorporating the resident's values and experiences, as well as the individual preferences into the definition and evaluation of quality of care and quality of life. At the same time, state governments should be granted regulatory flexibility so as not to just promote basic resident safety, but to actually improve quality of care.

While we support the intent of this recommendation, we believe it gives insufficient attention to defining quality standards from the perspective of the consumer, and fails to acknowledge that states and/or ALRs should consider equally effective alternative approaches to meet the intent of an appropriate recommendation.

*Assisted Living Federation of America, National Association for Home Care, Joint  
Commission on Accreditation of Health Care Organizations*



**Direct Care**

**D.12 Senior Wellness Programs in ALRs**

**Recommendation**

The assisted living residence may design and provide a senior wellness program that fits the overall needs of its residents. If components of a senior wellness program are unable to be offered on-site, the assisted living residence may make available community contacts for residents who desire services.

Components of a Senior Wellness Program, beyond what is required under state regulations, may include:

- Mental Health/Psychosocial Programs and Screenings
- Health Screenings (e.g., blood pressure; cholesterol)
- Nutritional counseling
- Physical exercise programs (e.g., walking programs, weight training for seniors)
- Recreational/activity programs
- Spiritual Enrichment
- Health educational seminars
- Holistic Therapies (e.g., aromatherapy; massage therapy; music therapy)

**Implementation**

Guideline for Operations

**Rationale**

Wellness programs have the ability to improve the quality of life for ALR residents from a holistic approach. Providing residents with wellness programs that include educational resources, physical activity programs and community referral sources may result in greater understanding of certain conditions associated with aging and prevent issues and illnesses from occurring.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Association for Regulatory Administration, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

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Center for Medicare Advocacy

**Supplemental Positions for D.12**

1) We dissent. There are recommendations within the ALW report that we, as individual organizations, helped to develop and continue to support. However, we have come to the conclusion that fundamental differences of principle exist between ALFA and the Assisted Living Workgroup (ALW) in its overall approach to developing recommendations as to how the states might best regulate assisted living. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

Any regulatory guidance to the states should recognize, reflect, and even foster resident-centered care--the unique characteristic that distinguishes assisted living from other forms of long-term care. Resident-centered care involves incorporating the resident's values and experiences, as well as the individual preferences into the definition and evaluation of quality of care and quality of life. At the same time, state governments should be granted regulatory flexibility so as not to just promote basic resident safety, but to actually improve quality of care.

We believe it gives insufficient attention to defining quality standards from the perspective of the consumer, and fails to acknowledge that states and/or ALRs should consider equally effective alternative approaches to meet the intent of an appropriate recommendation. Further, the recommendation would likely have a disproportionate impact on small providers who lack the resources to put into place all of the recommended components beyond what is already required under existing state regulations.

*Joint Commission on Accreditation of Health Care Organizations, Assisted Living Federation of America, National Association for Home Care*

## ***Topic Group Recommendations That Did Not Reach Two-Thirds Majority***

### **Direct Care Services**

*The following recommendations did not reach a two-thirds majority of the ALW. The recommendations showing a voting record were unable to reach two-thirds majority at the final vote. The recommendations that do not show a voting record were unable to reach two-thirds majority during the development process.*

**Direct Care**

**D.13 Shared Responsibility Agreement**

**2/3 Maj. Not Reached**

**Recommendation**

Shared Responsibility Agreements are a tool for communications. They may be exercised when the resident\* is not complying with the goals and outcomes listed in the Service Plan or the Policies and Procedures of the ALR. As an extension of the Service Plan, the ALR and the resident\* may enter into a Shared Responsibility Agreement. The Shared Responsibility Agreements should cover the exception not the rule.

Shared responsibility shall not be a waiver of liability. A shared responsibility agreement is simply a written agreement between both parties--the Assisted Living Residence and the resident\*--which memorializes the parties' discussions and agreements regarding the resident's preferences and how they will be accommodated in the community.

Shared Responsibility Agreements may be used when any or all of the following are true:

- There is a deviance from an accepted standard.
- There is a lack of consensus on a course of action.
- The risk of an adverse outcome is high.

The goals of the Shared Responsibility Agreement are:

- Empower the resident to exercise choice regarding service delivery (within established boundaries).
- Identify resident preferences
- Perform a realistic assessment of potential harm due to resident preferences.
- Identify potential outcomes
- Seek consensus around decision.
- Document process of negotiation and decision.
- Provide acknowledgement of the discussion

A Shared Responsibility Agreement should:

- Identify the cause for concern.
- Identify the probable consequences of the resident's choice.
- Make clear what the resident wants.
- Describe possible alternatives.
- Set forth the final agreement.
- Decide what staff will be notified of the agreement and how often follow-up is necessary
- Agreement is signed by the ALR and the resident\*.

**Implementation**

Guideline for Operations

**Rationale**

The agreement itself is an extension of the service plan and the end product of a process in which the Assisted Living Residence, or the ALR and the resident together, identify a resident preference (e.g., to engage in or avoid certain activities or behaviors) which the ALR normally would not recommend or allow, or would remove, because they involve unacceptable risk to the health and safety of the resident or others in the ALR.

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Ultimately, the shared responsibility agreement process is simply a systemized method of accommodating individual resident choices, or finding acceptable alternatives to those choices, and the propriety of its use depends upon the unique facts and circumstances pertaining to each resident.

Recognition of the need for a shared responsibility agreement normally arises in one of three ways. In some cases, a resident will verbally express to ALR staff a desire to engage in certain activities or behaviors that normally would be prohibited. In other cases, ALR staff may raise the issue where a resident repeatedly engages in behaviors which normally would not be allowed for that resident. Occasionally, third parties such as family members, or ombudsman or other resident advocates may suggest a shared responsibility agreement to resolve complaints or concerns raised by a resident or family.

**Organizations Supporting This Recommendation**

No Vote Recorded

**Organizations Opposing This Recommendation**

**Organizations Abstaining From the Vote on This Recommendation**

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**Supplemental Positions for D.13**

1) Many states are requiring shared responsibility or negotiated risk agreements as a part of the management of services in assisted living residences. Recommendation D.13 does an excellent job of describing the legitimate uses of such agreements, they are "a tool for communication" between residents and providers where residents are empowered to exercise choices in activities and expect services according to their preferences.

The recommendation also makes it very clear what are not legitimate uses of such agreements: "Shared responsibility shall not be a waiver of liability." While providers may reasonably use such agreements as part of their risk management policy, nothing in such agreements absolves providers from responsibility for negligent actions.

Perhaps the most useful part of the recommendation is its detailed outline of a process for negotiating such agreements. Many states require negotiated risk or shared responsibility agreements without providing guidance on how they should and should not be developed. The process recognizes that the provider has a responsibility to identify the consumer's preferences as well as potential risks that may be associated with certain behaviors. The process also recognizes that not all courses of action are possible or reasonable, but that resident preferences should be honored even when the provider does not believe them to be in the resident's best interest.

The undersigned organizations believe that this recommendation strikes the right balance between the resident's preferences and the provider's responsibility to provide services within a safe environment. It provides much needed guidance to states as they move into this relatively uncharted area of the law.

*AARP, American Association of Homes and Services for the Aging, American Seniors Housing Association, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, NCB Development Corporation, Association of*

**Direct Care**

*Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

2) We oppose this failed recommendation. This recommendation is confusing and unnecessary, and seems to reduce a resident's right to make choices.

It is unclear what type of real-world fact pattern would require the use of a "shared responsibility agreement," particularly given the availability and general acceptance of the care planning process. Although "shared responsibility agreements" purportedly are designed to advance resident choice, they actually diminish resident choice, as shown by the fact that they are to be employed when the resident "is not complying with the goals and outcomes listed in the Service Plan or the Policies and Procedures of the ALR," or there is "a deviance from an accepted standard" or "a lack of consensus on a course of action."

The rationale emphasizes that the "shared responsibility" process is to be employed when the assisted living residence disagrees with decisions made by the resident, even if the only person affected is the resident himself or herself. This raises the inference, confirmed by the debate within the Workgroup, that shared responsibility agreements are designed almost exclusively to protect the facility from regulatory requirements and legal action.

There is no need for this confusing and self-contradictory recommendation. Resident/facility disputes are currently being addressed through care planning in assisted living residences around the country.

*American Geriatrics Society, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of Social Workers, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Conference of Gerontological Nurse Practitioners, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

3) We support the recommendation. Negotiated risk agreements are becoming recognized as one of the primary tools through which assisted living providers can operationalize and preserve the values of independence, autonomy, and choice upon which the assisted living model rests so directly. Statutory and/or regulatory mandates in virtually every state direct both regulators and providers to further and nourish resident independence and autonomy in assisted living communities. The negotiated risk process focuses the attentions of resident, community staff, resident families, resident advocates, and regulators via a systematized process on one central issue – what are the wishes and preferences of the resident as balanced against the resident's health and safety needs. By so doing, the negotiated risk process responds to the legislative and regulatory directive to foster and promote these resident values and helps deliver the promise of assisted living.

The negotiated risk process is an individualized planning process designed to maximize a resident's ability to make his or her own decisions by facilitating discussions and analysis of a resident's stated choices where those choices create a normally unacceptable level of risk for the resident.

Negotiated risk is not a waiver of liability on the part of the provider of its obligations under governing regulations.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.14 Access to ALR's for Individuals with Personal Healthcare Needs**

**2/3 Maj. Not Reached**

**Recommendation**

The personal healthcare needs of individuals should not be a barrier to admission or an automatic trigger for discharge by providers or in state regulation for Assisted Living Residences when the resident\* or ALR chooses to provide or arrange care for the condition.

When a person with healthcare care needs wishes to or currently resides in an ALR, and care for the healthcare need is provided by the resident, caregiver (family or contracted), appropriately qualified and trained staff (if the ALR chooses to make those services available), the existence of the healthcare needs should not be a barrier to admission or a trigger for discharge. This recommendation does not permit ALRs to reduce services below those required by regulation, nor does it require that they provide additional services.

Examples of personal healthcare needs may include but are not limited to:

- Catheter use
- Oxygen
- Medical ostomy, i.e. colostomy, ileostomy, urostomy
- Temporary medical conditions that require bed rest, i.e. severe colds, grade I & II pressure ulcers
- Mobility impairments that require use of a wheelchair, walker, cane or scooter.

**Implementation**

Guideline for State Regulation

**Rationale**

Many individuals with personal healthcare needs are capable to manage their care. Others have the ability to self-direct their care with occasional assistance from qualified caregivers or trained staff. These conditions can be easily managed in a home environment, and therefore are manageable in an ALR. It would be discriminatory to exclude individuals with personal healthcare needs from living in an ALR.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Hospice and Palliative Care Organization, National Association of Professional Geriatric Care Managers, National Conference of Gerontological Nurse Practitioners, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

**Direct Care**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

American Bar Association

**Supplemental Positions for D.14**

1) The failure of Recommendation D.14, by one vote, on March 4, 2003, represents a major setback for people with disabilities and other older Americans who may develop personal healthcare needs and wish to choose assisted living as an alternative to nursing home care.

Current state assisted living regulations prohibit many individuals with disabilities and other aging individuals who may acquire conditions later in life from admission to assisted living because these individuals require the use of a catheter, require oxygen, or have some form of medical ostomy. Additionally, current state assisted living regulations can also require a person with a disability to leave their assisted living home when they develop a temporary medical condition that requires bed rest, i.e., severe colds or Grade I or II pressure ulcers.

People with disabilities who have personal healthcare needs have been living independent lives in their own homes for years and are capable to self-manage or self-direct the personal care they need through a spouse, caregiver, or paid personal assistant. Therefore, these personal care needs should not be a barrier to admission or a trigger for discharge from an assisted living residence.

Assisted living providers may choose to provide these services or not, but must allow an individual resident to choose the most appropriate assistant for her or his personal healthcare needs. Assisted living residents should have the option to select between provider services, when available, or choose the private caregiver of their choice to assist with their personal healthcare needs.

The failure of D.14 only serves to reinforce existing negative stereotypes regarding the abilities of individuals with disabilities and forces these individuals or the organizations that represent them to consider taking expensive legal action to protect their civil rights. Recommendation D.14 was consistent with the U.S. Supreme Court's Olmstead decision and President Bush's New Freedom Initiative which are both designed to provide services in the "most integrated setting" according to the Americans with Disabilities Act.

Recommendation D.14's intent was to correct state assisted living regulations that discriminate against people with disabilities and other aging Americans by unjustly forcing them into severely restricted institutional care environments.

*AARP, Alzheimer's Association, Consumer Consortium on Assisted Living, American Assisted Living Nurses Association, American Society of Consultant Pharmacists, NCB Development Corporation, National Association of Professional Geriatric Care Managers, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*



**Direct Care**

2) We oppose this failed recommendation. This recommendation would jeopardize residents' health and safety, because there is no assurance that assisted living residences would be capable of providing care for the residents with healthcare needs. The state licensing agency would be powerless to prevent an assisted living residence from admitting or retaining a resident, even if that assisted living residence was not capable of meeting the resident's needs.

As discussed in other dissents, the majority's recommendations require little health care expertise among assisted living residences. This recommendation establishes no quality of care standards whatsoever. Regardless, this recommendation defines "personal healthcare needs" to include colostomies, ileostomies, and urostomies. Also, the listed personal healthcare needs are just examples, so there is no real limit on the healthcare needs that could be cited by assisted living residences under this recommendation.

Also, this recommendation is completely one-sided. Although the state would be prohibited from citing a "personal healthcare need" as disqualification for assisted living, an assisted living residence could refuse admission or force discharge simply by refusing to provide necessary services.

As an alternative to this recommendation, we recommend a system that would establish levels of care within assisted living -- for example, the Florida system that licenses assisted living residences for either Limited Nursing Services or the more-extensive Extended Congregate Services. (Florida Administrative Code Ann. r. 58A-5.030- 5.031) Such a system would help assure that an assisted living residence would be prepared to meet the needs of a resident with a significant health care condition.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

3) We believe there should be agreement between the resident and the facility about the care being provided to a resident who wants to move into an ALR or who currently resides in the facility. To make a blanket statement that healthcare needs should not be a barrier or trigger encourages the provision of higher levels of care that may exceed the ALRs care capabilities. States must have the flexibility to determine what is best for their individual state with regard to admission and discharge criteria in ALRs.

*American College of Health Care Administrators, National Center for Assisted Living, American Seniors Housing Association*

4) We dissent. The recommendation states that it would be discriminatory to exclude individuals with specified personal health care needs from living in an ALR.

This statement is in conflict with the ALW's recommendation for Transfer and Discharge which states that while residents enjoy certain rights and protections regarding reasonable accommodation under federal statutes including the ADA, FHAA, and the Rehabilitation Act of 1973, there may also be instances where the ALR may not be required to make an accommodation, if the modification would impose an undue financial or administrative burden or would require the ALR to fundamentally alter the nature of its program.

Absent a full set of facts regarding a specific case under which a resident was involuntarily

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discharged, the ALW has no basis on which to declare when a discharge for specified health care conditions would categorically violate the ADA, FHAA or the Rehabilitation Act of 1973 and therefore constitute discrimination.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Direct Care**

**D.15 External Professional Consultant**

**2/3 Maj. Not Reached**

**Recommendation**

Consultant Role and Responsibility

To adequately provide for the needs of residents, each ALR should assess whether an agreement with certain consultants, including, but not limited to, physicians, consultant pharmacists, social workers, and registered dietitians with geriatric experience and an understanding of ALR philosophy to assist the ALR with their particular healthcare and wellness services. The consultants would have the following responsibilities based on the specific needs of the residents\* and the ALR, including:

- Assist the ALR in ensuring the provision and monitoring of those specific services;
- Assist the ALR in developing policies and procedures related to those specific services;
- Assist the ALR in developing performance expectations;
- Assist the ALR in establishing systems and methods for reviewing the quality and appropriateness of care, and other health-related services and provide appropriate feedback;
- Participate in the ALR's quality improvement process; and
- Assist the ALR in developing healthcare and wellness information and communication systems with staff, residents, families and others.

**Implementation**

Guideline for Operations

**Rationale**

The types of individuals moving into assisted living are changing. Residents of ALR on average are older and frailer and have more healthcare and cognitive problems. The need of these individuals span the spectrum from medical/ healthcare to nutritional and psychosocial services.

Because of these needs it is important to consider having an agreement with consultants who have specific knowledge of the healthcare/wellness issues that face this population and the training to help the ALR set up the systems needed to meet the needs of the residents.

**A. Physician Consultant Role**

Physician Coverage and Performance

- Assist the ALR in ensuring that residents have appropriate physician coverage and ensure the provision of physician and health care practitioner services;
- Assist the ALR in developing a process for reviewing physician and health care practitioner credentials;
- Provide specific guidance for physician and health care practitioner performance expectations;
- Assist the ALR in ensuring that a system is in place for monitoring the performance of health care practitioners;
- Facilitate feedback to physicians and other health care practitioners on performance and practices.

## Direct Care

- Assist ALR with resident assessment and development of the clinical component of the service plan, when necessary

### Clinical Care

- Participate in administrative decision-making and the development of policies and procedures related to resident care and medication management;
- Participate in administrative decision-making on staffing levels, coverage, licensing and training requirements for resident-care staff.
- Assist in developing, approving, and implementing specific clinical practices for the ALR to incorporate into its care-related policies and procedures, including areas required by laws and regulations;
- Review, respond to and participate in federal, state, local and other external inspections and
- Assist in reviewing policies and procedures regarding the adequate protection of residents' rights, advance care planning, and other ethical issues.

### Quality of Care

- Assist the ALR in establishing systems and methods for reviewing the quality and appropriateness of clinical care, medication management and other health-related services and provide appropriate feedback;
- Participate in the ALR's quality improvement process;
- Advise on infection control issues and approve specific infection control policies to be incorporated into ALR policies and procedures;
- Assist the facility in providing a safe and caring environment with optimal levels of family and community involvement;
- Assist in the promotion of employee health and safety; and
- Assist in the development and implementation of employee health policies and program

### Education, Information, and Communication

- Promote a learning culture within the facility by educating, informing, and communicating;
- Assist the ALR in developing medical information and communication systems with staff, residents, families and others
- Assist in establishing appropriate relationships with other healthcare professionals.

### B. Social Work Consultant Role

#### Access to Professional Social Work Services

- Assist the ALR staff in ensuring that residents have access to appropriate social work services and ensure the provision of social work and mental health practitioner services;
- Assist the ALR in developing social work staff qualifications and guidelines for practice;
- Assist the ALR in developing a process for reviewing social work practitioner credentials;
- Assist the ALR in developing a system for monitoring performance of social work practitioners;
- Assist the ALR with resident biopsychosocial assessment and development of the clinical component of the service plan, when appropriate.

### Clinical Care

## Direct Care

- Provide direct services to residents, families, and other involved in a resident's care;
- Assist residents, families and others in receiving the maximum benefit of the ALW and community-based social resources throughout the stay of each resident from preadmission to discharge;
- Assist in discharge planning, advocacy, and serve as a community liaison;
- Participate in administrative decision making and the development of policies related to resident biopsychosocial functioning and well being;
- Provide clinical supervision to staff or consulting social workers hired by the ALR as needed;
- Participate in administrative decision making and the development of policies related to resident access to community resources as necessary;
- Participate in administrative decision making on social work staffing levels, coverage, licensing and training requirements;
- Assist in developing, approving, and implementing clinical social work practices for the ALR to incorporate into its care plan related policies and procedures, including areas required by laws and regulations;
- Review, respond to and participate in federal, state, local and other external inspections;
- Assist in reviewing policies and procedures regarding resident's rights, advance care planning and other ethical issues.

### Quality of Care

- Assist the ALR in establishing systems and protocols for revising the quality and appropriateness of social work services, both inside and outside of the ALR;
- Participate in the ALR's quality improvement process;
- Advise the ALR in providing a caring environment and promote the highest level of family and community involvement as possible;
- Assist with establishing employee assistance programs to reduce employee stress and promote employee retention and well being.

### Education, Information and Referral, Interdisciplinary Communication

- Assist the ALR to achieve and maintain a therapeutic environment essential to the optimal quality of life and independent functioning of each resident.
- Assist the ALR in developing information about community resources and entitlements programs for residents, families and others involved with the resident's care;
- Assist in establishing appropriate relationships with other care providers, public and private community agencies, and other services as appropriate;
- Promote ALR-community interaction through encouraging community involvement in the ALR and resident and staff involvement in the community;
- Assist in developing linkages with a wide range of community resources;
- Strengthen and promote communications between residents, their families, and others, and the program or facility staff.

For more information contact:

The National Association of Social Workers, 750 First Street, NE Suite 700, Washington, DC 20002; (202) 408-8600

C. Assisted Living Dietitian Consultant

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Direct Care**

- Consultant Role and Responsibility
- Assist the ALR in assessing the kitchen and food service personnel by reviewing and providing consultation in the following areas:
  - Safe food handling procedures
  - HACCP guidelines
  - Sanitation and safety standards/policies throughout the kitchen
  - Proper techniques for equipment use. (i.e. slicers, ovens, etc.)
  - Nutritional care of residents
  - Assist the ALR in developing policies and procedures that will be implemented to achieve safe and sanitary manner.
  - Review and approve all menus for nutritional adequacy and variety
  - Review with developing policies and procedures that food, water, disposable items and food handling that food is received, stored, prepared, transported and served in a safe and sanitary manner.
  - Assist the ALR with meeting State regulations in kitchen, dining rooms and meal service areas.
  - Review, participate in, and respond to federal, state, local and other external inspection areas.
  - Assist FSD with any budgetary needs (i.e. food cost control, recommending products appropriate for special resident populations, etc.)
  - Monitor compliance of special diet orders.
  - Assist the ALR in hiring FSD or other kitchen personnel
  - Assist in training FSD if needed
  - Assist in providing FSD or other kitchen personnel
  - Monitor resident weights quarterly for weight trends
  - Assist the ALR in developing FSD or other kitchen personnel
  - Assist in training FSD in hiring FSD or other kitchen personnel
  - Assist the ALR in establishing systems and methods for screening residents regarding nutritional status.
  - Assist ALR with developing a process for screening residents regarding nutritional clinical status.
  - Assist ALR with developing FSD and ALR in providing "food council committee."
  - Assist the ALR in establishing criteria for requiring additional dietitian services for high risk nutritional needs.
  - Assist the ALR in establishing systems and methods for screening residents regarding nutritional health care practitioners on areas of nutritional care.
  - Assess any person with nutritional risk and make recommendations to PMD and other component of the service plan.
  - Assist ALR with resident assessment and development of the nutritional clinical component of the service plan.
  - Assist the ALR in recruiting, interviewing, checking references and hiring of activity sta and procedures
  - Assist the ALR in writing mission and philosophy statements, goals, objectives, policies and procedures
  - Assist in scheduling staff, participants, programs and resources

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- Assist the ALR in developing, implementing and evaluating budgets
- Assist in purchasing supplies, equipment, furniture, outdoor furniture and equipment
- Assist the ALR in adapting activities, supplies and equipment to meet residents functional needs and interests
- Monitor staff and participants in action and provide feedback
- Assist the ALR with resident assessments and development of an activity service plan
- Assist in developing community resources
- Develop and provide activity in services for all staff
- Assist the ALR with meeting local/state/federal regulations
- Coordinate transportation services

For More Information contact:  
National Association of Activity Professionals (NAAP), P.O. Box 5530, Sevierville, TN 37864-5530; (865) 429-0717

National Certification Council of Activity Professionals (NCCAP), P.O. Box 62589, Virginia Beach, VA. 23466-2589; (757) 552-0653

The book, *The Professional Activity Manager and Consultant* was developed and support by both the National Association of Activity Professionals (NAAP) and the National Certification Council of Activity Professionals (NCCAP). In 1996 it was copyrighted by the National Association of Activity Professionals and Idyll Arbor Inc. For more information contact Idyll Arbor Inc., P.O. Box 720, Ravensdale, WA., 98051. ISBN 882883-24-1

The agreement itself is an extension of the service plan and the end product of a process in which the Assisted Living Residence, or the ALR and the resident together, identify a resident preference (e.g., to engage in or avoid certain activities or behaviors) which the ALR normally would not recommend or allow, or would remove, because they involve unacceptable risk to the health and safety of the resident or others in the ALR. Ultimately, the shared responsibility agreement process is simply a systemized method of accommodating individual resident choices, or finding acceptable alternatives to those choices, and the propriety of its use depends upon the unique facts and circumstances pertaining to each resident.

Recognition of the need for a shared responsibility agreement normally arises in one of three ways. In some cases, a resident will verbally express to ALR staff a desire to engage in certain activities or behaviors that normally would be prohibited. In other cases, ALR staff may raise the issue where a resident repeatedly engages in behaviors which normal would not be allowed for that resident. Occasionally, third parties such as family members, or ombudsman or other resident advocates may suggest a shared responsibility agreement to resolve complaints or concerns raised by a resident or family.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic

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Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Hospice and Palliative Care Organization, National Association of Professional Geriatric Care Managers, National Conference of Gerontological Nurse Practitioners, Paralyzed Veterans of America, Pioneer Network

#### Organizations Opposing This Recommendation

American Seniors Housing Association, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

#### Organizations Abstaining From the Vote on This Recommendation

Joint Commission on Accreditation of Health Care Organizations

#### Supplemental Positions for D.15

1) Statement in support of the recommendation with modifications. As stated in the rationale section of the recommendation, the types of individuals moving into assisted living are changing. Residents of ALRs on average are older and frailer and have more healthcare and cognitive problems. The needs of these individuals span the spectrum from medical/healthcare to nutritional and psychosocial services.

Because of these needs, it is important for ALRs to consider having an agreement with certain consultants, including but not limited to, physicians, consultant pharmacists, social workers, registered dietitians, and activity consultants with geriatric experience and an understanding of ALR philosophy to assist the ALR with their particular healthcare and wellness services.

The External Professional Consultant recommendation is intended to assist ALRs in providing the highest quality service to its residents and to clarify and define the role of clinician consultants in assisted living.

We suggest that Recommendation D.15 should be a guideline for state regulation rather than an operational model but feel that the decision to contract with professional consultants such as a physician consultant be left up to the individual facilities and not mandated across the board to all ALFs.

As reported in the National Academy for State Health Policy State Assisted Living Policy: 2002, "the trend over that past five to ten years has been for states to offer flexibility [in their ALR requirements] in order to accommodate aging-in-place, which allows people with higher levels of impairment to remain in assisted living and allowing health related services to be provided."

*American Academy of Home Care Physicians, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Association of Professional Geriatric Care Managers, National Association of Activity Professionals,*



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*National Association of Social Workers, National Multiple Sclerosis Society,  
Paralyzed Veterans of America*

2) We oppose this failed recommendation because it does not go far enough. The recommendation does no more than require an assisted living residence to "assess" whether it would be appropriate to consult with a physician, pharmacist, social worker, dietician, or other professional. By contrast, we believe that under certain circumstances an assisted living residence should be required to employ or consult with an appropriate professional.

Existing state law already recognizes that it is sometimes appropriate to require that an assisted living residence employ or consult with a professional. For example, Alabama requires that a physician act as medical director in an assisted living residence providing dementia special care. (Alabama Administrative Code r. 420-5-20-.04, 420-5-20-.06, 420-5-20-.08) Arkansas and Oklahoma require under certain circumstances that an assisted living residence contract with and use a consultant pharmacist. (Code Arkansas Rules 016 06 002, § 702.2.1 (Level II assisted living facilities); Oklahoma Administrative Code § 310:663-9-2(a))

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy,  
National Association for Regulatory Administration, National Association of Local  
Long Term Care Ombudsmen, National Association of State Ombudsman Programs,  
National Citizens Coalition for Nursing Home Reform, National Committee to  
Preserve Social Security and Medicare, National Network of Career Nursing  
Assistants, National Senior Citizens Law Center*

3) We dissent. There are recommendations within the ALW report that we, as individual organizations, helped to develop and continue to support. However, we have come to the conclusion that fundamental differences of principle exist between ALFA and the Assisted Living Workgroup (ALW) in its overall approach to developing recommendations as to how the states might best regulate assisted living. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

Any regulatory guidance to the states should recognize, reflect, and even foster resident-centered care--the unique characteristic that distinguishes assisted living from other forms of long-term care. Resident-centered care involves incorporating the resident's values and experiences, as well as the individual preferences into the definition and evaluation of quality of care and quality of life. At the same time, state governments should be granted regulatory flexibility so as not to just promote basic resident safety, but to actually improve quality of care.

We believe this recommendation gives insufficient attention to defining quality standards from the perspective of the consumer, and fails to acknowledge that states and/or ALRs should consider equally effective alternative approaches to meet the intent of an appropriate recommendation. Further, the recommendation would likely have a disproportionate impact on small providers who lack the resources to have all of the specified consultant relationships.

*Assisted Living Federation of America, National Association for Home Care, Joint  
Commission on Accreditation of Health Care Organizations*

4) We are opposed to this recommendation due to its potential cost implications for residents. Many assisted living residents are on limited incomes. Assisted living providers are capable of

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determining when outside consultants are needed and for what issues.

*National Center for Assisted Living, American Seniors Housing Association*

## ***Topic Group Recommendations Adopted by Two-Thirds Majority of the ALW***

### **Medication Management**

#### **Purpose**

Medication management is an important issue and challenge facing the assisted living industry. Consumer understanding of the services provided, and safe and effective management of the resident's medication regimen are major concerns.

#### **Issues**

In its work on developing recommendations for the assisted living residence, the Medication Management topic group focused on the following areas:

- Development of policies and procedures regarding medication management
- Disclosure of ALR policies and procedures
- Role of licensed and unlicensed assistive personnel in medication management
- Resident assessment and service planning, with regard to medication management
- Medication orders, storage and documentation
- Quality improvement

#### **Participants**

The topic group was co-chaired by Josh Allen, RN, American Assisted Living Nurses Association and Ed Sheehy, Assisted Living Federation of America.

Topic group participants included Jan Brickley, American Society of Consultant Pharmacists; Tom Clark, American Society of Consultant Pharmacists; Diane Crutchfield, American Society of Consultant Pharmacists; Peggy Daley, RN, Consumer Consortium on Assisted Living; Sandi Flores, RN, American Assisted Living Nurses Association; Kathleen Frampton, RN, American Medication Directors Association; Genevieve Gipson, RN, National Network of Career Nursing Assistants; Brian Lindberg, National Association of State Ombudsman Programs; Willie Long, Sunrise Assisted Living; Jane Mayfield, RN, Senior Residential Care Advisors; Ethel Mitty, EdD, RN, National Committee to Preserve Social Security and Medicare; Martha Mohler, RN, National Committee to Preserve Social Security and Medicare; Jonathan Musher, MD, American Medical Directors Association; Mary Ann Outwater, Massachusetts Quality Committee; Doug Pace, American Association of Homes and Services for the Aging; Barbara Reznick, PhD, CRNP, American Geriatrics Society; Karen Kauffman, PhD, National Conference of Geriatric Nurse Practitioners; Carol Robinson, RN, American College of Healthcare Administrators; Shelley Sabo, National Center for Assisted Living; Bradley Schurman, American Association of Homes and Services for the Aging; Bill West, RN, Morningside Management.

## **Medication Management**

### **M.01 Policies and Procedures**

#### **Recommendation**

The assisted living residence will have and implement policies and procedures for the safe and effective distribution, storage, access, security, and use of medications and related equipment and services of the residence by trained and supervised staff.

Policies and procedures of the residence should address the following issues:

1. Medication orders, including telephone orders
2. Pharmacy services
3. Medication packaging
4. Medication ordering and receipt
5. Medication storage
6. Disposal of medications and medication-related equipment
7. Medication self-administration by the resident
8. Medication reminders by the residence
9. Medication administration by the residence
10. Medication administration – specific procedures
11. Documentation of medication administration
12. Medication error detection and reporting
13. Quality improvement system, including medication error prevention and reduction
14. Medication monitoring and reporting of adverse drug effects to the prescriber
15. Review of medications (e.g. duplicate drug therapy, drug interactions, monitoring for adverse drug interactions)
16. Storage and accountability of controlled drugs
17. Training, qualifications, and supervision of staff involved in medication management

#### **Implementation**

Guideline for State Regulation

#### **Rationale**

Many assisted living residents need some level of assistance with medications. Unless the resident is totally independent with regard to medication management, the residence assumes responsibility for the medication management services needed by that resident. Different residents may have differing levels of need for assistance, and the same resident may have differing needs at different times during the stay. The establishment of policies and procedures is a minimum standard that shall be met by any organization that expects to provide effective and accurate medication management services.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

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Workers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for M.01**

1) We dissent. This majority recommendation follows the majority's principal flawed assumption -- that the development of standards can be delegated to each individual assisted living residence. On the contrary, some basic standards must be set by the state, so that residents are adequately protected, and consumers can understand what an assisted living residence can do and must do. Development of facility policies is important -- but certainly not sufficient.

The majority's recommendation merely requires an assisted living residence to establish and implement policies and procedures related to medication. The recommendation (which is written as a proposed regulation) does not specify in any way what these policies and procedures might be, even though many of the 17 specified areas involve procedures that may require some significant level of health care expertise -- for example, "[d]isposal of medications and medication-related equipment," "[m]edication monitoring and reporting of adverse drug effects to the prescriber," "[s]torage and accountability of controlled drugs," and [t]raining, qualifications, and supervision of staff involved in medication management." The majority's recommendation is inadequate guidance, particularly given that the majority's recommendations contemplate that an assisted living residence will care for individuals who have significant health care needs.

In sharp contrast to the imprecise recommendation of the majority, some existing state laws establish meaningful substantive standards. Maine assisted living regulations, for example, establish required procedures for the destruction of medication, the administration of controlled substances, and the recording of medication errors.

(Code of Maine Rules 10-144-113, §§ 5080, 5090, 5120.3)

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. There are recommendations within the ALW report that we, as individual organizations, helped to develop and continue to support. However, we have come to the conclusion that fundamental differences of principle exist between ALFA and the Assisted Living Workgroup (ALW) in its overall approach to developing recommendations as to how the states might best regulate assisted living. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living

**Medication Management**

should look like.” Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

State governments should be granted regulatory flexibility so as not to just promote basic resident safety, but to actually improve quality of care. Further, the totality of the recommendations related to medication management would have a disproportionate impact on small providers. The vast majority of assisted living facilities in this country are less than 50 beds. In fact, the average facility size is less than 16 beds.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.02 Policies and Procedures**

**Recommendation**

Prior to signing the residency agreement, the assisted living residence will disclose and explain in easily understood language policies, procedures, and service capacity relevant to the medication management needs of the residents and associated costs, including the disposition of medications.

**Implementation**

Guideline for State Regulation

**Rationale**

Medications are an important part of the therapeutic regimen for residents. The resident's ability to manage his/her medications may change over time. The ALR shall disclose to the resident\* the policies and limitations of the assisted living residence with regard to medication management. The disposition of medications that are no longer needed is governed by federal and state laws and regulations. Prior to admission, the ALR shall disclose to the prospective resident\* policies of the assisted living residence pertaining to medication disposal.

**Organizations Supporting This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, American Seniors Housing Association, Catholic Health Association of the United States, National Center on Assisted Living, AARP, Alzheimer's Association, Consumers Consortium on Assisted Living, National Senior Citizens Law Center, American Assisted Living Nurses Association, American Medical Directors Association, American Society of Consultant Pharmacists, National Association of Social Workers, National Hospice and Palliative Care Organization, NCB Coming Home Program, National Association of Professional Care Managers, Association of Health Facility Survey Agencies, Pioneer Network, National Association of Activity Professionals

**Organizations Opposing This Recommendation**

National Association of Local Long Term Care Ombudsmen, Center for Medicare Advocacy

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for M.02**

1) We dissent. This recommendation is redundant with several recommendations. The recommendation on Contracts and Agreements which says in part that contracts should provide a comprehensive description of all services provided for a basic fee. Recommendations concerning Pre-Screening and Initial Assessment, and Service Plan also deal with assessing and implementing a care plan related to the resident's need for assistance with medication assistance which would necessitate disclosure of service capacity.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Medication Management

### **M.03 Resident Assessment and Management of Medication**

#### **Recommendation**

Residents who desire to manage and self-administer their own medications shall be assessed by a qualified licensed health professional regarding the ability of the resident to self-administer or the need for medication reminders or medication administration.

The resident's individual service plan should reflect the findings of the most recent resident assessment. The extent of the resident's ability to self-administer or manage medications will be mutually determined by the resident; assisted living residence; and a qualified licensed health professional; and will be included in the resident's individual service plan.

The resident will be re-assessed at least annually, and upon a significant change in physical, cognitive, functional status, or resident choice, to evaluate the resident's continued ability to self-administer or manage medications.

The service plan will be updated to reflect significant changes in the resident's ability to self-administer or need for medication reminders or medication administration.

#### **Implementation**

Guideline for State Regulation

#### **Rationale**

Mistakes made with medications can have serious consequences. While the resident may perceive his/her ability to self-administer to be adequate, these perceptions may not be accurate, especially if some degree of cognitive impairment is present. A qualified licensed health professional will conduct an assessment of the resident's ability to safely self-administer.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Multiple Sclerosis Society, Pioneer Network

#### **Organizations Opposing This Recommendation**



**Medication Management**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for M.03**

1) We dissent. This recommendation is redundant with several recommendations. Recommendations concerning Pre-Screening and Initial Assessment, and Service Plan also deal with assessing and implementing a care plan related to the resident's need for assistance with medication assistance, reporting a change in condition, periodic reassessments, etc

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.04 Resident Assessment and Management of Medication**

**Recommendation**

It is the responsibility of the resident who is self-administering medications his/her medication to provide the ALR with a written list of all prescribed and over-the-counter medication use and changes. When the resident is reassessed for continued ability to self administer or manage medications, the list of current medications will be updated.

**Implementation**

Guideline for State Regulation

**Rationale**

The ALR needs to know the resident's medications so that this information may be conveyed to the appropriate health professionals in the event of an emergency situation.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Senior Citizens Law Center, National Adult Family Care Organization

**Supplemental Positions for M.04**

1) We dissent. This recommendation is redundant with recommendations concerning Pre-Screening and Initial Assessment, and Service Plan which also deal with assessing and implementing a care plan related to the resident's need for assistance with medication assistance, reporting a change in condition, periodic reassessments, etc. The rights of residents to confidentiality of their medical affairs (refer to Recommendation on Residents Rights) would have to be discussed before assigning a responsibility to a resident to report medication usage to the ALR.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.05 Resident Assessment and Management of Medication**

**Recommendation**

For residents whom the ALR administers medication, an authorized prescriber(s) shall prescribe all medication, including over-the-counter medications. Such orders are kept current for all medications. The facility shall develop a process to ensure that the primary care physician be kept aware of all medications taken by the resident.

**Implementation**

Guideline for State Regulation

**Rationale**

This guideline is for the protection of the resident and the residence. Facility staff may not have the expertise to evaluate possible interactions between prescription drugs and over-the-counter medications or herbal supplements.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Association for Regulatory Administration, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

American Seniors Housing Association, Assisted Living Federation of America, Joint Commission on Accreditation of Health Care Organizations, National Center on Assisted Living

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for M.05**

1) We dissent. The general thrust of this recommendation is that a person who prescribes medications must be authorized under existing laws. As such, this recommendation provides no new guidance to the states as to how improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

2) The organizations below agree with the concept of the recommendation passed as recommendation M.05 --Resident Assessment and Management of Medication--with one slight difference of opinion. We believe that the sentence that states that the "ALR must develop a process to ensure that the primary care physician be kept aware of all medications taken by the resident" places a burden on the ALR that is not achievable. Indeed, it is the ALR that must be kept aware by the primary care physician of the medications for which their residents have been prescribed for whom they provide medication management.

*American Seniors Housing Association, National Center for Assisted Living*

## **Medication Management**

### **M.06 Medication Administration by Medication Assistive Personnel**

#### **Recommendation**

Medication assistive personnel (MAP) may administer medications after successfully completing a state approved training course that includes a written and performance-based competency examination. To qualify for training as a MAP, the individual shall be a high school graduate (or equivalent) and have English language proficiency.

#### **Implementation**

Guideline for State Regulation

#### **Rationale**

When used incorrectly, medications may fail to achieve their intended purpose of controlling chronic diseases, and improving functional status and quality of life. Medication errors can also result in severe adverse effects, including loss of life. Because the consequences of inappropriate medication use are potentially severe, safeguards are needed to prevent harm to residents.

While it may not always be possible or feasible to have a licensed nurse to administer or supervise all medications for residents who need assistance in the assisted living setting, the personnel who provide this support need adequate training and supervision to safely fulfill these responsibilities. When the assisted living residence assumes responsibility for medication administration for one or more residents, the MAP who provides these duties shall have the training, supervision and evaluation needed for effective performance.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Pioneer Network

#### **Organizations Opposing This Recommendation**

AARP, Assisted Living Federation of America, National Association of Home Care, Center for Medicare Advocacy, National Association of State Ombudsman Programs, National Senior Citizens Law Center, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants

#### **Organizations Abstaining From the Vote on This Recommendation**

Association of Health Facility Survey Agencies, Joint Commission on Accreditation of Health Care Organizations, National Association of Social Workers

**Medication Management**

**Supplemental Positions for M.06**

1) To meet the demands of safe and effective care, the performance of MAP medication administration should be under the supervision of a registered nurse (who may delegate this supervision to an LPN). States should allow the MAP to perform their duties through either or both approaches:

- 1) The state supports/creates a category of trained and certified medication assistive personnel who administer medication under the supervision of a registered nurse;
- 2) A registered nurse may delegate medication administration to MAP.

The RN may delegate supervision of the MAP to a Licensed Practical/Vocational Nurse. When the licensed nurse is not supervising onsite, he/she will be accessible by other means (e.g. telephone, pager, etc.).

The ALR administrator (or manager) and nurse supervisor are responsible for medication administration. MAP are accountable to the state, the facility administrator, and nurse supervisor for safe, efficient, and effective performance of their duties.

Appropriate qualified licensed health professionals should work with the ALR to develop policies and procedures related to:

- a) Medication management
- b) Receipt of medications and medication orders
- c) PRN medication administration
- d) Complex or high-risk drug regimens
- e) Supervision of the MAP, including determining when more frequent visits by the nurse are necessary
- f) Appropriate measures to address inadequate performance by the MAP
- g) Communication between MAP and supervising nurse
- h) Definition and documentation of medication errors and adverse medication events

The resident should be informed, in writing and prior to admission, of the ALR policies regarding medication administration by the MAP

Personnel who administer medications must be trained to practice under prevailing standards of medication administration as taught in accredited schools of nursing, and supervise to safely fulfill these responsibilities.

*AARP, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Healthcare Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Activity Professionals, Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

2) We dissent. This dissent is based on opposition to the broad authorization by medication management recommendations for "Medication Assistive Personnel" to administer medication. Although we recognize that there may be a need in an assisted living setting for administration of medication by non-nurses, the majority's recommendations give broad authority to MAPs, but require little training or oversight.

**Medication Management**

Specifically, the majority's recommendations would allow any virtually any type of medication to be administered by a person with a high school equivalency degree, and some unspecified modicum of particularized training. This would be true in any assisted living residence, even if a nurse was almost never present, or if (for example) the residence claimed a specialization in the care of complex medical conditions.

It should be noted that existing state law offers much more specificity about training requirements. In Indiana, for example, a "qualified medication aide" must complete at least 100 hours of training – at least 60 hours of classroom instruction, plus at least 40 hours of supervised practicum. The practicum supervision must be conducted by a nurse. (Indiana Administrative Code, Title 412, §§ 2-1-3, 2-1-5)

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

3) We dissent. Recommendation requires states to adopt a state-approved training course for MAPs. Some states currently allow aides who have completed and passed a training program to administer medications, while other states do not. To a large extent, the use of MAPs depends on the scope and interpretation of statutory or regulatory language related to delegation in each state's Nurse Practice Act (NPA). There may be additional statutes and regulations outside of those governed by state boards of nursing that will impact on delegation.

This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.07 Medication Assistive Personnel Job Description**

**Recommendation**

The MAP shall have a job description that identifies the nature and scope of medication-related responsibilities. These duties shall not exceed the scope of the training and competency examination.

**Implementation**

Guideline for State Regulation

**Rationale**

The greater the expectations and duties of the MAP, the more training will be needed to meet the expectations. The job description should not include duties for which the MAP is not trained and evaluated.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Adult Family Care Organization, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Association of Home Care, National Association of State Ombudsman Programs, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Senior Citizens Law Center, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants

**Organizations Abstaining From the Vote on This Recommendation**

Joint Commission on Accreditation of Health Care Organizations

**Supplemental Positions for M.07**

1) We dissent. There is no real content to this recommendation, particularly because this recommendation purportedly is a guideline for state regulation. The substance of the job description is left entirely to the assisted living residence, subject to other weak recommendations pertaining to medication assistive personnel.

The rationale acknowledges: "The greater the expectations and duties of the MAP, the more training will be needed to meet the expectations." Nonetheless, none of the recommendations pertaining to medication assistive personnel (with the sole exception of M.18, for insulin injections) makes any



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accommodation for the complex medical conditions presented by some assisted living residents.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. This recommendation for state regulation attempts to micromanage routine administrative paperwork and is beyond the mandate of the ALW.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Medication Management

### M.08 Curriculum for MAP Training Program

#### Recommendation

The learning and performance objectives for the MAP training program shall include:

- a. Satisfactorily demonstrate the six rights of medication administration (right resident, right drug, right dose, right route, right time, right documentation)
- b. Measure pulse, temperature, blood pressure, and respirations
- c. Measure pain using (an) appropriate scale(s)
- d. Describe the purpose of the various routes of medication administration
- e. Demonstrate appropriate storage of medications
- f. Follow appropriate infection control measures
- g. Understand anatomy as it relates to routes of medication administration
- h. Administer medications via the following routes: oral; topical, including topical patches; rectal; vaginal; stomal; eye, ear and nasal drops; inhalers; nebulizers; sublingual
- i. Documentation associated with the administration of medications
- j. Identification and reporting of common medications and their side effects
- k. Use resources/references related to medications
- l. Understand regulatory requirements related to medications

#### Implementation

Guideline for State Regulation

#### Rationale

The training program for the MAP within each state should be standardized to ensure the minimum standards are achieved. The items included on this list are considered to be important in any training program for MAPs involved in assisted living.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Pioneer Network

#### Organizations Opposing This Recommendation

American Seniors Housing Association, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Association of Home Care, National Committee to Preserve Social Security and Medicare, Center for Medicare Advocacy, National Association for Regulatory Administration, National Senior Citizens Law Center, National Academy of Elder Law Attorneys, National Citizens' Coalition for Nursing Home Reform, National Network of Career Nursing Assistants

#### Organizations Abstaining From the Vote on This Recommendation

Joint Commission on Accreditation of Health Care Organizations, Association for Social Workers

**Medication Management**

**Supplemental Positions for M.08**

1) We dissent. In general, the recommendations for medication assistive personnel do not recognize that some assisted living facilities care for residents with significant health care conditions. The very general standards set forth in this recommendation are inadequate to meet the needs of these vulnerable residents. The standards are set improperly at the lowest common denominator. This is particularly troubling given that a MAP has authority in the recommendations to administer medication through the rectum, the vagina, or a stoma.

These standards need more detail, and trainers should be required to meet certain minimum standards. Curriculum and trainers should be approved by the state health department or board of nursing.

Some existing state laws contain the type of detail that recommendation M.08 lacks. In Indiana, for example, training for "qualified medication aides" must include fundamentals of pharmacology, fundamentals of each of nine systems within the body, psychotherapeutic medications, infection, nutritional deficiencies, positioning of the patient, use of an oximeter, hemocult testing, applying a dressing to a healed gastrostomy tube site, and 21 other topics related to the administration of medication. The classroom training must be conducted by a registered nurse who has completed a state health instructor course. (Indiana Administrative Code, Title 412, § 2-1-3(2))

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. This recommendation sets forth the requirements that a state must include in a training program and infringes upon state authority. This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living. There is also an absence of any data to support what is considered to be the optimal training curriculum for assistive personnel.

*American Seniors Housing Association, Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.09 Ongoing MAP Training**

**Recommendation**

After successful qualification, MAP will receive relevant, regularly scheduled and as needed inservice or continuing education by a qualified licensed health professional that will enhance the MAP's ability to perform with confidence and competency, proficiency, safe practice, and meeting residents needs.

**Implementation**

Guideline for State Regulation

**Rationale**

New medications are continually being introduced in the market, and the residence may periodically change procedures as part of continuous quality improvement. It is important for MAP to keep informed of changes that impact the safe oversight or administration of medications.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Adult Family Care Organization, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Association of Home Care, Center for Medicare Advocacy, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center, National Association for Regulatory Administration, National Academy of Elder Law Attorneys, National Citizens' Coalition for Nursing Home Reform, National Network of Career Nursing Assistants

**Organizations Abstaining From the Vote on This Recommendation**

Joint Commission on Accreditation of Health Care Organizations, National Association of Social Workers

**Supplemental Positions for M.09**

1) We dissent. This recommendation – which is being recommended as a guideline for state regulation – could never be enforced. Who is to say what is “relevant, regularly scheduled and as needed inservice or continuing education”? This recommendation, like many others, is so general that it provides no meaningful guidance for state regulation.

Existing state laws provide the content that this recommendation lacks. For example Kansas, which

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limits its nurse aides to oral administration and external application, requires ten hours of continuing education every two years. The continuing education must be provided by a registered nurse approved as an instructor by the state. (Kansas Administrative Regulations § 28-39-170(a), (b)(1)) Oklahoma requires at least eight hours of continuing education annually. (Oklahoma Administrative Code § 310:677-13-1(b))

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. Some states currently allow aides who have completed and passed a training program to administer medications, while other states do not. To a large extent, the use of MAPs and training requirements depends on the scope and interpretation of statutory or regulatory language related to delegation in each state's Nurse Practice Act (NPA). There may be additional statutes and regulations outside of those governed by state boards of nursing that will impact on delegation.

This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Medication Management

### M.10 MAP Activities Related to Medication Administration

#### Recommendation

MAP may perform the following activities related to medication administration, according to the needs of the individual resident:

- a. Receive medication and store it in an appropriate and secured location
- b. Identify the correct resident
- c. When indicated by the prescriber's orders, measure vital signs and administer medications accordingly
- d. Take the medication from the original container
- e. Crush or split the medication as necessary and ordered by the prescriber
- f. Place the medication in a medication cup or other appropriate container
- g. Bring and hand the medication to the resident
- h. Place the medication in the resident's mouth (or other route as indicated)
- i. Observe the resident taking their medication
- j. Complete documentation associated with medication administration.

MAPs may administer medication by the following routes: Oral; Topical, including topical patches; Rectal; Vaginal; Stomal; Eye, ear and nasal drops; Inhalers; Nebulizers; Sublingual

#### Implementation

Guideline for State Regulation

#### Rationale

At least 17 definitions of "medication administration" or "assistance with self-administration" have been developed in various states. There is no practical difference between these concepts, as confirmed by the wide variation in attempts to distinguish them.

The key issue in assisted living is whether the resident is able to independently manage medications without assistance. If the resident needs assistance at any level, the resident has accepted responsibility for managing the medications. The staff of the organization should then be expected to provide the needed assistance.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Pioneer Network

#### Organizations Opposing This Recommendation

## Medication Management

Assisted Living Federation of America, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

### Organizations Abstaining From the Vote on This Recommendation

Joint Commission on Accreditation of Health Care Organizations, National Association of Social Workers

### Supplemental Positions for M.10

1) We dissent. This recommendation puts residents' health at risk. The recommendation contemplates that medication assistive personnel could administer medication through the rectum, the vagina, or a stoma, and could administer any type of medication. This would be done even though the "supervising" nurse would infrequently or never be at the assisted living residence.

As explained above, in a dissent to recommendation M.09, the majority's training requirements for MAPs are very sketchy. Many existing state laws are much more careful in authorizing unlicensed staff members to handle medication. In Ohio, for example, staff members must be trained by a nurse, and are limited to assistance with a resident's self-administration of medication – reminding a resident to take medication, helping a resident to read and open a medication bottle, or assisting "a physically impaired but mentally alert resident" in the necessary physical tasks. (Ohio Administrative Code §§ 3701-17-55(E)(2)(a), 3701-17-59(F)) In Kansas a medication aide can administer medication only if the medication is for oral administration or external application. (Kansas Administrative Regulations § 28-39-170 (b)(1))

Administration of medication by unlicensed personnel might be an appropriate option in some circumstances, but such a program would need stricter limitations on the medication to be administered, and/or higher standards for training and supervision.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. Some states currently allow aides who have completed and passed a training program to administer medications, while other states do not. To a large extent, the use of MAPs and the scope of practice depend on the specification and interpretation of statutory or regulatory language related to delegation in each state's Nurse Practice Act (NPA). There may be additional statutes and regulations outside of those governed by state boards of nursing that will impact on delegation.

This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint*

**Medication Management**

*Commission on Accreditation of Health Care Organizations*



## Medication Management

### M.11 Medication Packaging

#### Recommendation

Each assisted living residence should adopt a consistent style of medication packaging for all residents for whom the residence provides medication administration. To the extent possible and consistent with meeting the needs of providing affordable care, medications for ALR residents should be provided in specialized packaging systems.

#### Implementation

Guideline for State Regulation

#### Rationale

Reducing process variation is a standard principle of continuous quality improvement. The consistent use of a specialized medication packaging system, such as unit dose or "bingo cards" throughout the facility provides a means of positive medication identification and reduces the risk of medication errors. Some systems may allow return and reuse of medications, which provides a cost savings to the resident.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Adult Family Care Organization, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

#### Organizations Opposing This Recommendation

Assisted Living Federation of America, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

#### Organizations Abstaining From the Vote on This Recommendation

None

#### Supplemental Positions for M.11

1) We dissent. The specialized packaging systems referenced in this recommendation are extremely important. In general, these specialized packaging systems hold one dosage of medication in a separate plastic bubble. Use of these packaging systems, instead of pouring out pills from a bottle, makes it much more likely that a resident will get a correct dosage – particularly if medication is to be administered by unlicensed "medication assistive personnel."

## Medication Management

Unfortunately, the majority's recommendation contains no requirement that these specialized packaging systems actually be used. The recommendation suggests that medications "should be" provided in specialized packaging systems, but only "[t]o the extent possible and consistent with meeting the needs of providing affordable care." If adopted as a regulation (as suggested by the majority), this recommendation would be meaningless, because an assisted living residence could be exempted merely by claiming that the appropriate packaging system was too expensive. By contrast, a meaningful regulation would require use of these specialized packaging systems.

Existing state laws are more appropriately prescriptive. For example, Alabama currently requires that assisted living facilities use these specialized packaging systems. (Alabama Administrative Code r. 420-5-4-.06(4)(j) (requiring "unit dose packaging"))

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. It is not known whether the process for timely adjustment of medications (when medications are added or deleted) is feasible with multi-dose packaging, especially in ALRs that receive medication from several pharmacies. The issue is when a medication is added or discontinued from a multi-dose pack, only the pharmacist may break into the pack and make the change – this is a logistical problem when a pack is already dispensed with multiple doses and either the pharmacy has to issue a new multi-dose pack (and the old one is discarded and wasted) or the pharmacist has to come to the ALR to remove/add the medication to the pack.

There are issues related to limiting consumer choice as well— requiring the resident to use a designated packaging system from a single pharmacy eliminates the resident's right to choose their own pharmacy; and the practice may result in increased medication costs if the resident was able to receive a better deal for their routine medications via mail order or another pharmacy provider.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Medication Management

### **M.12 Medication Packaging**

#### **Recommendation**

Congress and states should require all publicly funded pharmacy benefit programs to provide payment for specialized packaging for medications for older adults, including those who reside in assisted living. These pharmacy benefit programs include those affecting the Veterans Administration; retired federal employees; retired military personnel; medicare outpatient pharmacy benefit, if implemented; Medicaid.

#### **Implementation**

Guideline for Federal and State Policy

#### **Rationale**

To promote safe, accurate, and efficient medication administration to residents, the assisted living residence needs to adopt a consistent style of specialized medication packaging throughout the residence. Pharmacy benefit programs for older adults shall consider the special needs of those older adults who reside in assisted living or nursing facilities, or need specialized packaging to promote safe medication management practice

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Social Workers, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

#### **Organizations Opposing This Recommendation**

Assisted Living Federation of America

#### **Organizations Abstaining From the Vote on This Recommendation**

None

#### **Supplemental Positions for M.12**

1) We dissent. No estimate is given of the cost of this recommendation or how it would be funded. Beyond the mandate of the ALW to make recommendations for new federal spending.

*Assisted Living Federation of America, National Association of Home Care, Joint*

**Medication Management**

*Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.13 Storage**

**Recommendation**

Medications shall be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier, and in accordance with federal and state laws and regulations. Medications stored inside of a resident's unit shall be secured and accessible only to the resident, authorized persons, or both. Medications stored by the assisted living residence shall be stored in a designated area, which is secure, locked, and accessible only to authorized personnel.

**Implementation**

Guideline for State Regulation

**Rationale**

When stored at inappropriate temperatures, some medications are subject to rapid deterioration. Other medications, such as morphine and related products, are desirable targets for theft or diversion, and shall be stored securely. Residents with cognitive impairment and mental confusion may attempt to take medications that are not intended for them, if conditions permit. The residence has a responsibility to ensure that medications are stored appropriately.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Social Workers, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Adult Family Care Organization, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for M.13**

- 1) We dissent. The thrust of this recommendation is that ALR must comply with existing federal

**Medication Management**

and state laws and regulations regarding storage of medications. As such, this recommendation provides no new guidance to the states as to how to improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Medication Management

### **M.14 Medication Records**

#### **Recommendation**

(1) The ALR shall maintain and periodically update the following medical information on every resident:

- (a) Emergency contacts (family/guardian)
- (b) Primary physician
- (c) Pharmacy provider
- (d) Current medical conditions and diagnoses
- (e) Allergies

(2) The ALR shall maintain a record on each resident to whom the residence administers medications. The record should include:

- (a) Resident's name;
- (b) Room number;
- (c) Allergies;
- (d) Diagnoses;
- (e) Prescriber's name;
- (f) Current record of all prescription and non-prescription medication;
- (g) Medication name, strength, dosage form, dose, route of administration, and any special precautions;
- (h) Frequency of administration and administration times;
- (i) Duration of therapy;
- (j) Date ordered, date changed, date discontinued;
- (k) Indication for use of as needed (PRN) medications;
- (l) Date and time of medication administration;
- (m) Name and initials of the person administering the medication; and
- (n) Location of where resident's medications are stored

#### **Implementation**

Guideline for State Regulation

#### **Rationale**

Assisted living residents are usually frequent users of the health care system. The assisted living residence should maintain basic information about each resident so that critical information can be available to the health professionals who care for the resident, especially in emergency situations.

When the residence accepts responsibility for medication management, basic information about the resident, medications, and conditions being treated shall be maintained. This information may be critical in later evaluations of the resident's drug therapy, including effectiveness and safety of the medications in use.

#### **Organizations Supporting This Recommendation**

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Medication Management**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Social Workers, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for M.14**

1) We dissent. In our view, the bulk of the ALW's recommended "guidance" to the states does not, as the Senate Special Committee on Aging asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*



***Topic Group Recommendations  
That Did Not Reach Two-Thirds Majority  
Medication Management***

*The following recommendations did not reach a two-thirds majority of the ALW. The recommendations showing a voting record were unable to reach two-thirds majority at the final vote. The recommendations that do not show a voting record were unable to reach two-thirds majority during the development process.*

**Medication Management**

**M.15 Definitions**

**2/3 Maj. Not Reached**

**Recommendation**

- a. Significant Change: A new or markedly different physical, functional, cognitive or psychosocial condition in a resident that impacts the service delivery of the resident's individual service plan, to include:
- Deterioration or improvement in an individual's health status or ability to perform activities of daily living;
  - A deterioration or improvement in an individual's behavioral or mood status.
- b. Authorized Prescriber – A licensed health professional that meets the federal and state requirements for prescribing medications and treatments.
- c. Medication Assistive Personnel (MAP) are caregivers who are not licensed health professionals but have successfully completed training and a state-approved competency examination, that permits the person to administer medications to a resident.
- d. Medication Management is the structures and processes established by the assisted living residence to establish accountability and safe use of medications. Elements of medication management include:
- Acquisition of medications
  - Storage of medications
  - Receipt and verification of medications
  - Administration of medications
  - Medication reminders
  - Disposition of medications
  - Resident assessment and monitoring
  - Record keeping
  - Medication review
  - Quality improvement
  - Resident identification system (e.g. photographs)
- e. Medication Administration is the process of providing medications to residents or assisting residents with taking their medications. Medication administration may include the following elements, which can only be performed by medication assistive personnel or qualified licensed health professionals:
- Observe the resident taking their medication, to verify consumption of the medication
  - Take the medication from the original container
  - Correctly identify the resident
  - Place the medication in a medication cup or other appropriate container
  - Crush or split the medication as necessary and ordered by the prescriber
  - Bring and hand the medication to the resident
  - Place the medication in the resident's mouth (or other route as indicated)
  - Document that the medication was administered to the resident, or refused by the resident
  - Assisting the resident with self-administration

## Medication Management

f. Medication Reminder – Verbal or written= cuing to alert the resident to take scheduled medication, including documentation that the resident was reminded.

g. Qualified licensed health professional is a physician, physician's assistant, pharmacist, nurse practitioner, or registered nurse acting within their scope of practice.

h. Self-Administration – Independent management and administration of medication by the resident without assistance or oversight from the assisted living residence. This could include the use of electronic cuing devices.

### **Implementation**

Guideline for State Regulation

### **Rationale**

In summary, three levels are recognized with regard to residents and medications:

- Resident self-administration (no involvement by residence staff)
- Medication reminders (can be done by staff who are not trained as MAPs)
- Medication administration, which can be done by appropriate health professionals or unlicensed assistive personnel (MAPs)

Balancing the goals of the assisted living workgroup was a driving force in developing these recommendations. Consumers, providers, regulators, and health professionals have valid concerns related to medication management in the assisted living residence. These sometimes-differing goals include:

- Resident autonomy in decision-making
- Resident safety and protection from medication errors and medication-related problems
- Flexibility for the assisted living residence
- Managing costs for the resident and the assisted living residence
- Responsibility of the nurse and other licensed health professionals for the role of the medication assistive personnel
- Reciprocity between states of qualifications and certifications for medication assistive personnel

State laws and regulations governing the administration and use of medications in assisted living vary considerably. In some states, the term "assistance with self-administration" is used in place of "administration" to describe the same process. This is due to legal restrictions that permit the use of the term "administration" only in the context of licensed health professionals. The Assisted Living Workgroup recommends that the term "assistance with self-administration" NOT be used because of the confusion that results from use of the term.

The assisted living workgroup recommends that the term "administration" be used to describe the activities associated with administering or assisting residents with medications, whether these activities are conducted by a health professional or by unlicensed assistive personnel (with appropriate training and competency testing).

## **Medication Management**

It is recognized that some states will need to change laws or regulations to adopt the medication management model presented here. Because of the wide variability in state laws and regulations on this subject, this would be true no matter what model or recommendations are made. This model was designed to provide a medication management system that meets the needs of the residents and the residence.

### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

### **Organizations Opposing This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

### **Organizations Abstaining From the Vote on This Recommendation**

None

### **Supplemental Positions for M.15**

1) Statement in support of the recommendation. It is necessary to clarify the ambiguity that exists in many state regulations regarding the terms medication management, medication administration, and assistance with medications. It is additionally necessary to clarify the role of unlicensed staff persons in medication management and administration. This position is intended to show strong support for the definitions and medication management model as described in the above recommendation.

To clarify this, text from the rationale is restated:

State laws and regulations governing the administration and use of medications in assisted living vary considerably. In some states, the term "assistance with self-administration" is used in place of "administration" to describe the same process. This is due to legal restrictions that permit the use of the term "administration" only in the context of licensed health professionals. The Assisted Living Workgroup recommends that the term "assistance with self-administration" NOT be used because of the confusion that results from use of the term.

It is recommended that the term "administration" be used to describe the activities associated with administering or assisting residents with medications, whether these activities are conducted by a health professional or by unlicensed assistive personnel (with appropriate training and competency testing).

## Medication Management

It is recognized that some states will need to change laws or regulations to adopt the medication management model presented here. Because of the wide variability in state laws and regulations on this subject, this would be true no matter what model or recommendations are made. This model was designed to provide a medication management system that meets the needs of the residents and the assisted living residence.

*AARP, American Seniors Housing Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, Association of Professional Geriatric Care Managers, American College of Healthcare Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Activity Professionals, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

2) We oppose this failed recommendation. This opposition is based on the recommendation's definition of "Medication Assistive Personnel" or "MAP."

Medication mistakes have been recognized as a serious problem within assisted living. See, e.g., General Accounting Office, Assisted Living: Quality-of-Care and Consumer Protection in Four States 27, GAO/HEHS-99-27 (1999) (medication administration the third most common problem in assisted living). This problem could be addressed by requiring all medication administration to be performed by nurses, but other medication management recommendations authorize the use of MAPs for the administration of virtually all types of medication, even though the MAPs may be minimally-trained for the administration of medication, without knowledge of even basic personal care skills, and without meaningful supervision.

Medication administration by unlicensed personnel might be an acceptable strategy for some residents, and for some medication. But the other medication management recommendations make no allowances for the resident's health care conditions, or for the type of medication being administered. Existing state laws are far superior in balancing safety with expense, and in recognizing that some assisted living residents have health care conditions that require nurse expertise.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

3) We agree with much of the recommendation but believe that letter G needs to read as follows: Qualified Licensed Health Professional is a physician, physician's assistant, pharmacist, nurse practitioner, or licensed nurse (in lieu of registered nurse) acting within their scope of practice.

*Alzheimer's Association, American Seniors Housing Association, National Center for Assisted Living*

4) We dissent. Many of the ALW's recommendations on Medication Management hinge on the use Medication Assistive Personnel (MAPs) administering medications to residents. MAPs would perform their duties under the supervision of a RN.

Some states currently allow aides who have completed and passed a training program to administer

**Medication Management**

medications, while other states do not. To a large extent, the use of MAPs depends on the scope and interpretation of statutory or regulatory language related to delegation in each state's Nurse Practice Act (NPA). There may be additional statutes and regulations outside of those governed by state boards of nursing that will impact on delegation.

This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.16 Supervision of Medication Assistive Personnel**

**2/3 Maj. Not Reached**

**Recommendation**

The performance of MAP medication administration is under the supervision of a registered nurse. States will allow the MAP to perform their duties through either or both approaches:

- 1) The state creates a new category of trained and certified medication assistive personnel who administer medication under the supervision of a registered nurse;
- 2) A registered nurse may delegate medication administration to MAP.

When not supervising onsite, a registered nurse will be accessible by other means (e.g. telephone, pager, etc.). The RN may delegate supervision of the MAP to a Licensed Practical/Vocational Nurse.

A Registered Nurse will verify the MAPs medication administration competencies, including basic knowledge regarding medication issues, at the time of employment by the ALR and/or prior to the MAPs administration of any medication.

The ALR administrator (or manager) and RN supervisor are responsible for medication administration. MAP are accountable to the state and to the facility administrator, and RN supervisor for safe, efficient, and effective performance of their duties.

The RN and appropriate qualified licensed health professionals will work with the ALR to develop policies and procedures related to:

- a) Medication management
- b) Receipt of medications and medication orders
- c) PRN medication administration
- d) Complex or high-risk drug regimens
- e) Supervision of the MAP, including determining when more frequent visits by the RN are necessary
- f) Appropriate measures to address inadequate performance by the MAP
- g) Communication between MAP and supervising RN; role of LPN/LVN if applicable
- h) Definition and documentation of medication errors

The resident is informed in the admission agreement of the ALR policies regarding medication administration of the MAP and supervision by the RN (and licensed nurse, if applicable).

**Implementation**

Guideline for State Regulation

**Rationale**

Personnel who administer medications shall be trained to practice under prevailing standards of medication administration as taught in accredited schools of nursing, and supervise to safely fulfill these responsibilities.

Definitions (from Delegation: Concepts and Decision-Making Process, National Council o

## Medication Management

State Boards of Nursing, 1995)

--Accountability: Being responsible and answerable for actions or inactions of self or others in the context of delegation.

--Delegation: Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation.

--Supervision: The provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to unlicensed assistive personnel.

The National Council on State Boards of Nursing (NCSBN) is recommended as a resource for guidelines regarding the principles and practices of appropriate and safe delegation

### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

### **Organizations Opposing This Recommendation**

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

### **Organizations Abstaining From the Vote on This Recommendation**

American Bar Association

### **Supplemental Positions for M.16**

1) We oppose this failed recommendation. Under this recommendation, a nurse might only be at the assisted living residence once or twice a year, or even less frequently. The recommendation in December 2002 stated that "[a] registered nurse will be onsite to directly observe each MAP at least quarterly," but the current recommendation contains no requirement at all that a nurse be present.

The recommendation acknowledges that medication assistive personnel might be involved with "PRN [as-needed] medication administration" and "[c]omplex or high-risk drug regimens." The recommendation, however, contains no assurances that medication assistive personnel would be capable of handling such difficult situations, particularly considering that a nurse almost certainly would not be on-site.

The recommendation also attempts to draw a confusing distinction between supervision and



## Medication Management

delegation. The distinction suggests that delegation to medication assistive personnel could be carried out even if the personnel were neither trained nor certified.

Many state laws require much greater participation by licensed health care professionals. In many states – California, Florida, and Illinois, for example – all medication administration must be performed by a licensed health care professional. (California Code of Regulations, Title 22, §§ 87575,(a)(5), (6), 87582(b); Florida Administrative Code Annotated r. 58A-5.0181(1)(e)(2); 210 Illinois Compiled Statutes Annotated 9/70) Participation by licensed health care professionals is mandated even in those states that authorize administration by unlicensed personnel; in Oklahoma, for example, medications must be reviewed monthly by a registered nurse or pharmacist, and quarterly by a consultant pharmacist. (Oklahoma Administrative Code § 310:663-9-2(a))

*American Geriatrics Society, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Conference of Gerontological Nurse Practitioners, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. Some states currently allow aides who have completed and passed a training program to administer medications, while other states do not. To a large extent, the use of MAPs depends on the scope and interpretation of statutory or regulatory language related to delegation in each state's Nurse Practice Act (NPA). There may be additional statutes and regulations outside of those governed by state boards of nursing that will impact on delegation.

This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

3) We support the use and training of MAP and medication administration. The performance of MAP medication administration should be under the supervision of a licensed nurse (in lieu of registered nurse) acting within their scope of service.

*National Center for Assisted Living, American Seniors Housing Association*

**Medication Management**

**M.17 MAP and PRN Medications**

**2/3 Maj. Not Reached**

**Recommendation**

MAP may administer PRN (as needed) medications when the medication orders meet all of the following specifications:

- a. The PRN medication has been prescribed for the resident by an authorized prescriber.
- b. The minimum time interval for the medication is clearly defined in the prescriber's instructions (e.g. every 4 hours, not every 4-6 hours)
- c. The symptom or conditions for administration of the medication are clear and specific in the prescriber's instructions (e.g. PRN headache or knee pain, not PRN pain).
- d. Instructions for contacting the prescriber are included in the prescriber's instructions (e.g. Acetaminophen 325 mg tablets, two tablets every four hours PRN fever < 101 degree F, contact prescriber if 101 or above).

When the resident is capable of requesting a dose of PRN medication, the MAP may administer the medication to the resident. When the resident is unable to initiate the request for a PRN medication, the MAP should check for the symptoms or conditions related to the administration of the PRN medication and administer the PRN medication as needed.

**Implementation**

Guideline for state regulation.

**Rationale**

Clearly defining criteria for the use of PRN medications, it removes the need for a MAP to make a clinical assessment and judgment as when to administer it.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Adult Family Care Organization, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

American College of Health Care Administrators, American Seniors Housing Association, Assisted Living Federation of America, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association of State Ombudsman Programs, National Association of Home Care, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Association of Health Facility Survey Agencies, Joint Commission on Accreditation of Health Care Organizations, National Association of Social Workers, National Association of Local Long Term Care Ombudsmen

**Medication Management**

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**Supplemental Positions for M.17**

1) Statement in support of the recommendation. PRN medications are commonly prescribed and administered in a variety of settings, including one's own home. In order for the role of the MAP to be complete and to truly meet the needs of the resident, PRN medications must be addressed. The above recommendation (M.17) provides for a system of training and competency verification prior to allowing the MAP to administer the PRN medication. The recommendation also provides for additional safety by ensuring proper documentation both in the prescriber's instructions and on the medication label.

*AARP, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, National Association of Activity Professionals, NCB Development Corporation, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Paralyzed Veterans of America*

**Medication Management**

**M.18 MAP and Insulin Injections**

**2/3 Maj. Not Reached**

**Recommendation**

MAP may administer insulin injections to residents who have stable diabetes, when all of the following conditions are met:

- a. The MAP has completed a state-approved training program ((with input from the state board of nursing) that includes instruction on diabetes symptoms and complications, and safe and accurate administration of insulin injections, with practical experience in insulin injection technique.
- b. The residence has policies and procedures on administration of insulin injections.
- c. The MAP has been tested and demonstrated competency on administration of insulin injections and use of a blood glucose monitor by a qualified licensed health professional. If the blood glucose value is outside the range established by the resident's physician, the MAP will immediately contact the appropriate qualified licensed health professional, according to the ALR policy.
- d. A qualified licensed health professional observes the MAP's ability to administer insulin injections at least every 90 days. This review will include a review of medication administration records by a qualified licensed health professional.

**Implementation**

Guideline for State Regulation

**Rationale**

Because of the risk associated with inappropriate administration or dosing of insulin, special training and competency checks are necessary. Residents with unstable diabetes, such as those receiving insulin according to a sliding scale schedule, require close medical supervision. If unable to manage their insulin without assistance, these residents should be assisted by a licensed nurse.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

**Medication Management**

Association of Health Facility Survey Agencies, Joint Commission on Accreditation of Health Care Organizations

**Supplemental Positions for M.18**

1) Statement in support of the recommendation. The risk for Type 2 diabetes increases with age. Nearly 20.1% of the United States population or 7.0 million people age 65 and older have diabetes. (American Diabetes Association)

Medical and indirect expenditures attributable to diabetes in 2002 were estimated at \$132 billion, with 51.8% of direct medical expenditures incurred by people over 65 years of age. The report also states that more than \$1 out of every \$4 spent for nursing home, home health, and hospice care is spent to provide services to someone with diabetes. (Economic Costs of Diabetes in the U.S. in 2002. American Diabetes Association. 2003.)

These statistics demonstrate a clear need for a safe, and cost-effective alternative for seniors with diabetes. This recommendation begins to lay the ground-work for this type of solution. To that end, the recommendation includes several important elements that help to ensure the safe administration of insulin injections by MAP:

1. Only recommended for stable diabetics.
2. State-approved training must be completed prior to administering insulin.
3. Ongoing monitoring by a qualified licensed health professional.

*AARP, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Society of Consultant Pharmacists, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

2) We oppose this failed recommendation. As set forth in more detail in dissents for recommendations M.06, M.07, M.08, M.09, M.10, and failed recommendation M.16, the recommendations for medication assistive personnel are fundamentally flawed. Although recommendation M.18 attempts to set legitimate standards for insulin injections, it is based untenably on the unsound framework set forth in the other recommendations related to medication assistive personnel.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

3) We believe that residents with diabetes who are insulin dependent should be able to live in assisted living if their needs can be met. Insulin injections should be administered in accordance to the individual state nurse practice act.

*American College of Health Care Administrators, National Center for Assisted Living, American Seniors Housing Association*

**Medication Management**

4) We dissent. Many ALW's Recommendations on Medication Management hinge on the use Medication Assistive Personnel (MAPs) administering medications to residents. MAPs would perform their duties under the supervision of a RN.

Some states currently allow aides who have completed and passed a training program to administer medications, while other states do not. To a large extent, the scope of practice of assistive personnel depends on statutory or regulatory language related to delegation in each state's Nurse Practice Act (NPA). There may be additional statutes and regulations outside of those governed by state boards of nursing that will impact on delegation.

This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living.

*Assisted Living Federation of America, National Association of Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.19 MAP and Enteral Medication Administration**

**2/3 Maj. Not Reached**

**Recommendation**

MAP may administer medications through an enteral tube (e.g. NG (nasogastric), gastrostomy, or PEG (percutaneous enteral gastrostomy tube) to residents when the following conditions are met:

- a. The MAP has completed a training program that includes instruction in proper technique for administration of medications through an enteral tube, including checking for proper placement of the enteral tube.
- b. The MAP has been tested on administration of medications via enteral tube by a qualified licensed health professional.
- c. The qualified licensed health professional observes the MAP's ability to administer medications via an enteral tube at least every 90 days. This review will include a review medication administration records by the qualified licensed health professional.
- d. The residence has policies and procedures on administration of medications via entera tube, including what to do if the tube gets clogged.
- e. If there is any doubt that the enteral tube is not in proper placement, the resident's physician is immediately contacted. No medications or feedings are administered until receiving further orders from the physician..

**Implementation**

Guideline for State Regulation

**Rationale**

Enteral therapy is a special skill that requires additional instruction and competency, du to risks associated with enteral therapy, such as misplacement of the tube or incompatibility of medications.

**Organizations Supporting This Recommendation**

No Vote Recorded

**Organizations Opposing This Recommendation**

**Organizations Abstaining From the Vote on This Recommendation**

**Supplemental Positions for M.19**

1) MAP should be authorized to administer medications through an enteral tube to residents when the following conditions are met:

- a.The MAP has completed a training program that includes instruction in proper technique for administration of medications through an enteral tube, including checking for proper placement of the enteral tube.
- b.The MAP has been tested on administration of medications via enteral tube by a qualified licensed health professional.
- c.The qualified licensed health professional observes the MAP's ability to administer medications via an enteral tube at least every 90 days. This review will include a review of medication

**Medication Management**

administration records by the qualified licensed health professional.

d. The residence has policies and procedures on administration of medications via enteral tube, including what to do if the tube gets clogged.

e. If there is any doubt that the enteral tube is not in proper placement, the resident's physician is immediately contacted. No medications or feedings are administered until receiving further orders from the physician.

*AARP, American Assisted Living Nurses Association, NCB Coming Home Project*



**Medication Management**

**M.20 Telephone Orders**

**2/3 Maj. Not Reached**

**Recommendation**

MAP shall not have the authority to receive medication orders. When a prescriber attempts to issue an order for a medication via telephone to the MAP, the MAP will instruct the prescriber to do one of the following:

1. Fax the order directly to the ALR, or
2. Issue the order via telephone to a licensed nurse who is onsite in the ALR, or
3. Issue the order directly to the pharmacy

**Implementation**

Guideline for State Regulation.

**Rationale**

The completeness and accuracy of medication orders are essential to safe and successful medication administration. Because of potential risks and the complexity of medication orders, they are to be submitted to the facility in writing or directly to a qualified license health professional.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Association of Health Facility Survey Agencies, Joint Commission on Accreditation of Health Care Organizations

**Supplemental Positions for M.20**

1) The completeness and accuracy of medication orders are essential to safe and successful medication administration. Because of the potential risks and the complexity of medication orders, the protocol for telephone orders must be addressed by state regulation. The undersigned fully support M.20.

*AARP, American Association of Homes and Services for the Aging, American Society*

**Medication Management**

*of Consultant Pharmacists, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

2) We dissent. Many ALW's Recommendations on Medication Management, such as this one, hinge on the use Medication Assistive Personnel (MAPs) administering medications to residents. MAPs would perform their duties under the supervision of a RN.

Some states currently allow aides who have completed and passed a training program to administer medications, while other states do not. To a large extent, the scope of practice of assistive personnel depends on statutory or regulatory language related to delegation in each state's Nurse Practice Act (NPA). There may be additional statutes and regulations outside of those governed by state boards of nursing that will impact on delegation.

This recommendation offers no alternative recommendations for those states where existing laws or regulations do not allow MAPs in assisted living nor does it suggest guidance as to how licensing agencies or ALRs should approach reconciling statutory conflicts that lie outside the arena of assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Medication Management

### M.21 Quality Improvement

2/3 Maj. Not Reached

#### Recommendation

Each assisted living residence that administers medications shall adopt or create a quality improvement program to set and implement standards, evaluate performance and implement necessary changes for improvement of medication management. This quality improvement program should address the full range of medication management services provided by the residence.

The quality improvement program includes a system for identifying, collecting, documenting, and reporting medication errors. The QI team reviews results of medication error reports and medication reviews to identify areas where improvements can be made in the medication management system.

The QI team also establishes residence policies and guidelines for medication usage (e.g. psychotropics, pain management, anticoagulants, etc.) and reviews patterns of use of psychotropic medications to ensure appropriate use of these agents. Non-pharmacologic approaches should always be considered in the management of various conditions (e.g. pain, behavioral symptoms associated with dementia, etc.).

The quality improvement program is directed and implemented by a team that includes:

- The administrator or manager of the residence
- A consultant pharmacist
- A registered nurse (e.g. staff, consultant, home health or hospice nurse)
- Physician or other authorized prescriber
- A Medication Assistive Personnel (MAP), if employed by the facility

2. An ALR that provides medication reminders shall implement a quality oversight and improvement process that relates to the system of reminding residents.

#### Implementation

Guideline for State Regulation

#### Rationale

Medication management is affected by a variety of factors, which are subject to change over time. A structured quality improvement process is needed to evaluate the effectiveness of the medication management program on a regular basis, so that needed changes can be identified and improvements made as needed.

Quality improvement efforts require participation by all the key stakeholders in the medication management system. The interdisciplinary team should work together to coordinate quality improvement efforts.

Medication errors are usually caused by deficiencies in the medication use system. Reports of errors are collected and analyzed to identify ways to improve the medication system and build in safeguards to prevent injury to residents. The residence should encourage reporting of medication errors in an environment and culture that focuses on

**Medication Management**

improving medication accuracy.

Evaluation of results of medication reviews can help the residence identify high-risk medications or conditions that may require special monitoring or interventions to improve safe use of medications in the residence.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, Catholic Health Association of the United States, Center for Medicare Advocacy, Joint Commission on Accreditation of Health Care Organizations, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

Association of Health Facility Survey Agencies, National Committee to Preserve Social Security and Medicare

**Supplemental Positions for M.21**

1) Medication management is affected by a variety of factors that are subject to change over time. A structured quality improvement process is needed to evaluate the effectiveness of the medication management system on a regular basis so that needed changes can be identified and improvements made. The undersigned fully support M.21.

*AARP, American College of Health Care Administrators, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Professional Geriatric Care Managers, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

2) We encourage assisted living residences to develop a process for improving the overall quality of care provided to its residents, not simply medication management. Providers can design these programs to review medication errors, falls, and any other issues the assisted living residence deems important.

*Catholic Health Association of the United States, National Center for Assisted Living, American Seniors Housing Association, American Association of Homes and Services for the Aging*

3) We dissent. This recommendation for a quality improvement program assumes a multi-disciplinary team akin to a SNF. This is not typically the case in assisted living, nor are the health

**Medication Management**

records as complete as a SNF. Given typical staffing models and the current lack of contracted pharmacists and attending physicians, the recommendation is not realistic and could be cost prohibitive for many small providers.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Medication Management**

**M.22 Consultant Pharmacist Role**

**2/3 Maj. Not Reached**

**Recommendation**

Each ALR shall assess whether an agreement is needed with a consultant pharmacist to assist the residence with medication management is necessary. The consultant pharmacist may be contracted for independently or through the ALR's primary pharmacy. The consultant pharmacist is responsible to assist the ALR with medication management issues, including ensuring the security and accountability of controlled substances.

To assist the ALR with medication management, the consultant pharmacist duties, in collaboration with the quality improvement team, shall include:

- a. Assist the residence in setting standards and developing, implementing, and monitoring policies and procedures for the safe and effective distribution, storage, control and use of medications, including controlled substances, and related equipment and services of the residence
- b. Assist with inservice education of ALR staff on medication management issues
- c. Review ALR documentation related to medication orders and administration of medications to residents
- d. Review patterns of use of various medications (e.g. psychotropics, pain management, anticoagulants, etc.) for compliance with ALR policies and guidelines.
- e. Provide a written report of findings and recommendations resulting from the review. The report is provided to the ALR administrator, who shares it with the QI team and discusses it with appropriate ALR personnel. and follow-up actions are recommended as needed.

**Implementation**

Guideline for State Regulation

**Rationale**

Medication management is a critical function that provides essential support to most assisted living residents, and serious harm can result to residents when the system fails to function properly. Consultant pharmacists have specialized expertise in developing, monitoring, and improving medication management systems in long-term care settings. Involvement by a consultant pharmacist is a minimum standard to help prevent medication errors and ensure accountability of controlled drugs in the ALR. States should develop criteria to assist ALRs in assessing the need for a consultant pharmacist.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, National Association of Activity Professionals, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Medication Management**

American Association of Homes and Services for the Aging, American Seniors Housing Association, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Joint Commission on Accreditation of Health Care Organizations, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association of Social Workers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

NCB Development Corporation, National Association of Professional Geriatric Care Managers

**Supplemental Positions for M.22**

1) We oppose this failed recommendation. Under this recommendation, an assisted living residence is required only to "assess" whether an agreement with a consultant pharmacist is necessary. This would be a meaningless and unenforceable regulation.

A comparison with existing state law indicates the flimsiness of this recommendation. For example, state laws in Arkansas and Oklahoma contain requirements that assisted living residences contract with and use a consultant pharmacist. (Code Arkansas Rules 016 06 002, § 702.2.1 (Level II assisted living facilities); Oklahoma Administrative Code § 310:663-9-2(a))

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We dissent. Unlike in a SNF, consent by the ALR resident would be needed for review of medication records and could impact on a resident's right to privacy. Refer to the recommendation on Resident Rights and a resident's right to confidentiality of medical records. The financial cost of contracting for a consultant pharmacist could have a disproportionate impact on small providers.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

3) We are opposed to this recommendation due to its cost implications for residents. It is important to keep in mind that many assisted living residents are on limited incomes. In addition, we believe assisted living providers are capable of determining when outside consultants are needed and for what issues.

*National Center for Assisted Living, American Seniors Housing Association*

## ***Topic Group Recommendations Adopted by Two-Thirds Majority of the ALW***

### **Operations**

#### **Purpose**

The Operations Topic Group of the Assisted Living Workgroup had as its focus both environmental elements and operational processes which foster quality of life, quality of care, and safety for everyone involved in an assisted living residence.

#### **Issues**

The topic group made recommendations in the following areas: activities; activities for special care populations; assisted living resident councils; food storage, preparation and transporting; transportation; smoking; environmental management; building codes, fire safety, life safety, evacuation plans, contingency plans, emergency protocols; and security for wandering residents.

#### **Participants**

The topic group was co-chaired by Mary Anne Kelley of the Pioneer Network and Ken Preede of the American Seniors Housing Association.

Topic group participants included Lyn Bentley, National Center for Assisted Living; Marianna Grachek, Joint Comm. on the Accreditation of Healthcare Organizations; Rick Harris, Association of Health Facility Survey Agencies; Donna Lenhoff, National Citizens' Coalition for Nursing Home Reform; Toni McMonagle, Consulting Dieticians in Healthcare Facilities; Doug Pace, American Association of Homes and Services for the Aging; Jackie Pinkowitz, Consumer Consortium on Assisted Living; Bonnie Ruechel, National Association of Activity Professionals; Beth Singley, Assisted Living Federation of America; Catherine Zofkie, American Medical Directors Association.



**Operations**

**O.01 Building Codes**

**Recommendation**

Assisted living residences should comply with applicable state and/or local building codes according to the residents they serve. States should regularly update their requirements and adopt the most current national version of building codes to ensure that state of the art perspectives on building safety which have been incorporated into national building codes are incorporated in state requirements.

**Implementation**

Guideline for State Regulation

**Rationale**

There are various building codes, Building Occupational Code Authority (BOCA) and International Building Code (IBC) to name two, and the codes have been developed by professionals who are familiar with both necessary construction standards and the provider entity for which the code has been developed. It seems counter-productive for u to attempt to reinvent what is already in existence. Furthermore, states and local jurisdictions often include additional requirements specific to certain conditions in their locale: for example, requirements based on ensuring safe buildings in the event of an earthquake, a tornado or a hurricane.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Multiple Sclerosis Society, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

Center for Medicare Advocacy

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for O.01**

- 1) We dissent. The general thrust of this recommendation is that ALRs must comply with existing

**Operations**

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state and local building codes. As such, this recommendation provides no new guidance to the states to improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care,  
National Association for Regulatory Administration, Joint Commission on  
Accreditation of Health Care Organizations*

2) We support this recommendation as it is written and want to clarify a portion of the Rationale. Since the recommendation was written, the National Fire Protection Association (NFPA) 5000 Building Code was adopted by NFPA. This is the first building code developed through an open, consensus-based process that is accredited by the American National Standards Institute (ANSI), the administrator and coordinator of the United States private sector voluntary standardization system. Requirements in NFPA 5000 are designed to be consistent with the NFPA 101 Life Safety Code.

*Consumer Consortium on Assisted Living, National Center for Assisted Living,  
American Seniors Housing Association, American Association of Homes and Services  
for the Aging*

## Operations

### O.02 Life Safety Compliance

#### Recommendation

According to services provided and evacuation capacity assisted living residences should comply with the most appropriate chapter, and the most current version of the National Fire Protection Association Life Safety Code (NFPA 101) and/or the International Code Council's (ICC) International Fire Code (IFC), or equivalent standards.

#### Implementation

Guideline for State Regulation

#### Rationale

There are two primary Life Safety Codes that have been developed: NFPA 101 and ICC's International Fire Code. These codes have been created by groups of experts in both fire safety and the provider entity for which the code has been developed. These codes are updated on a regular basis to reflect the most current safety standards and measures recognized by fire safety professionals. Many jurisdictions develop their own codes using one of these documents as a template.

Each code is reviewed and updated on a three-year cycle. The codes always include specifications related to "new buildings" and "existing buildings". The requirements for new buildings tend to reflect the most current and up to date life safety standards that are in existence. For "existing buildings" new requirements are imposed when they reflect new, state of the art equipment or design that will clearly provide increased protection for building occupants. For example, when smoke detectors first came on the market, all new facilities had to have them and existing facilities also had to install smoke detectors. Additionally, when "significant renovations" are made to an existing building, that portion of the building shall comply with new life safety code standards for new buildings.

When a state is adopting a particular building classification, it is important to consider the type of residents who will likely be living in an assisted living facility paying particular attention to the level of frailty, cognitive ability, and the degree to which the residents may need assistance in evacuating the building. It is also important for the state to consider the cost to the consumer of the particular building classification and the relative safety that will be created.

When a state is determining to which building code assisted living facilities shall comply, there are several questions that shall be asked and answered:

- What type of evacuation capabilities will be necessary?
- What type of individuals will be living in the building and how quickly will they be likely to evacuate?
- What level of frailty will individuals residing in this building eventually reach (based on move-in and move-out criteria of provider policies and the state regulations)?
- Will many individuals require the use of assistive devices for purposes of mobility, such as walkers and wheelchairs?

## Operations

### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Multiple Sclerosis Society, National Adult Family Care Organization, National Center for Assisted Living, Pioneer Network

### Organizations Opposing This Recommendation

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

### Organizations Abstaining From the Vote on This Recommendation

National Network of Career Nursing Assistants

### Supplemental Positions for O.02

1) We dissent. This recommendation has no content. It fails to set a standard and, instead, merely asks assisted living operators to voluntarily comply with what the operator believes or claims is the appropriate NFPA chapter according to services provided and evacuation capacity. A more appropriate recommendation would require states to adopt specific NFPA or other applicable safety code. We recommend NFPA Life Safety Code: Residential Board and Care Occupancies, Impractical Evacuation Capability, excluding NFPA 101A Alternative Approaches to Life Safety.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) We support this recommendation as it is written and want to clarify a portion of the rationale. The National Fire Protection Association (NFPA) 101 Life Safety Code is the only life safety code that is developed through an open, consensus-based process that is accredited by the American National Standards Institute (ANSI), the administrator and coordinator of the United States private sector voluntary standardization system. Requirements in NFPA 101 are consistent with the NFPA 5000 Building Code.

*Consumer Consortium on Assisted Living, National Center for Assisted Living, American Seniors Housing Association, American Association of Homes and Services for the Aging*

3) We dissent. The general thrust of this recommendation is that ALRs must comply with existing Life Safety Code standards. As such, this recommendation provides no new guidance to the states or ALRs to improve quality in assisted living.

**Operations**

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*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Operations**

**O.03 Communication of Life Safety Standards**

**Recommendation**

An assisted living facility shall provide information to prospective residents and/or their families about the type of life safety standards that are in place that offer protection for residents. This information shall include such things as: whether the facility is sprinklered; and if the building is designed such that residents who require significant assistance for evacuation will be protected and able to reside in the ALR.

**Implementation**

Guideline for State Regulation

**Rationale**

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Citizens' Coalition on Nursing Home Reform, National Adult Family Care Organization, National Committee to Preserve Social Security and Medicare, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, Association of Health Facility Survey Agencies, American Seniors Housing Association, Center for Medicare Advocacy, Joint Commission on Accreditation of Health Care Organizations, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for O.03**

1) In large measure, the real need for this recommendation derives from the fact that the previous recommendation (O.02), in the form submitted by the majority, fails to ensure that appropriate life safety code standards apply to all facilities. This recommendation, then, is an inadequate attempt to provide protection to residents by ensuring some pro forma disclosure concerning the degree of life safety code protection provided. Such disclosure is no substitute for requiring compliance with specific, enforceable life safety standards. Moreover, it is not at all clear that such disclosure would really give consumers useful information about the fire safety risks in a particular facility. The codes themselves and other aspects of safety features would be difficult for the average consumer to understand, being technical in nature and addressing characteristics of materials, construction, and other building features.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy,*

**Operations**

*National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) Communication of life safety information to residents\* is very important, particularly when a resident is cognitively impaired and the family seeks assurance that the individual's needs in this regard will be met. We have concern with phrase in the last sentence: "designed such that residents who require significant assistance for evacuation will be protected and able to reside in the ALR." There are no life safety protections in existence that will absolutely provide 100% safety to every individual in any building.

We suggest the recommendation should read:

An ALR should disclose upon request their life safety plan and fire plan. This information should include such things as: whether the facility is sprinklered; and if the building and evacuation plan are designed such that residents who require significant assistance for evacuation will be able to reside in the ALR with as much protection from fire as is reasonably possible.

*Association of Homes and Services for the Aging, National Center for Assisted Living, American Seniors Housing Association*

3) We dissent. This recommendation requires ALRs to disclose to residents if the building is designed in such a way that residents who require significant assistance for evacuation will be protected and able to reside in the ALR. The wording of the recommendation is unclear as to intent. The wording could be interpreted to mean that an ALR must give assurance a resident will be able to reside in the building if they need significant assistance for evacuation without regard for limitations set by occupancy use standards and/or life safety code standards.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Operations**

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**O.04 Emergency and Disaster Preparedness Plans**

**Recommendation**

An assisted living residence shall develop a written emergency and disaster preparedness plan for fires and other natural disasters. This plan shall also include emergency protocols to deal with catastrophic events such as chemical spills, biohazardous events and weather-related emergencies. Evacuation routes shall be developed for all parts of the building. The relevant evacuation route should be posted in each common area, by all building exits, by all fire extinguishers and provided to all residents on admission and updated as needed. All staff should be provided a copy of all evacuation routes.

**Implementation**

Guideline for State Regulations

**Rationale**

It is essential that providers develop plans to deal with emergencies such as fires or natural disasters. Unless plans are developed before the emergency occurs, it is possible that key elements for providing protection will be overlooked. An evacuation plan is the method by which the facility is prepared to get the residents and staff out of the building (or to a point of safety within the building) in case of an emergency. It is important to note that "evacuation" may be either to the outside of the building to a point of safety, or inside the building to a point of safety. It is also important for the ALR to develop emergency protocols for events that may not require a building evacuation, but do require that the ALR take some sort of action to protect the well-being of its residents and staff (such as chemical spills and/or extreme heat or cold).

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration

**Organizations Abstaining From the Vote on This Recommendation**

None



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**Operations**

**Supplemental Positions for O.04**

1) We dissent. While we support the intent of the recommendation, it is beyond the scope of most ALRs and particularly small providers to have protocols to deal with catastrophic chemical spills and biohazardous events. Plans to deal with these sort of catastrophic emergencies are the province of civil authorities and homeland security personnel.

*Assisted Living Federation of America, National Association for Home Care,  
National Association for Regulatory Administration, Joint Commission on  
Accreditation of Health Care Organizations*

2) We recommend the following revision to Recommendation O.4

An assisted living residence must develop a written emergency and disaster preparedness plan for fires and other natural disasters. This plan must also include emergency protocols to deal with catastrophic events such as chemical spills, biohazardous events and weather related emergencies. Evacuation routes must be developed for all parts of the building and posted.

*American Association of Homes and Services for the Aging, American Seniors  
Housing Association, National Center for Assisted Living*

## Operations

### O.05 Contingency Plan

#### Recommendation

An assisted living residence shall have a written contingency plan in place for both short- and long-term evacuations and for when a building system fails and when utilities are interrupted.

#### Implementation

Guideline for State Regulation

#### Rationale

A contingency plan is the method by which the facility will be prepared to care for the residents after an evacuation has occurred. In some instances, the building can be immediately reoccupied, but when that is not the case, the contingency plan will prepare the facility for that eventuality. This contingency plan should be discussed with local and/or state authorities.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association for Regulatory Administration, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Adult Family Care Organization, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

#### Organizations Opposing This Recommendation

None

#### Organizations Abstaining From the Vote on This Recommendation

None

#### Supplemental Positions for O.05

1) We dissent. Contingency planning in the event of an evacuation are generally covered by local and state laws. As such, this recommendation provides no new guidance to the states that will improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Operations**

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**O.06 Food Storage, Preparation and Transporting**

**Recommendation**

Foods handled by the ALR will be stored, prepared, transported, and served in a safe and sanitary manner, and at appropriate temperatures as recommended by the Food and Drug Administration (FDA). The ALR shall have written policies and procedures that it will implement to achieve this recommendation.

**Implementation**

Guideline for State Regulation and Operations

**Rationale**

Proper food storage, handling and preparation are essential for ensuring that there are no food-borne illnesses in an ALR.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Adult Family Care Organization, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Committee to Preserve Social Security and Medicare, National Conference of Gerontological Nurse Practitioners, National Hospice and Palliative Care Organization, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Association of Health Facility Survey Agencies, National Association of Home Care, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Academy of Elder Law Attorneys, National Citizens' Coalition for Nursing Home Reform, National Network of Career Nursing Assistants, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

American Bar Association

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**Supplemental Positions for O.06**

1) We dissent. This recommendation is too vague to provide a meaningful standard. We believe that the only specifics that provide substance to this recommendation – now recorded in the "Operational Models" section - must be moved into the body of the recommendation to make it useful. Further, the current language should be strengthened to require that the "food service supervisor who need not be a registered dietitian" be at least knowledgeable and trained in food safety procedures as evidenced by successful completion of a state-approved course for food-handlers.

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*Association of Health Facility Survey Agencies, Center for Medicare Advocacy,  
National Association for Regulatory Administration, National Association of Local  
Long Term Care Ombudsmen, National Association of State Ombudsman Programs,  
National Citizens' Coalition for Nursing Home Reform, National Committee to  
Preserve Social Security and Medicare, National Network of Career Nursing  
Assistants, National Senior Citizens Law Center*

## Operations

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### **O.07 Food & Nutrition**

#### **Recommendation**

The assisted living residence will ensure that food provision corresponds to the recommended number of servings and categories of food on the USDA Food Guide Pyramid.

Meals shall be provided and / or coordinated at least three times a day, seven days per week, and snacks shall be available seven days per week.

Availability of meals should allow for reasonable flexibility in resident schedules.

Menus shall be planned taking into consideration residents' personal, ethnic and religious preferences and with resident input.

Menus shall be accessible to residents when completed and when the menus are prepared by the ALR, this should be at least one week in advance.

A variety of food choices shall be available to accommodate resident preferences, special needs and diets.

Reasonable menu or food substitutions shall be offered.

Resident meals, snacks and nutritional supplements shall be attractive and palatable. Fluids shall be available and appropriately offered to residents and assistance provided, as needed, to promote adequate fluid intake.

Menus shall be reviewed and approved by a registered dietitian for nutritional adequacy and variety.

#### **Implementation**

Guideline for State Regulation and Operations

#### **Rationale**

Food service is more than meeting nutritional needs; at its best, it is an opportunity for social engagement, enjoyment and meeting nutritional needs. Meals served at consistent and culturally appropriate dining times and for a sufficient length of time to meet resident needs will help to achieve these goals. It is also important for residents to be able to obtain delivery of meals under special circumstances such as illness, injury, or needs delineated in service plans.

Because fluid intake plays a critical role in health and well being, assisted living residences should encourage residents to drink fluids during and between meals and make fluids available to residents throughout the day, both in private areas and areas where residents gather and group activities occur.

#### **Organizations Supporting This Recommendation**

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AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Association for Regulatory Administration, National Adult Family Care Organization, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, Joint Commission on Accreditation of Health Care Organizations, National Association of Home Care

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for O.07**

1) We agree with much of this recommendation but believe that certain parts should be eliminated. We believe the recommendation should read:

The assisted living residence will ensure that food provision corresponds to the recommended number of servings and categories of food on the USDA Food Guide Pyramid or other generally accepted guidelines.

Meals must be provided and/or coordinated at least three times a day, seven days per week, and snacks must be available seven days per week.

Availability of meals should allow for reasonable flexibility in resident schedules.

Menus must be planned taking into consideration residents' personal, ethnic and religious preferences with resident input.

Menus must be accessible to residents when completed and when the menus are prepared by the ALR, this should be at least one week in advance.

A variety of food choices must be available to accommodate resident preferences, special needs and diets. Reasonable menu or food substitutions must be offered.

Resident meals, snacks and nutritional supplements must be attractive and palatable. Fluids must be available and appropriately offered to residents and assistance provided, as needed, to promote adequate fluid intake.

*National Center for Assisted Living, American Seniors Housing Association*

## Operations

### O.08 Smoking

#### Recommendation

The assisted living residence will have a policy regarding smoking and the use of other tobacco products, which will be disclosed to the prospective resident prior to his/her entering into a residency agreement.

#### Implementation

Guideline for State Regulation

#### Rationale

Smoking in assisted living residences is a hotly debated issue, with some states more permissive than others in allowing smoking and some states silent on this issue. In assisted living residences where smoking is permitted, this recommendation provides for clearly articulated and communicated smoking guidelines for the well being and safety of residents, staff, families and visitors and the reduction of passive smoking to others.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

#### Organizations Opposing This Recommendation

Center for Medicare Advocacy

#### Organizations Abstaining From the Vote on This Recommendation

None

#### Supplemental Positions for O.08

1) We dissent. Recommendation micromanages the house rules of an ALR. Beyond the mandate of the ALW.

*Assisted Living Federation of America, National Association for Home Care*

## Operations

### O.09 Activities

#### Recommendation

Assisted living residences shall provide daily structured and unstructured, and individual and group, activities in accordance with residents needs, interests, choices, beliefs, values, functioning levels and abilities. Activity programs shall be directed by appropriately qualified and trained individuals. Activity plans, identifying resident preferences, shall be part of each resident's ongoing assessment and service plan. Current, understandable and accessible activity calendars shall be conspicuously posted in assisted living residences.

Assisted living residences shall adopt objective methods that include measures of resident satisfaction for evaluating the participation in, and effectiveness of, activities.

#### Implementation

Guideline for State Regulation

#### Rationale

Properly designed and delivered activities can maintain and enhance resident life. To achieve maximum outcomes, activities shall be: resident centered; provide materials, approaches, interactions and environments which enhance resident well-being; and assist in achieving or maintaining resident functional levels and abilities, focusing on resident strengths and not weaknesses. Given the diversity of residents in assisted living, it is important that those responsible for planning activities understand resident characteristics in order to provide a meaningful activity environment, with activities that create a stimulating social culture within the assisted living community.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American Medical Directors Association, American Seniors Housing Association, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Association for Regulatory Administration, National Adult Family Care Organization, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

#### Organizations Opposing This Recommendation

Assisted Living Federation of America, National Association of Home Care

#### Organizations Abstaining From the Vote on This Recommendation

American College of Health Care Administrators



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**Supplemental Positions for O.09**

None Submitted

## Operations

### O.10 Activities for Special Care Residents

#### Recommendation

ALRs that accommodate special care residents shall provide daily interactions and experiences that are meaningful (based upon residents' interests, feelings, and lifestyle), appropriate (for their abilities and functioning levels), and respectful (of their age, beliefs, cultures, values, and life experiences) of residents, as determined by individual assessments and indicated in their service plans.

Activity programs shall be directed by appropriately qualified and trained individuals who have experience in activities responsibilities and training in special care.

Staff involved in planning and implementing activities for special care residents shall, on an on-going basis, be given training that includes, but is not limited to: basic physiological understanding of dementia and other special conditions of residents being served; behavioral symptoms and consequences; behavioral intervention and management strategies, including redirection techniques; understanding of individual resident's special needs, appropriate activities and accommodations for meeting special resident needs (e.g. cognitive, language, behavioral, motor, and social skills).

#### Implementation

Guideline for State Regulation

#### Rationale

ALRs are encouraged to view activities as every interaction that occurs between the resident and their environment and as the foundation for quality care. The scope of activities therefore includes every encounter and exchange between residents and all members of and visitors to the ALR community. Interactions centered around activities of daily living and scheduled activities should be viewed by staff and family members as significant elements in meeting resident's physical, psycho-social and behavior management needs and enhancing resident's care and quality of life. Education, collaboration and communication among staff and family members is a relevant component in achieving intended outcomes of meeting the residents' needs and fostering quality care and psychological comfort within the ALR.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and

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Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

American Assisted Living Nurses Association

**Supplemental Positions for O.10**

1) We dissent. We respect the fact that many states have set additional requirements for ALRs that seek a special designation to serve people with cognitive impairments. However, we do not attempt to prescribe the specific procedures that a state must regulate.

Residents with mild to moderate dementia can still participate in care decisions and express life long values and wishes regarding the care they are currently receiving. Therefore, our recommended guidance to the states and ALRs is to consider a quality monitoring component that focuses on the perspective of the resident and other responsible parties to look beyond the procedures, and to see if the resident and other affected parties feel that their choices are being respected, their needs are being met, and their opinion is sought as to the quality of the services provided.

Examples of suggested areas for quality monitoring could include:

- Does the resident acknowledge having opportunities to exercise lifestyle preferences (dining, receiving visitors, activities, directing provision of services)
- Does the resident acknowledge being consulted as to his/her satisfaction with the quality of care and services provided;
- Does the staff have the willingness and the ability to communicate with, and respond to, resident's preferences;
- Does the surrogate decision-maker acknowledge that he/she is encouraged to be involved in the development and implementation of the resident's service plan.
- Do family members report having opportunities for involvement in resident's care.
- Does the resident acknowledge being able to make decisions regarding services to be provided to the extent possible and involvement of his or her family as appropriate.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Operations

### O.11 Transportation

#### Recommendation

All assisted living residences shall provide and/or arrange for both the scheduled and unscheduled transportation needs of its residents. Clear, written information shall be provided to all assisted living residents and prospective residents about which types of transportation are available, at what times those services are available by the ALR and in the community (e.g., regularly scheduled van trips to the shopping mall), and any additional costs associated with transportation services over and above the monthly service fee.

In cases in which the assisted living residence owns or leases the vehicle providing transportation to the residents, all safety and inspection records shall be kept and the vehicle shall meet all local and state safety standards for the class of vehicle.

Staff responsible for the operation of vehicles will receive training on how to operate the vehicles and the equipment inside the vehicle, and how to assist residents who are utilizing the service, including assisting residents with special needs for transportation, such as those with cognitive impairments, dementia or special needs due to physical disabilities. When transporting residents with special needs, the ALR will ensure that adequate staff is provided.

Staff responsible for the operation of vehicles will have current, appropriate licenses and classes of licenses to operate the vehicles.

#### Implementation

Guidelines for State Regulation

#### Rationale

According to the most recent research, the proportion of assisted living residents who still own or drive a car is less than 5%. Because the vast majority of assisted living residents no longer drive or own a car, an assisted living residence's transportation services are considered a key component of its service package.

There are several ways that an assisted living residence can meet the transportation needs of its residents: by directly providing the transportation with an assisted living residence owned or leased vehicle (e.g., a bus or van), and/or by arranging for transportation services through a third party (e.g., a service agreement with a local taxi cab company or utilizing other currently offered transportation programs).

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of

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Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, National Association of Home Care

**Organizations Abstaining From the Vote on This Recommendation**

American Seniors Housing Association

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**Supplemental Positions for O.11**

None Submitted

**Operations**

**O.12 Environmental Management**

**Recommendation**

The ALR shall maintain safe conditions for residents, staff, and visitors. The facility shall be properly maintained in compliance with applicable federal, state and local laws. Appropriate to the size of the ALR and the scope of services provided, buildings and outdoor areas shall maintain effective utility capacity (electric, plumbing, water, refrigeration, etc), lighting, and accommodate residents' needs and safety. Common areas shall accommodate residents using assistive devices for mobility. The ALR and outdoor areas shall be kept clean and free of potential hazards and hazardous substances.

**Implementation**

Guideline for State Regulation

**Rationale**

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Adult Family Care Organization, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Conference of Gerontological Nurse Practitioners, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Center for Medicare Advocacy, National Academy of Elder Law Attorneys

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for O.12**

1) We dissent. The general thrust of this recommendation is that ALRs must comply with existing laws and regulations. As such, this recommendation provides no new guidance to the states as to how improve quality in assisted living.

However, the degree to which a resident feels that his/her assisted living community is a safe and homelike residential environment is of vital importance to a resident's perception of their quality of life. Therefore, our recommended guidance to the states and ALRs is to consider a quality

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monitoring focus from the perspective of the resident to look at how well the residential environment is supporting consumer choice, autonomy, independence, and privacy.

For example:

- Does the resident acknowledge that the AL setting feels homelike.
- Resident acknowledges/denies having opportunities to control private space:
  - food storage/preparation
  - individual temperature control
  - roommate provision consultation
  - use of personal vs. ALR furnishings in unit
  - modifications to unit
  - availability of personal key to unit
- Does the resident acknowledge availability of staff assistance to help resident use inaccessible public areas?
  - Dining rooms, activity room, library, TV room; limitations to areas within/outside setting due to: cognitive limitations; physical barriers (steps, doorways, etc.)
- Does the resident report a lack of access to a private phone/key to a mailbox
- Is the staff able/unable to demonstrate knowledge regarding methods to promote a homelike setting; resident lifestyle preferences; methods to protect resident privacy.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Operations**

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**O.13 Assisted Living Residence Councils**

**Recommendation**

ALRs shall provide opportunities and space for resident council meetings, schedule regular meetings, and encourage residents to attend those meetings. The Resident Council may be organized by the staff but should be led by the residents. The staff may participate in the Resident Council, as invited by residents.

An ALR may have a Family Council as part of the activity or social service programming, with space made available by the ALR. This council allows families to be aware of, and participate in, residence operations in a welcoming and productive manner.

**Implementation**

Guideline for State Regulation

**Rationale**

Community Councils offer meaningful opportunities for enhanced participation and community-building that ultimately benefit the quality of life for all members of the ALR. Resident Councils are formal meetings where residents can learn, interact and come to better understand the various psycho-social activities of the assisted living residence. Because assisted living residents are the guiding force in planning activities, their wishes should always be taken into consideration and Resident Council gives the residents a place to ask questions and express concerns, with the aim of information sharing, building community and resolving potential problems. Residents may also desire to fulfill a need or role through volunteering, which can increase their sense of self-esteem and usefulness, as well as provide opportunities to meaningfully utilize the vast experience they have attained during their lives for the betterment of the ALR and/or extended community. Family Councils can provide opportunities for support and education within a comfortable peer group setting.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Adult Family Care Organization, National Association of Social Workers, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Conference of Gerontological Nurse Practitioners, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**



**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

**Operations**

Assisted Living Federation of America, National Association of Home Care, National Academy of Elder Law Attorneys

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for O.13**

1) We dissent. Resident input is critical to a well-run community. Yet, there are any number of methods ALR management might employ to assure that input is both solicited and acted upon. Some managers might prefer focus groups. Other might utilize customer satisfaction surveys. Yet others might "manage by walking around" and engaging residents in one-on-one discussions. All can be effective. No one process is likely to be unique in achieving desired results. Yet, this recommendation is reflective of the ALW's focus, not on outcomes, but on the means by which facilities, in the ALW's judgment, must strive to achieve those outcomes.

Rather than specifying that the required process for scheduling and convening a resident council meeting, our Supplemental Position recommends suggested areas for monitoring to determine if the desired result of promoting resident autonomy is being met. For example:

- Do residents report having opportunities to provide input into development and implementation of existing house rules and community decision-making;
- Do residents report that requested changes to rules that have been accepted or acted upon by management.
- Do residents acknowledge receiving an explanation for maintaining current policy upon request for a change;
- Do residents acknowledge management/staff responsiveness to grievances/complaints.
- Do residents acknowledge receiving requested clarification of existing rules
- Do residents acknowledge being informed of community governance events (Resident Council, committee meetings, etc.)

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Operations**

**O.14 Community Environment & Standards**

**Recommendation**

Pets may be allowed to live in or to visit the ALR to provide resident companionship and comfort if it is within the policy of the ALR. For live-in pets, it shall be clearly determine who is responsible for feeding, grooming and providing for the general care of the pet, an veterinary records and vaccination records shall be made available to the ALR. Pet polici shall follow applicable state and local health regulations.

**Implementation**

Guideline for Operations

**Rationale**

Assisted living residences are based on a home-like model and pets can be a nurturing element within the ALR. Pets can provide companionship, comfort, and stimulation, and enhance positive feelings among all community members.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Adult Family Care Organization, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, National Association of Home Care

**Organizations Abstaining From the Vote on This Recommendation**

Center for Medicare Advocacy

**Supplemental Positions for O.14**

None Submitted

## Operations

### O.15 Security for Wandering Residents

#### Recommendation

If an ALR accommodates residents who exhibit unsafe wandering behaviors, then the ALR shall have a secure boundary or perimeter to safely accommodate residents. In no event shall locking devices violate life safety codes. Approved locking devices shall not be considered a physical restraint. An ALR with secure perimeters shall conduct frequent staff training on the importance of preventing unsafe wandering and maintaining alarm systems and door locking systems in a functional capacity.

#### Implementation

Guideline for State Regulation

#### Rationale

A secure perimeter defines the boundaries within which wandering residents may be safely accommodated. These boundaries may change during the day or during other periods, and may depend on such factors as exterior weather and scheduled, supervised activity periods. For example, an interior courtyard may be included within the secure perimeter during daylight hours on a warm day, but may be outside the secure perimeter at night or on a cold winter day. Exterior building walls and doors, and walled or fenced outdoor areas may be used to form this boundary. Doors forming parts of the outer boundary of a secure perimeter may be secured by electrical or electro-magnetic locking devices with key card or security code keypad access, by physical human intervention (as, for example, when the front door of a building has a reception desk that is staffed by individuals who are trained and prepared to intervene if a resident attempts to exit), with manual locks (if and only if the manually locked door is not part of a required means of egress from the building), or by some combination of these methods.

Assisted living residents who exhibit wandering behavior are likely to be residents with dementia, although other residents may also exhibit this behavior. A 1997/98 study of 2,078 residents age 65+ in 193 assisted living residences in 4 states (FL, MD, NJ, and NC) found that, depending on the size and type of facility, 19% to 26% of residents with dementia in non-specialized facilities and 28% to 44% of residents with dementia in special care units exhibited pacing and aimless wandering behaviors. In contrast, only 4% to 5% of non-demented residents exhibited these behaviors (Sloan, P.D. et al., "Caring for Persons with Dementia." Assisted Living: Needs, Practices, and Policies in Residential Care for the Elderly, Baltimore, MD: Johns Hopkins University Press, 2001).

Clearly, not all pacing and wandering behaviors are unsafe, but assisted living staff are rightly concerned about residents who may wander off and get lost. In addition to secure perimeters, many other approaches for managing pacing and wandering have been developed and tested (Rader, J. "A Comprehensive Approach to Problem Wandering," *Gerontologist* 27(6): 756-760, 1987). These other approaches begin with identification of the reason for the behavior. Some residents with dementia may believe they have to go to work or go home to take care of their children; often staff can find ways to distract or otherwise satisfy them. Other residents with dementia may pace and wander because they do not know where they are; environmental cues can help them find their way to their

## Operations

room or other familiar spot in the facility. Pacing and wandering can also indicate general restlessness or boredom; individual escorted walking and activity programs may reduce or eliminate these problems. Exercise programs can help not only with pacing and wandering behaviors but also with agitation and sleep problems. Lastly, residents with dementia who exhibit potentially unsafe wandering behaviors should be enrolled in the Alzheimer's Association's Safe Return Program so that they can be quickly located if they do become lost.

### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Social Workers, National Association of Professional Geriatric Care Managers, National Center for Assisted Living, National Conference of Gerontological Nurse Practitioners, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Seniors Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

### Organizations Opposing This Recommendation

Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Association of Local Long Term Care Ombudsmen, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants

### Organizations Abstaining From the Vote on This Recommendation

None

### Supplemental Positions for O.15

1) We dissent. Although some of the material in the rationale is useful, the recommendation itself is too weak to serve as a guideline for state regulation, or even as operational guidance. It does not address or specify such essential areas as:

- Ensuring that secure perimeters are never substituted for an adequate number of well-trained direct care staffs and well-designed programs that respond to the special needs of cognitively impaired residents;
- Ensuring that any measures to protect residents who are cognitively impaired and/or engage in unsafe wandering behavior are based on sound initial and ongoing assessments and care/service planning, and are designed to protect the resident from harm while maximizing autonomy and quality of life;
- Assurance that residents have routine access to safe outdoor areas and, as appropriate, to opportunities for planned community excursions; and
- Assurance that the secured environment is kept free of ordinary substances, objects and furnishings that might be hazardous to seriously cognitively impaired residents

Also, this recommendation states "[an] Approved locking devices shall not be considered a physical

**Operations**

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restraint." This language is much too general; any types of physical restrictions must be subject to strict scrutiny to ensure they do not constitute inappropriate restraints.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants*

2) We dissent. Infringes on state authority and flexibility to decide how it will meet the intent of an appropriate recommendation in equally effective alternative ways.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

***Topic Group Recommendations  
That Did Not Reach Two-Thirds Majority  
Operations***

*The following recommendations did not reach a two-thirds majority of the ALW. The recommendations showing a voting record were unable to reach two-thirds majority at the final vote. The recommendations that do not have a voting record were unable to reach two-thirds majority during the development process.*

**Operations**

**O.16 Restraints**

**2/3 Maj. Not Reached**

**Recommendation**

No form of restraint or seclusion shall be applied to residents of an ALR except in extreme emergency situations when the resident presents a danger of harm to himself or herself or to other residents. In such an event, the ALR shall immediately notify the resident's physician and sponsor, and appropriate treatment, transfer to an appropriate health care facility, or both shall be provided without any avoidable delay.

**Implementation**

Guideline for State Regulations

**Rationale**

None

**Organizations Supporting This Recommendation**

No Vote Recorded

**Organizations Opposing This Recommendation**

**Organizations Abstaining From the Vote on This Recommendation**

**Supplemental Positions for O.16**

1) We strongly support this failed recommendation. Restraints are dangerous medical devices that should not be used in the assisted living setting, except in extreme emergency situations pending the arrival of emergency personnel or transport to an appropriate psychiatric facility.

Restraints are so dangerous that hospitals require stringent safety measures and extraordinary physician oversight when restraints are used in emergency situations. It is unlikely that any assisted living residence has the ability to offer similar safety measures, and for good reason. ALR's are not psychiatric treatment facilities for violent patients.

The use of restraints in the long term setting for chronic (non-emergency) conditions has long been discredited among knowledgeable medical professionals. This is because they often result in serious injury or death even when properly applied, and, when improperly applied, as frequently occurs, the risks of serious adverse outcomes become even greater. Restraints result in more serious injuries than the ones they are implemented to prevent. It is often said about restraints that the cure is worse than the disease.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) The use of restraints is an important topic to address in assisted living. The undersigned support the following guideline for state regulations regarding restraints.

## Operations

Assisted living residents have the right to be free from physical or chemical restraints for the purposes of discipline or convenience or to prevent wandering. Restraints shall only be used when required to treat the resident's medical symptoms. The resident\* has the right to accept or refuse restraints. The ALR shall implement a system that emphasizes alternatives to restraints, with the goal of achieving a restraint-free environment.

There are limited circumstances under which the use of a restraint is temporarily justified for an assisted living resident. Under these circumstances, restraints shall be safely and appropriately used. Restraints shall be used only when based on a documented assessment of the resident's needs. Restraints shall be used only after an evaluation of less restrictive alternatives and only if and when these less restrictive measures have been ruled out as ineffective. No form of restraint or involuntary seclusion shall be applied to residents of an ALR except in an emergency and under a physician's order. The physician's order shall last not more than 12 hours. In such an event, the ALW shall immediately notify the resident's physician and sponsor and the local ombudsman without any avoidable delay. Use of a restraint in an emergency situation is to be temporary, while appropriate treatment is sought. When restraints are used, the resident shall be observed and assessed, attention shall be paid to the resident's needs, and the restraints shall be periodically removed or released in accordance with the resident's needs.

States shall enforce standards to eliminate the unnecessary use of physical and chemical restraints. States shall ensure that physicians, ALR staff, and families are educated about the negative effects of restraints and about alternatives to their use.

### Definitions

"Chemical restraints" are any drugs that are used for discipline or convenience and not required to treat medical symptoms.

"Emergency" shall be defined as an unanticipated and rarely occurring situation when the resident presents an immediate and serious danger of harm to himself or herself, residents, staff, or other individuals in the ALR.

"Involuntary seclusion" is a means of separation of a resident from other residents or from his or her room against the resident's will.

"Physical restraints" are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restrict freedom of movement or normal access to one's body. "Physical restraints" include, but are not limited to, bedrails, leg restrains, arm restrains, hand mitts, soft ties or vests, and wheelchair safety-bars and lap trays. Also included are ALR practices that meet the definition of restraints.

*AARP, American Seniors Housing Association, American Assisted Living Nurses Association, NCB Development Corporation, National Association of Social Workers, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

3) There are limited circumstances under which the use of a restraint is temporarily justified for an assisted living resident. No form of restraint or seclusion shall be applied to residents of an ALR except in the extreme emergency situations when the resident presents a danger of harm to himself or herself, to other residents or staff. In such an event, the ALW shall immediately notify the resident's physician and sponsor without any avoidable delay. Use of a restraint in an extreme emergency situation is to be temporary, limited to only a few hours, while appropriate treatment is



**Operations**

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sought.

*Consumer Consortium on Assisted Living, American Assisted Living Nurses Association, National Association of Professional Geriatric Care Managers*

## ***Topic Group Recommendations Adopted by Two-Thirds Majority of the ALW Resident Rights***

### **Purpose**

The Resident Rights Topic Group focused on issues pertaining to disclosure, marketing practices, and the rights of residents.

### **Issues**

The recommendations from this topic group centered on open disclosure of information about various ALR services and fees to residents and prospective residents, consistency of marketing information, discharge policies, appeals systems, contracts and resident rights.

### **Participants**

The topic group was co-chaired by Donna Lenhoff of the National Citizens' Coalition for Nursing Home Reform and David Kylo representing the National Center for Assisted Living.

Topic group participants included Sharon Bridger, National Committee To Preserve Social Security and Medicare; Eric Carlson, National Senior Citizens Law Center; Stephanie Edelstein, American Bar Association Commission on Law and Aging; Marsha Greenfield, American Association of Homes and Services for the Aging; Dan Haimowitz, American Medical Directors Association; Karen Kauffman, National Conference of Gerontological Nurse Practitioners; Cherry Meier, National Hospice and Palliative Care Organization; Mark Miller, National Association of State Units on Aging; Doug Pace, American Association of Homes and Services for the Aging; Mary Parker, Institute for Palliative and Hospice Training, Inc.; Bonnie Ruechel, National Association of Activity Professionals; Ed Sheehy, Assisted Living Federation of America; Beth Singley, Assisted Living Federation of America; Erica Wood, Consumer Consortium on Assisted Living.

**Resident Rights**

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**R.01 Consistency in Contracts and Marketing**

**Recommendation**

All information conveyed by an assisted living residence (ALR) to prospective residents (e.g. marketing materials, sales presentations, and tours) should be consistent with the contract.

**Implementation**

Guideline for State Regulation

**Rationale**

This recommendation is the foundation for an ethical assisted living marketing program and emphasizes the importance of consistency and accuracy of all oral and written communications.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Hospice and Palliative Care Organization, National Association of Local Long Term Care Ombudsmen, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for R.01**

1) We support the recommendation. The assisted living marketing professional is charged with educating the public about assisted living, but even more importantly, plays a critical role in helping families decide if the assisted living option is the correct choice for them. What is involved in "full disclosure?" Disclosure is not just what is written in a legally binding contract, it's also about what's said in sales conversations and marketing materials. It's about constantly keeping people informed. It's about understanding that families in crisis may remember only a fraction of what they are told, so "disclosure" is an ongoing process. Disclosure has to be part of the ALR's culture.

## Resident Rights

During the sales and marketing process, dialog with the potential resident and their family must include information that falls into two key areas: explanation of assisted living and critical information regarding fees, services, and policies that impact on the resident.

Full disclosure is, itself, a process that occurs through ongoing communication and education and culminates the signing of the resident agreement. Approached sensitively, full disclosure is a win-win for the consumer and the ALR:

1. Full disclosure builds a foundation of trust between the consumers and the provider.
2. Full disclosure builds credibility.
3. Full disclosure ensures that customers know what to expect and receive the services they want..
4. Greater customer satisfaction results from giving consumers realistic expectations and then meeting them.

*American Assited Living Nurses Association, Assisted Living Federation of America, Consumer Consortium on Assisted Living, National Association for Home Care, National Center for Assisted Living, Joint Commission on Accreditation of Health Care Organizations*

**Resident Rights**

**R.02 Contracts and Agreements: Consistency with Applicable Law**

**Recommendation**

All contract provisions shall be consistent with applicable law. The parties may agree to modify the contract as long as all parties agree to the modification and signify their agreement. Such modification will be consistent with applicable law.

**Implementation**

Guideline for State Regulation

**Rationale**

Contracts or similar agreements are the legal documents that disclose the obligations of the resident and ALR to each other. Recommendation R-02 recognizes that each resident is individual and may have a particular want, need or circumstance that would require modifying a standard contract or agreement. It also recognizes that both the ALR and resident shall agree to any modifications.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Association of Local Long Term Care Ombudsmen, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.02**

1) We dissent. The general thrust of this recommendation is that all contract provisions must be consistent with applicable law. As such, this recommendation provides no guidance to states or ALRs that will help to improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Resident Rights**

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**R.03 Contracts and Agreements: Readability and Pre-Signing Review**

**Recommendation**

Contracts shall be written in simple language and be understandable. Prior to signature, the prospective resident has the right to review a contract and/or have the contract reviewed by a third party. Prior to the execution of the contract, a representative of the ALR shall offer to read and explain the contract and answer any questions.

**Implementation**

Guideline for State Regulation

**Rationale**

None listed

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Adult Family Care Organization, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for R.03**

None Submitted

## Resident Rights

### R.04 Contracts and Agreements: Required Elements

#### Recommendation

Contracts/agreements should include at a minimum the following information:

- a) the term of the contract;
- b) a comprehensive description of the ALR's billing and payment policies and procedures;
- c) a comprehensive description of services provided for a basic fee;
- d) a comprehensive description of and the fee schedule for services provided on an a la carte basis or as part of a tiered pricing system that are not included in a basic fee;
- e) the policy for changing the amount of fees;
- f) how much advance notice the ALR will give before changing the amount of fees (e.g., 30 days, 60 days). Notices should be readable and understandable by the resident;
- g) whether the ALR requires an entrance fee, security deposit, and/or other fee(s) at entry, the amount of those fees and/or deposits and the policies for whether or not fees and deposits are refundable and procedures for refunding those fees and/or deposits;
- h) a description of the circumstances under which residents may receive a refund of any prepaid amount such as monthly rent;
- i) a description of the ALR's policy during a resident's temporary absence;
- j) the process for initial and subsequent assessments and the development of the service plan based on these assessments, including notification that the resident has the right to participate in the development of the service plan;
- k) a description of all requirements for assessments or physical examinations, including the frequency and assignment of financial responsibility for such assessments and/or examinations;
- l) an explanation of the use of third party services (including all health services), how they may be arranged, accessed and monitored (whether by the resident, family or the ALR), whether transportation is available if the services are not provided on-site, any restrictions on third party services, and who is financially responsible for the third party services and transportation costs;
- m) a description of all circumstances and conditions under which the ALR may require the resident to be involuntarily transferred, discharged or evicted, an explanation of the resident's right to notice, the process by which a resident may appeal of the ALR's decision and a description of the relocation assistance (if available) offered by the ALR;
- n) a description of the ALR's process for resolving complaints or disputes, including any appeal rights, and a list of the appropriate consumer/regulatory agencies (if applicable; e.g. appropriate state/local long-term care ombudsman program, the state regulatory agency, the local legal services program, and other advocacy bodies/agencies);
- o) a description of the procedures the resident or ALR shall follow to terminate the agreement; and,
- p) a list of residents rights as detailed in the statute or regulations governing assisted living residences is incorporated by reference and attached.

#### Implementation

Guideline for State Regulation

#### Rationale

**Resident Rights**

Recommendation R-04 contains a detailed list of elements to be included in contracts. The topic group recognizes the high level of detail in Recommendation R-04 but believes such detail is necessary because of the importance of contracts and similar agreements to the provider and the resident. This list contains key contract provisions generally disclosed by most assisted living providers today. In addition, the topic group believes it is essential to include such detail in this recommendation to address past concerns raised by the General Accounting Office and Congress with regard to contracting and disclosure practices in assisted living.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of Local Long Term Care Ombudsmen, National Hospice and Palliative Care Organization, National Association for Regulatory Administration, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.04**

None Submitted



**Resident Rights**

**R.05 Contracts and Agreements: Prohibition on Waiver of Right to Sue**

**Recommendation**

The contract should not require the resident to waive the right to sue the ALR under applicable law. The contract may disclose but not require options for alternative dispute resolution available to the resident or ALR.

**Implementation**

Guideline for State Regulation

**Rationale**

Recommendation R-05 is a common provision often used in other contracts and agreements

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Network of Career Nursing Assistants, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America, Joint Commission on Accreditation of Health Care Organizations

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.05**

1) We dissent. Recommendation attempts to preempt state law by stating that contracts may not stipulate a provision for alternative dispute resolution.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Resident Rights**

**R.06 Posting Contact Information**

**Recommendation**

Current contact information for the appropriate state/local long-term care ombudsman program, the state regulatory agency, the local legal services program, and other advocacy bodies/agencies mandated by the state should be posted in a size and format that is easily read and placed in a conspicuous public location in the ALR and provided to residents upon request.

**Implementation**

Guideline for State Regulation

**Rationale**

While the same contact information is listed under recommendation R-04-n dealing with contracts, Topic Group participants believe that this information also should be made readily available to residents and their families by being posted in the residence and provided to the resident upon request.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for R.06**

None Submitted

## Resident Rights

### R.07 Pre-Admission Disclosure for Specialized Programs of Care

#### Recommendation

ALRs representing in any way that they provide special care programs for persons with Alzheimer's disease or other dementias, or any other specific health conditions, shall disclose how the program and its services are different from the basic services. At a minimum, the ALR shall disclose the following information to each prospective resident prior to admission:

- The ALR's philosophy of the special care program.
- The process and criteria for placement in, and transfer or discharge from, any specialized unit and/or the ALR.
- The process for assessing residents and establishing individualized service plans.
- Additional services provided and the costs of those services relevant to the special care program.
- Specialized (condition-specific) staff training and continuing education practices relevant to the special care program.
- How the physical environment and design features are appropriate to support the functioning and safety of residents with the specific condition(s).
- The frequency and types of activities offered to residents.
- Options for family involvement and the availability of family support programs.

#### Implementation

Guideline for State Regulation

#### Rationale

The most common forms of special care programs found in ALRs/units today are those designed for individuals with Alzheimer's disease and other dementias. On a much smaller scale, some ALRs have been developed to care for individuals with other diseases such as diabetes. This specialization and diversification of assisted living is expected to continue. Such special care programs hold themselves out to be different – something beyond traditional assisted living programs. As such, special attention should be given by the ALR to clearly communicate how the special care program is designed differently from traditional assisted living and how the resident benefits from these differences. In addition, the ALR should disclose any costs or additional fees it charges as part of the specialized program.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Adult Family Care Organization, National Hospice and Palliative Care

## Resident Rights

Organization, Pioneer Network

### Organizations Opposing This Recommendation

Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of State Ombudsman Programs, National Senior Citizens Law Center

### Organizations Abstaining From the Vote on This Recommendation

Assisted Living Federation of America, National Network of Career Nursing Assistants

### Supplemental Positions for R.07

1) We dissent because disclosure alone is insufficient. Quality-of-care standards are also necessary, but the majority recommendations include no meaningful quality-of-care standards for dementia care.

This recommendation requires assisted living residences that offer special care or programs for residents with Alzheimer's Disease or other dementias to disclose certain information about those programs and services. While disclosure has great merit as a consumer education tool, disclosure must be accompanied by enforceable standards for the services being disclosed, to ensure that residents needing those services are protected.

In proposing R-07, the topic group anticipated that enforceable standards for specialized services or programs, including dementia care, would be included elsewhere in the report. The majority's recommendation on Dementia Care Services (D-11) as adopted includes no such enforceable standards. D-11 does little more than require an assisted living residence to establish policies regarding certain aspects of care, which renders R-07 inadequate.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

## Resident Rights

### **R.08 Contracts and Agreements: Third Party Responsibility**

#### **Recommendation**

The contract shall disclose clearly that a signature by a third party (such as a "responsible party") does not indicate acceptance of any personal financial responsibility for fees, costs or charges incurred by the resident, and does not make the third party a guarantor, unless the third party has signed a separate agreement indicating such.

The separate agreement shall include, at a minimum, the following information:

1. Third party voluntarily agrees to be financially liable for paying the residents' expense as agreed.
2. Third party has the right to have this agreement reviewed by an attorney or other person.
3. Third party has the right to revoke the separate agreement with 30 days notice.

#### **Implementation**

Guideline for State Regulation

#### **Rationale**

Contracts are legally binding agreements between the resident and the ALR. Frequently family members or others with close relationships to the residents may want to help residents pay for ALR expenses. Third party payers may or may not be legal surrogates. These third parties taking financial responsibility shall clearly understand that they are financially obligating themselves to pay for ALR expenses. To avoid confusion, such agreements should be handled separately from the contract with the resident.

Sometimes, residents move into an ALR quickly and under difficult circumstances (such as a quick discharge following a short hospital stay). Regardless, third parties accepting financial obligations should have the ability to have their attorneys or others review the agreements and adequate time to weigh their decisions. However, ALRs and third party payers should make every effort to sign the separate agreements well in advance of move in so that the 48-hour "cooling off" has expired to minimize the potential for unnecessary emotional trauma to individuals on the cusp of moving into the ALR.

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dieticians on Healthcare Facilities, Consumer Consortium on Assisted Living, NCB Development Corporation, National Adult Family Care Organization, National Academy of Elder Law Attorneys, National Association of Social Workers, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Conference of Gerontological Nurse Practitioners, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Hospice and Palliative

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Care Organization, National Network of Career Nursing Assistants, National Adult Family Care Organization, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

American Seniors Housing Association, Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

National Association of Home Care, Joint Commission on Accreditation of Health Care Organizations

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**Supplemental Positions for R.08**

1) We dissent. Recommendation attempts to preempt state law by requiring contracts to have specifically worded provisions regarding third party payors. Beyond the mandate of the ALW.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Resident Rights**

**R.09 Pre-Admission Disclosure on Advance Directives**

**Recommendation**

ALRs shall provide residents\* with information about their rights under state law to make decisions about medical care, including their right to accept or refuse health-related services, the right to formulate advance medical directives, such as a living will, a directive to physicians or durable power of attorney for health care.

The ALR information should disclose its philosophy and policies about implementation of advance medical directives, including, but not limited to, implementation of Do Not Resuscitate order (DNRs) and medical directives that require limitations on delivery of medical services, food, or hydration, and situations in which the ALR is required to summon emergency medical services.

**Implementation**

Guideline for State Regulation

**Rationale**

The goal of this recommendation is to ensure that prospective residents\* can make informed decisions about whether the ALR will meet their needs and follow their care directives. It is important for the resident\* and ALR to openly discuss and understand each other's position. The laws surrounding advance medical directives vary from state to state, and who has the authority to honor these directives also may vary. It is not the intent of this recommendation to address these differences but to stress the importance of full disclosure and understanding between a prospective resident\* and the ALR about the implementation of this important resident right to health care decision making.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Academy of Elder Law Attorneys, National Adult Family Care Organization, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Association for Regulatory Administration, National Conference of Gerontological Nurse Practitioners, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

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None

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**Supplemental Positions for R.09**

1) We dissent. Redundant with recommendation dealing with advance directives in conjunction with the pre-move in screening and initial assessment.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*



**Resident Rights**

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**R.10 Pre-Admission Disclosure on End-of-Life Care**

**Recommendation**

ALRs shall clearly disclose information to residents\* about applicable state laws and about the ALR's philosophy and policies regarding delivery of end-of-life care, including delivery of hospice and palliative care services. Disclosure shall include the circumstances, if any, under which a resident with terminal illness or in the process of dying may be required to leave.

**Implementation**

Guideline for State Regulation

**Rationale**

The goal of this recommendation is for full disclosure and a clear understanding of the roles, rights and responsibilities of a prospective resident and of the ALR with regard to end-of-life care needs. This recommendation recognizes the ALR's as a residence for people who may have chronic illness and frail health, and who may expect that as a resident in this supportive living environment they will be able to come to the end of their lives in peace and comfort.

In some states, there may be laws or regulations that affect the provision of end-of-life care within an ALR and these laws vary from state to state. It is not the intent of this recommendation to address these differences in law, but to stress the importance of disclosure and common understanding between a prospective resident\* and the ALR about the implementation of this important resident right to exercise choice about end-of-life care, including dying in chosen surroundings with peace and in comfort.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Academy of Elder Law Attorneys, National Adult Family Care Organization, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Conference of Gerontological Nurse Practitioners, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

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None

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**Supplemental Positions for R.10**

None Submitted

## Resident Rights

### R.11 Resident Rights and Provider Responsibilities

#### Recommendation

Within the boundaries set by law, residents have the right to:

- Be shown consideration and respect;
- Be treated with dignity;
- Exercise autonomy;
- Exercise civil and religious rights and liberties;
- Be free from chemical and physical restraints;
- Be free from physical, mental, fiduciary, sexual and verbal abuse, and neglect;
- Have free reciprocal communication with and access to the long term care ombudsmen program;
- Voice concerns and complaints to the ALR orally and in writing without reprisal;
- Review and obtain copies of their own records that the ALR maintains;
- Receive and send mail promptly and unopened;
- Private unrestricted communication with others;
- Privacy for phone calls and right to access a phone;
- Privacy for couples and for visitors;
- Privacy in treatment and caring for personal needs;
- Manage their own financial affairs;
- Confidentiality concerning financial, medical and personal affairs;
- Guide the development and implementation of their service plans;
- Participate in and appeal the discharge (move-out) planning process;
- Involve family members in making decisions about services;
- Arrange for third party services at their own expense\*;
- Accept or refuse services;
- Choose their own physicians, dentists, pharmacists and other health professionals;
- Choose to execute advance directives;
- Exercise choice about end of life care;
- Participate or refuse to participate in social, spiritual or community activities;
- Arise and retire at times of their own choosing;
- Form and participate in resident councils;
- Furnish their own rooms and use and retain personal clothing and possessions;
- Right to exercise choice and lifestyle as long as it does not interfere with other residents' rights;
- Unrestricted contact with visitors and others as long as that does not infringe on other residents' rights; and,
- Come and go and rights that one would enjoy in their own home.

In addition, residents' family members have the right to form and participate in family councils.

In the context of resident rights, providers have a responsibility to:

- Promote an environment of civility, good manners and mutual consideration by requiring staff, and encouraging residents, to speak to one another in a respectful manner;
- Provide all services for the resident or the resident's family that have been contracted for

## Resident Rights

- by the resident and the provider as well as those services that are required by law;
- Obtain accurate information from residents\* that is sufficient to make an informed decision regarding admission and the services to be provided;
  - Maintain an environment free of illegal weapons and illegal drugs;
  - Obtain notification from residents of any third party services they are receiving and to establish reasonable policies and procedures related to third party services;
  - Report information regarding resident welfare to state agencies or other authorities as required by law;
  - Establish reasonable house rules in coordination with the resident council.
  - Involve staff and other providers in the development of resident service plans; and,
  - Maintain an environment that is free from physical, mental, fiduciary, sexual and verbal abuse and neglect.

\*An ALR may require that providers of third party services ensure that they and their employees have passed criminal background checks, are free from communicable diseases and are qualified to perform the duties they are hired to perform.

### Implementation

Guideline for State Regulation

### Rationale

These resident rights support resident dignity, privacy and choice and are essential to the mission of assisted living and cornerstones of quality in an ALR. For assisted living to promote individualized care and quality of life, residents shall be treated with respect and their legal rights, individuality and autonomy shall be recognized.

The rights described recognize the importance of a resident's right to make decisions that affect his or her quality of life in assisted living within the boundaries set by law. To avoid duplication, the list includes a general category of civil and religious rights and liberties (e.g., constitutional rights and rights under the Americans with Disabilities Act and the Fair Housing Amendments Act) but does not include issues addressed in other recommendations, e.g., copy of the contract, review of inspection and survey reports, procedural protections upon discharge from the facility. The list of resident rights will be included in the contract as recommended in R.4.

It is also recognized that providers have responsibilities that support their ability to deliver quality services to assisted living residents in a safe, homelike environment. The responsibilities strike a necessary balance between an individual's ability to exercise his or her rights and the ALR's responsibility to establish reasonable rules and guidelines that will ensure the dignity, privacy, comfort and well-being of all residents.

The provider responsibilities (which were originally contained in R.12) contained in this recommendation are intended to establish a framework within which providers and residents may work together to maintain a quality living environment. They are not intended to discourage residents from exercising legal rights or lifestyle choices. However, they do acknowledge the responsibility of the provider to enforce rules commonly recognized as necessary in any group living environment. (For example, the ALR should

**Resident Rights**

establish and enforce rules prohibiting the playing of loud music at 2 a.m. when most residents are asleep.)

A list of provider responsibilities should be given to the resident when the ALR gives the resident a copy of the list of resident rights that accompanies the contract.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.11**

1) We dissent. We support the intent of this recommendation, however this recommendation attempts to hold the ALR accountable to a capricious standard for promoting "good manners".

*American College of Health Care Administrators, Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Resident Rights

### R.12 Ethics Committee/Consultation

#### Recommendation

An ALR should have knowledge of how to access an ethics committee or a source of ethics consultation to: (1) advise in development of policies and procedures; (2) educate staff, families, residents and its own members on ethical issues; and (3) provide a forum for cas consultation on ethical issues concerning resident care and services.

#### Implementation

Guideline for Operations

#### Rationale

Ethics committees or consultation teams offer a forum for thorough and thoughtful examination of difficult ethical concerns, in accordance with pre-established procedures. Ethical questions can arise in dealing with residents and families as care needs change with illness or the aging process. Ethical questions might involve choices about major medical treatment, end of life treatment, or matters of "everyday ethics" that surface from residents living in close proximity with others. Questions might be triggered when the physician seeks guidance on treatment choices, or when there is a difference of interests perspectives between the ALR and the physician, physician and family/resident, family and resident, or resident and resident. There may be questions in which the resident's decision-making capacity or identification of a surrogate is at issue; in which the safety and best interests of the resident shall be weighed against resident autonomy; or in which individual choice may conflict with the common good.

The committee or consultation team should be objective and sufficiently independent from the ALR. It should be multidisciplinary in composition, and should include long-term or acute care staff (including direct care staff), families, residents/patients, and community representatives, e.g., from religious, medical, legal and consumer advocacy organizations. The ALR may use the services of an ethics committee or consultation team in a hospital, nursing home or other nearby health care organization – or may develop its own committee or consultation team that maintains independence and objectivity from the ALR. The committee or consultation team is an advisory body, not a decision making body, and accordingly cannot limit the decision making rights of the resident or the ALR.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of Local

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Long Term Care Ombudsmen, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for R.12**

1) We dissent. A focus of the Ethics Committee is to be on the development of policies and procedures. This recommendation, like many others does not, as the Senate Committee asked, define "what quality assisted living should look like." Rather, it is devoted to prescribing, in detail, the processes that a state should require of its assisted living residences (ALRs), not the quality goals that the good ALR should strive to achieve.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Resident Rights**

**R.13 Room/Unit Hold During Resident Absence**

**Recommendation**

The resident has the right to leave the unit temporarily as long as fees are paid.

**Implementation**

Guideline for State Regulation

**Rationale**

The purpose of this recommendation is to ensure the resident's right to hold his/her unit long as fees are paid.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Association of Local Long Term Care Ombudsmen, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.13**

None Submitted



**Resident Rights**

**R.14 Acceptance of Public Funds: ALR Policy and Information for Residents**

**Recommendation**

The contract/agreement shall include the ALR's policies concerning acceptance of public benefits and continued residency by a resident whose private funds have been exhausted.

When a resident\* informs an ALR that personal funds will become exhausted, the ALR shall inform or refer the resident to sources of information about Medicaid and other benefits before initiating discharge procedures.

**Implementation**

Guideline for State Regulation

**Rationale**

The goal of this recommendation is to ensure that residents\* understand prior to move-in whether the ALR participates in any public or other financing programs that would help pay their expenses should they "spend down" and no longer be able to pay for their care and services. When residents can no longer pay privately, the ALR should inform or refer residents to sources that can help residents with their options under public programs such as Medicaid.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Association of Local Long Term Care Ombudsmen, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.14**

## **Resident Rights**

### **R.15 Fee Increases, Security Deposits and Resident Finances**

#### **Recommendation**

##### Fee Increases

The ALR shall give residents a minimum of 30 days notice in writing before changing the amount of the basic fees or other fee schedules as set forth in the contract. This 30-day requirement does not apply to a fee increase specified in the contractual fee schedule, and triggered by a change in the resident's service plan.

##### Security Deposits

The ALR shall hold security deposits in an interest bearing account and shall return any deposits plus accrued interest as set forth in the contract or as required by state law, minus allowable deductions for unpaid fees or damage to the unit within 30 days of the date the resident leaves the ALR.

##### Resident Finances

The operator or staff of an ALR shall not serve as a resident's guardian, attorney-in-fact, representative payee. The ALR may manage the resident's funds only with a written authorization by the resident, witnessed by a person with no affiliation to the ALR management. The ALR has a fiduciary responsibility to the resident in any management of a resident's money.

#### **Implementation**

Guideline for State Regulation

#### **Rationale**

These three recommendations are designed to ensure residents' funds and deposits are protected and that residents receive adequate notice of fee increases so that they have adequate time to evaluate how or whether the changes will affect their lives and finances

#### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Association of Local Long Term Care Ombudsmen, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

#### **Organizations Opposing This Recommendation**

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American Seniors Housing Association, Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.15**

1) We dissent. Fee increases – redundant with recommendation on terms and conditions of the resident contract. Security Deposits- redundant, says ALR must comply with existing requirements in state law.

*American College of Health Care Administrators, Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

2) We agree with this recommendation with the exception of the language stating that the operator/staff serve as the representative payee. Operators/staff do serve this role when residents are beneficiaries in certain government programs. Therefore, we believe the "Resident Finances" section should read:

Resident Finances: The operator or staff of an ALR shall not serve as a resident's guardian or attorney-in-fact. The ALR may act as representative payee for Social Security or SSI payments, but must have written authorization, approval from the Social Security Administration, and annually file accounting reports with the Social Security Administration. The ALR may manage the resident's funds only with a written authorization by the resident, witnessed by a person with no affiliation to the ALR management. The ALR has a fiduciary responsibility to the resident in any management of a resident's money.

*American College of Health Care Administrators, National Center for Assisted Living, American Seniors Housing Association, American Association of Homes and Services for the Aging*

## Resident Rights

### R.16 Resident Rights Upon Transfer or Discharge

#### Recommendation

##### Transfer or Discharge

An ALR intending to transfer or discharge a resident involuntarily in a non-emergency situation shall provide written notice of such intent to the resident\* at least 30 days prior to transfer or discharge. The notice shall include:

- Effective date of the transfer or discharge.
- Reason(s) for transfer or discharge, including facts and circumstances on which the decision is based.
- Resident's right to appeal the decision.
- Information on where to appeal and timeframe for filing appeal.
- Contact information for the Long Term Care Ombudsman Program.
- Resident's right to represent himself/herself or to be represented by legal counsel, a relative, friend or other spokesperson.

This notice shall be provided in a format that is readable and in language that the resident\* can understand.

##### Emergency Transfer or Discharge

In case of emergency (as defined by Recommendation D-5), no written notice is required prior to the transfer or discharge; however the ALR shall provide verbal notice to family members or other individuals designated by the resident, and such notice should be given as soon as is practical under the circumstances.

##### Appeal of Transfer or Discharge

Residents\* have the right to appeal an involuntary transfer or discharge decision to the state licensing or other appropriate agency as determined by the state. States shall designate an agency or agencies for hearing such appeals, and shall develop processes that are expeditious, impartial, and staffed by qualified personnel. These processes shall provide for an in-person hearing accessible to the resident. The resident and the ALR shall have the right to present evidence and arguments and to refute evidence and arguments presented by other parties. Residents may also appeal the decision to the ALR in accordance with internal procedures developed by the ALR. Residents shall not be required to exhaust internal procedures before appealing the ALR decision to the state.

In states without appeals systems it is recommended that ALRs create an appeal process that utilizes neutral outside mediation. (This recommendation should not be construed as supporting or requiring mandatory arbitration.)

#### Implementation

Guideline for State Regulation

#### Rationale

Recommendations D.4 and D.5 address the reasons why ALRs may seek to transfer or discharge residents (D.4) and the internal protocols for implementing such a decision (D.5). Recognizing seriousness of such decisions and its impact on residents, this

**Resident Rights**

Recommendation supplements D.4 and D.5 by providing residents with procedural rights and protections.

Many ALRs have internal mechanisms for reviewing transfer or discharge decisions but because they are conducted by ALR staff or administrators, these reviews may not be as objective as if they were performed by a third party. A number of states have implemented external systems and identified an agency, frequently the licensing agency, to hear appeals of ALR discharge decisions.

R.16 requires ALRs to provide residents\* with adequate notice of a decision to transfer or discharge the resident, reasons for the decision, and the opportunity to appeal it. It also provides ALR residents with a right they would have as residents of traditional rental housing or nursing homes - the right to appeal to an impartial forum, a decision that affects one of the most important areas of their lives.

The recommendation does not remove the authority of ALRs to establish their own review mechanisms, but it does allow residents to appeal to the external forum without waiting for the ALR to make a final decision. Understanding the need for all parties to have time and effective decisionmaking in this area, the recommendation calls for external processes that are expeditious, objective, and staffed by qualified personnel.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consultant Dietitians on Healthcare Facilities, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Social Workers, National Academy of Elder Law Attorneys, National Association of Local Long Term Care Ombudsmen, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Association of Professional Geriatric Care Managers, National Adult Family Care Organization, National Conference of Gerontological Nurse Practitioners, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America

**Supplemental Positions for R.16**

**Resident Rights**

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1) We dissent. The general thrust of this recommendation is that an ALR must comply with existing state laws regarding transfer and discharge. Also holds state governments accountable for designating certain agencies for hearing appeals and ensuring that the agency is staffed. Beyond the mandate to the ALW. Infringes on state authority to decide how it will meet the intent of an appropriate recommendation.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Resident Rights**

**R.17 Access to State Survey/Inspection Reports**

**Recommendation**

The ALR shall at all times have readily available copies of all inspection reports and plan of corrections from the past 12 months or, if they have not had a survey in 12 months, the most recent survey cycle. The ALR shall post notice of the availability of such report in a visible, public location and provide copies upon request to prospective and current residents.

**Implementation**

Guideline for State Regulation

**Rationale**

Such reports are public documents and residents\*, their families and prospective residents can use to provide a recent history of a state's review of the ALR's performance.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for R.17**

None Submitted

**Resident Rights**

**R.18 Disclosure of Staffing Levels**

**Recommendation**

The ALR shall disclose the minimum number of direct-care staff available on each shift.

**Implementation**

Guideline for State Regulation

**Rationale**

While a rough guide, minimum staffing levels may be helpful in selecting an ALR.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Social Workers, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Association of Local Long Term Care Ombudsmen, National Adult Family Care Organization, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, Assisted Living Federation of America, Catholic Health Association of the United States, Joint Commission on Accreditation of Health Care Organizations, National Center for Assisted Living

**Organizations Abstaining From the Vote on This Recommendation**

American College of Health Care Administrators

**Supplemental Positions for R.18**

1) We believe the following revised recommendation better meets consumer information needs.

The ALR shall disclose upon request the number of staff available each day.

While a rough guide, disclosing staffing patterns may be helpful to consumers when selecting an ALR. Several different staff positions contribute to the quality of life of residents, not just direct-care staff (as defined by the ALW). For instance, activities staff can significantly contribute to the well being of residents. For some residents, these types of services go further to meet resident needs than services traditionally delivered by direct care staff. In addition, it is worth noting that resident ADL and health needs vary from facility to facility making it difficult for consumers to determine whether the minimum number of direct care staff is adequate in a particular ALR. Finally, it is important to recognize that not all ALRs staff in the traditional day, evening and night shifts.

*American Association of Homes and Services for the Aging, Catholic Health*



**Resident Rights**

*Association of the United States, National Center for Assisted Living, American Assited Living Nurses Association, American Seniors Housing Association*

2) We dissent. The number of direct care staff on each shift can vary from day to day according to resident needs. Unclear as to how and in what manner this disclosure would be expected to be made and in what context it would be presented to describe the care planning and service need assumptions that go into staffing schedules.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

***Topic Group Recommendations  
That Did Not Reach Two-Thirds Majority***  
**Resident Rights**

*The following recommendations did not reach a two-thirds majority of the ALW. The recommendations showing a voting record were unable to reach two-thirds majority at the final vote. The recommendations that do not have a voting record were unable to reach two-thirds majority during the development process.*

**Resident Rights**

**R.19 Lost and Stolen Property**

**2/3 Maj. Not Reached**

**Recommendation**

An ALR shall take reasonable efforts to safeguard the property of residents. If an ALR believes that a resident's property has been stolen, the ALR should contact local police. An ALR shall reimburse residents for lost or stolen property if the ALR has failed to make a reasonable effort to safeguard that property.

**Implementation**

Guideline for State Regulation

**Rationale**

The intent of this recommendation is not to make ALR's responsible for every loss of resident property. Rather it is to encourage ALRs to take whatever steps are reasonable under the circumstances to help residents ensure the safety of their possessions.

**Organizations Supporting This Recommendation**

No Vote Recorded

**Organizations Opposing This Recommendation**

**Organizations Abstaining From the Vote on This Recommendation**

**Supplemental Positions for R.19**

1) We support this failed recommendation because it sets a standard of care that assisted living providers must follow in safeguarding resident property, and places responsibility for resulting loss on a provider who fails to meet that standard.

The recommendation recognizes that by caring for residents who need oversight and assistance as a result of physical or mental incapacities, assisted living providers assume responsibility for helping those residents to safeguard their possessions. When providers fail to exercise reasonable care, and resident property is lost or stolen as a result, providers should be liable for that loss.

Proposed substitute recommendation: An assisted living residence shall exercise reasonable care in safeguarding the personal property of residents. If the residents' property is lost or stolen as a result of the assisted living residence's failure to exercise reasonable care, the facility shall reimburse residents for the value of the property. An assisted living residence operator who believes that a resident's property has been stolen should contact, or facilitate the resident's\* efforts to contact, appropriate law enforcement agencies.

Implementation: Guideline for state regulation

Rationale: This recommendation recognizes the obligation of assisted living residences to exercise reasonable care in helping residents who are living in their facilities because they need oversight and assistance as a result of physical or mental incapacities, to safeguard their possessions.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy,  
National Association for Regulatory Administration, National Association of Local*

**Resident Rights**

*Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) Loss and theft of personal property does occasionally happen in ALRs. A recommendation is needed to address this possibility. The undersigned support the following language: An ALR shall take reasonable efforts to safeguard the personal property of residents. If an ALR believes that a resident's property has been stolen, the ALR shall contact local police. An ALR shall disclose and provide information in its resident contract that the ALR can not guarantee the safekeeping of personal property. Residents will need to make decisions about what personal property (including jewelry) to bring.

*AARP, Consumer Consortium on Assisted Living, National Association of Professional Geriatric Care Managers, NCB Development Corporation, National Center for Assisted Living, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

3) We agree that ALRs should take reasonable efforts to safeguard the property of residents. However, how "reasonable efforts" would be defined was unclear. Because of this, there is strong likelihood of abuse of such a facility policy by some. Further, this recommendation would have held ALRs to a higher level of liability for lost or stolen items than in other settings or businesses in this country.

*National Center for Assisted Living, American Seniors Housing Association, American Association for Homes and Services for the Aging*

## Resident Rights

### R.20 Medicaid Reimbursement

2/3 Maj. Not Reached

#### Recommendation

An ALR that has agreed to participate in the Medicaid program should make every effort to accept Medicaid reimbursement for any current resident for whom Medicaid reimbursement is available.

#### Implementation

Guideline for Operations

#### Rationale

By definition, a Medicaid-eligible resident has spent down virtually all of his/her savings and has relatively little income. To prevent residents from having to move, Medicaid-certified providers are encouraged to accept Medicaid reimbursement on behalf of Medicaid-eligible individuals.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Center for Assisted Living, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

#### Organizations Opposing This Recommendation

American Association of Homes and Services for the Aging, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

#### Organizations Abstaining From the Vote on This Recommendation

Joint Commission on Accreditation of Health Care Organizations

#### Supplemental Positions for R.20

1) We oppose this failed recommendation because it requires nothing and, in any case, it has been made merely a non-binding guideline for operations (as opposed to a guideline for state regulation).

This recommendation is a radically watered-down version of the language approved by the Resident Rights Topic Group. As the recommendation now stands, assisted living providers are merely encouraged to retain residents for whom Medicaid reimbursement becomes available, as guideline for operations. There is no requirement that they do so. The original language, a guideline for state regulation, stated: "An ALR that participates in the Medicaid program shall be required to accept

**Resident Rights**

reimbursement for any current resident for whom Medicaid reimbursement has become available during his/her stay in the facility." This was a reasonable requirement: if an assisted living residence has chosen to be certified for Medicaid reimbursement, and Medicaid reimbursement for a resident is available, the assisted living residence should be required to accept that reimbursement. This is particularly important because, by definition, the resident in question likely has become financially eligible for Medicaid by paying much of his or her life savings to the assisted living residence as payment for care received.

Federal law prohibits Medicaid-certified long-term care providers from discriminating on the basis of payment source. 42 U.S.C. §§ 1395i-3(c)(4), 1396r(c)(4)(A), 42 C.F.R. § 483.12(A)(2)(v). There is no principled reason to make an exception for assisted living. It is unconscionable to allow an assisted living residence to discharge an individual who becomes eligible for Medicaid after impoverishing herself by paying for her care in the residence.

*Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center*

2) We dissent. Goes beyond the mandate to the ALW to stipulate the degree to which an ALR must go to accept Medicaid reimbursement.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## ***Topic Group Recommendations Adopted by Two-Thirds Majority of the ALW Staffing***

### **Purpose**

The staffing topic group of the ALW focused on practices and procedures related to the staffing components of ALRs.

### **Issues**

Recommendations related to staffing were made in the following areas: communication; criminal background checks; abuse registry; job descriptions; staff vaccinations; compliance with federal employment laws; verification of employment history; administrator qualifications; workload; awake staff; acting administrator authorization; management recruitment and retention practices; human resources recruitment and retention practices; direct care training and supervision; orientation; and performance evaluations.

### **Participants**

The topic group was co-chaired by Bernadette Wright of AARP and Karen Love of the Consumer Consortium on Assisted Living.

Topic group participants included Linzi Burns, American College of Health Care Administrators; Steven Evans, American Medical Directors Association; Sandy Flores, American Assisted Living Nurses Association; Iris Freeman; Elinor Fritz, New Jersey LTC Assessment and Survey Division; Genevieve Gipson, National Network of Career Nursing Assistants; Marianna Grachek, Joint Commission on Accreditation of Healthcare Organizations; Marsha Greenfield, American Association of Homes and Services for the Aging; Rick Harris, Association of Health Facility Survey Agencies; Gerald Kasunic, National Association of State Ombudsmen Programs; Karen Kauffman, National Conference of Gerontological Nurse Practitioners; Martha Mohler, National Committee to Preserve Social Security and Medicare; Jonathan Musher, American Medical Directors Association; Doug Pace, American Association of Homes and Services for the Aging; Mary Parker, Institute for Palliative and Hospice Training Inc.; Jackie Pinkowitz, Consumer Consortium on Assisted Living; Brian Rasmussen, United Cerebral Palsy; Barbara Resnick, American Geriatric Society; Shelley Sabo, National Center for Assisted Living; Beth Singley, Assisted Living Federation of America; Mary Tellis-Nayak, American College of Health Care Administrators; Janet Wells, National Citizens' Coalition for Nursing Home Reform; Jacquie Woodruff, National Association of Local LTC Ombudsman Programs.

## Staffing

### S.01 Staffing Qualifications: Communication

#### Recommendation

In ALRs serving a majority English speaking population, staff who interact with residents in the delivery of services will have the ability to communicate in English with ALR residents and the community at large. Staff shall be able to communicate or have a method or mechanism to communicate with all residents. There shall be at least one person on duty at all times who has the ability to communicate in English.

#### Implementation

Guideline for State Regulation

#### Rationale

It is important that service staff have the ability to communicate with residents. For most ALRs, proficiency in English will be necessary to communicate with residents and with the community at large (e.g., residents' families, physicians, outside service providers).

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association for Regulatory Administration, National Network of Career Nursing Assistants, National Adult Family Care Organization, National Senior Citizens Law Center, National Multiple Sclerosis Society, Pioneer Network

#### Organizations Opposing This Recommendation

Assisted Living Federation of America, National Association of Home Care

#### Organizations Abstaining From the Vote on This Recommendation

NCB Development Corporation

#### Supplemental Positions for S.01

1) We dissent. Although we can support the intent of this recommendation, it goes beyond the mandate of the ALW.

*Assisted Living Federation of America, National Association of Home Care, Joint Commission on Accreditation of Health Care Organizations*



**Staffing**

**S.02 Federal Criminal Background Checks**

**Recommendation**

The federal government should establish an affordable and timely system that allows ALRs to access the national criminal background check registry. The system should use appropriate technologies to ensure the validity of the information (e.g. fingerprints, retin scans, etc.).

**Implementation**

Guideline for Federal Policy

**Rationale**

State criminal background checks only provide information on an individual's criminal record in that state. If an individual has been convicted of a crime in one state and then applies for a job in another state, a criminal background check in that state would not detect the prior conviction in the other state.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for S.02**

None Submitted

**Staffing**

**S.03 Staff Qualifications: Use of Information from Criminal Background Checks**

**Recommendation**

Each state should enact legislation or adopt rules requiring health care providers, including assisted living residences, to conduct criminal background checks before hiring staff members. The legislation or rules should also specify the crimes, conviction of which will result in disqualification from employment in the ALR.

**Implementation**

Guideline for State Regulation

**Rationale**

The benefits of conducting criminal background checks, as well as other measures to screen those who have access to vulnerable AL residents, are intuitively obvious. Of course, a criminal background check does not, by itself, provide any protection. It merely provides information. The critical factor is how the information gathered by criminal background checks will be used. There is a tremendous potential benefit to residents and to providers in having a uniform set of standards specifying which crimes ought to disqualify an individual from working in the AL setting, as well as how long a particular crime's disqualification should last.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Local Long Term Care Ombudsmen, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Adult Family Care Organization, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for S.03**

**Staffing**

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**S.04 Federal Abuse Registry**

**Recommendation**

The federal government should establish and fund a national registry of individuals with histories of abuse, to include founded complaints substantiated by state survey agencies. system of due process should be in place to allow workers to appeal a finding of abuse.

**Implementation**

Guideline for Federal Policy

**Rationale**

All 50 states have a nursing home aide abuse registry. This could be expanded to cover assisted living.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for S.04**

None Submitted

**Staffing**

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**S.05 Verification of Employment History**

**Recommendation**

The ALR should contact prior employers for all potential employees in order to verify employment history. Written documentation should be kept in the employee's confidential file.

**Implementation**

Guideline for Operations

**Rationale**

Contacting references can be a useful tool for assessing the fit between the applicant and the job and for screening out applicants who are untruthful about their work history.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America

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**Supplemental Positions for S.05**

1) We dissent. This recommendation attempts to micromanage routine administrative paperwork by requiring ALRs to keep verification of employment history in a file folder. It provides no guidance to the states or ALRs that would improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Staffing**

**S.06 Compliance with Federal Employment Laws**

**Recommendation**

Assisted living residences shall comply with all applicable federal employment laws, including, but not limited to the American Disabilities Act (ADA), the Fair Labor Standards Act (FLSA), the Civil Rights Act, and the Occupational Safety and Health Act (OSHA).

**Implementation**

Guideline for Operations

**Rationale**

Several federal employment laws apply to ALRs. ALRs should comply with all of these laws.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for S.06**

1) We dissent. The thrust of this recommendation is that ALR must comply with existing laws. As such, it is redundant, and provides no new guidance to the states that will improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Staffing

### S.07 24-Hour Awake Staff

#### Recommendation

The ALR shall ensure that the right number of trained and awake staff are on duty and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the ALR's written emergency and disaster preparedness plan for fires and other natural disasters.

#### Implementation

Guideline for State Regulation

#### Rationale

For the ALR to be able to protect residents in the event of an emergency or disaster, it is essential that the ALR ensure that there are present at all times staff who are trained to implement the ALR's written emergency plans. At a minimum, this will require at least one awake trained staff person at all times. The number of staff needed to respond to emergencies will vary, depending on the size and layout of the ALR and the needs of its residents.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Adult Family Care Organization, National Center for Assisted Living, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

#### Organizations Opposing This Recommendation

Assisted Living Federation of America, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Network of Career Nursing Assistants, National Academy of Elder Law Attorneys, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

#### Organizations Abstaining From the Vote on This Recommendation

American Bar Association

#### Supplemental Positions for S.07

1) We dissent. A minimum number of trained, alert staff on duty must be specified in state regulation. It should not be left to the ALR alone to determine "the right number." States must also set a standard for augmenting the number of staff above the required minimum, in proportion to the number of dependent residents. At the very least there should be two staff members on duty on each residential floor or unit of more than five residents, thus allowing at least one to attend to an urgent

**Staffing**

situation and one to call for help and meet on-going needs of residents. Beyond the baseline minimum, there should be additional staff persons to provide routine observation and assistance according to identified individual needs and the ability of residents to exit the unit or building by themselves in an emergency.

Provision for at least two staff for emergencies is currently found in proposed or existing requirements of some states. E. g., Virginia requires dementia units to have at least two direct care staff members awake and on duty at all times, unless fewer than six residents are present and at least two other direct care staffs are in the building.

*National Committee to Preserve Social Security and Medicare, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs*

**Staffing**

**S.08 Authorized Acting Administrator**

**Recommendation**

There shall be an individual authorized in writing to act for the administrator during absences.

**Implementation**

Guideline for State Regulation

**Rationale**

This recommendation is intended to ensure that an individual is designated to act in place of the administrator during their absence from the facility.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, Assisted Living Federation of America, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Adult Family Care Organization, National Center for Assisted Living, National Hospice and Palliative Care Organization, Pioneer Network

**Organizations Opposing This Recommendation**

Center for Medicare Advocacy, National Association for Regulatory Administration, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for S.08**

1) We dissent. As written, this recommendation leaves open the possibility that a person of no specified qualifications could be designated as acting administrator for any period of time. States should set minimum requirements for the qualifications of an acting administrator and limit the period of time an ALR can be directed by an acting administrator.

*Consumer Consortium on Assisted Living, National Committee to Preserve Social Security and Medicare, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs*



## Staffing

### S.09 Vaccinations

#### Recommendation

All staff, including volunteers the ALR or state policy determine necessary, will be tested for and vaccinated against communicable diseases, consistent with the most current CDC and OSHA requirements and all applicable state requirements. A record of vaccinations and test results will be kept in the individual's confidential file.

#### Implementation

Guideline for State Regulation

#### Rationale

CDC's "Immunizations for Staff of Long Term Care Facilities" can be found in Prevention and Control of Vaccine-Preventable Diseases in Long Term Care Facilities, available at <http://www.cdc.gov/nip/publications/Long-term-care.pdf>. To briefly summarize:

(1) Hepatitis B Vaccine: "Any health care worker who performs tasks involving contact with blood, blood-contaminated body fluids or other body fluids or sharps should be vaccinated."

(2) Influenza Vaccine: "To reduce staff illnesses and absenteeism during the influenza season and to reduce the spread of influenza to and from workers and patients, all health care workers who work in long term care facilities should be vaccinated in the fall of each year." The CDC suggests ways to improve influenza vaccination use among employees.

(3) Measles, Mumps and Rubella Vaccine: "While older residents of long term care facilities may have had these diseases and be immune, staff immunization requirements should comply with the ACIP recommendations for health care workers, i.e. demonstration of immune status either by means of a vaccination record or documentation of physician-diagnosed disease, or if they were born before 1957."

(4) Herpes Zoster and Varicella Vaccine (125): "Varicella (chicken pox) is a highly contagious disease caused by the varicella zoster virus (VZV). Varicella vaccine is recommended for susceptible adults in the following high risk groups: a) persons who live or work in environments where transmission of VZV is likely (teachers of young children, day care employees, and residents and staff members in institutional settings); b) persons who live and work in environments where transmission can occur (college students, inmates, and staff members of correctional institutions and military personnel); c) non-pregnant women of childbearing age; d) adolescents and adults living in households with children; e) international travelers.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Center for Medicare Advocacy,

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Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, NCB Development Corporation, National Association of Social Workers, National Association of Activity Professionals, National Association of Home Care, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America, National Association for Regulatory Administration

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**Supplemental Positions for S.09**

None Submitted

**Staffing**

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**S.10 Discussion of Job Descriptions with Potential Employees**

**Recommendation**

The ALR will ensure that relevant job descriptions are discussed with potential employees, students, and volunteers and that employees receive written copies of their job descriptions upon the start of employment, or before.

**Implementation**

Guideline for State Regulation

**Rationale**

It is important that potential employees, students, and volunteers understand the nature and responsibilities of their job prior to hire.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Network of Career Nursing Assistants, National Senior Citizens Law Center, Pioneer Network

**Organizations Opposing This Recommendation**

None

**Organizations Abstaining From the Vote on This Recommendation**

Assisted Living Federation of America

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**Supplemental Positions for S.10**

1) We dissent. Recommendation attempts to micromanage routine administrative paperwork by requiring ALRs to provide employees with written copies of their job descriptions. Recommendation does not provide guidance to the states that will improve quality in assisted living.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Staffing

### S.11 Qualifications for Administrators

#### Recommendation

To qualify as an assisted living administrator, individuals who are not qualified nursing home administrators shall complete a state-approved ALR licensure course and pass a state-approved exam.

#### Minimum Qualifications of a Licensure Course and Exam

The licensure course and exam shall cover the following areas:

(1) Philosophy of assisted living; (2) Organizational management and governance; (3) Resident services; (4) Clinical services; (5) Environmental management; (6) Financial management; (7) Personnel management; (8) Applicable regulations.

#### Continuing Education

To maintain licensure, an AL administrator shall complete 18 hours of state-approved continuing education per year on subjects relevant to assisted living operations, management, and philosophy.

#### Current Assisted Living Administrators and Interim Administrators

Current assisted living administrators who have worked for a period of at least one (1) year should not be required to take an ALR licensure course, but still shall take and pass the state approved ALR Administrator exam within six (6) months. Interim administrators shall be licensed within 6 months.

#### Minimum Education and Experience

An individual shall have one of the following combinations of education and experience, in order to take the AL administrator licensure exam:

1. A high school diploma or equivalent plus 4 years experience working in assisted living or health or aging related setting, including 2 years in a leadership or management position
2. An associate's degree plus 2 years experience working in assisted living or health or aging related setting, including 1 year in a leadership or management position
3. A bachelor's degree plus 1 year experience in a health or aging related setting.

#### Implementation

Guideline for State Regulation

#### Rationale

In developing the above recommendation, the topic group examined the qualifications for certification or licensure by national organizations and modified these to include additional skills recognized as important by the topic group. Modifications were also made to take into consideration differences in ALR size.

#### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, Catholic Health Association of the United States, National Network of Career Nursing Assistants, Consumer

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Consortium on Assisted Living, NCB Development Corporation, National Association of Activity Professionals, National Association of Local Long Term Care Ombudsmen, National Association of Professional Geriatric Care Managers, National Association of State Ombudsman Programs, National Citizens' Coalition on Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Assisted Living Nurses Association, American Seniors Housing Association, Assisted Living Federation of America, Center for Medicare Advocacy, Joint Commission on Accreditation of Health Care Organizations, National Association of Home Care, National Center for Assisted Living

**Organizations Abstaining From the Vote on This Recommendation**

National Association of Social Workers, National Association for Regulatory Administration

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**Supplemental Positions for S.11**

1) We oppose the recommendation and the operational model. We believe each state is capable of determining the level of education and experience needed for assisted living administrators.

*National Center for Assisted Living, American Seniors Housing Association*

## Staffing

### S.12 Recruitment and Retention: Management Practices

#### Recommendation

To aid in the recruitment and retention of staff, management shall foster an assisted living culture that values, respects, and supports all residents, staff, family, and volunteers. Management shall implement operational and staffing practices that promote effective communication, collaboration, responsibility, and accountability among its members.

#### Implementation

Guideline for Operations

#### Rationale

Effective recruitment, staff development and retention practices lead to enhanced quality of life for both residents and staff members of the ALR. They have direct and significant implications for residents with respect to quality of care and services provided them; for staff with respect to job effectiveness and job satisfaction; and for providers with respect to operating costs associated with high staff turnover. Indeed, high turnover in the LTC workforce has long been associated with poorer resident outcomes--as it places greater, often unrealistic and unmanageable, workload demands on remaining staff. Decreased worker effectiveness, increased levels of stress, and increased job dissatisfaction have all been cited as negative outcomes of, and potential triggers for more, staff turnover. As Susan Eaton notes in her research paper "Keeping Caring Caregivers": "From the research literature in organizational behavior, management, sociology and human resources, it is known that supervisory relationships, staffing levels, wage levels, benefit levels, and even the organizational culture of care could make working in two apparently similar facilities very different experience (Herzenberg et al 1999)." Indeed, her findings indicate that a well-managed organization that respects and develops caregivers and utilizes thoughtful work structures, implements positive and flexible human resource policies that build on workers intrinsic motivation, and maintains adequate staffing levels can do much to ameliorate staffing and quality care issues.

Susan Eaton in "Beyond 'Unloving Care:' Linking Human Resource Management and Patient Care Quality in Nursing Homes" (full text at <http://www.ksg.harvard.edu/socpol/eatonpaper.htm>): "The most striking characteristic of the working conditions in the higher quality nursing homes was that the facilities were not understaffed....Work organization also differed. Nurse aides often worked in teams, or "care partners", so they could assist each other. Information on resident health status was freely shared by nurse supervisors, often in a "team meeting" at the beginning of a shift."

Susan Eaton in "Keeping Caring Caregivers: How Managerial Practices Affect Turnover among Front-line Nursing Assistants": "...five areas stand out as distinguishing facilities with low nursing staff turnover:

(1) High quality leadership and management, offering recognition, meaning, and feedback as well as the opportunity to see one's work as valued and valuable; Managers who built the intrinsic motivation of workers in this field

(2) An organizational culture, communicated by managers, families, supervisors, and

## Staffing

nurses themselves, of valuing and respecting the nursing caregivers themselves as well as residents

(3) Basic positive or 'high performance' Human Resource policies, including wages and benefits but also in the areas of 'soft' skills and flexibility, training, and career ladders, scheduling, realistic job previews, etc.

(4) Thoughtful and effective, motivational work organization and care practices

(5) Adequate staffing ratios and support for high quality care.”

Iowa Caregivers C.N.A. Recruitment/Retention Project  
([www.gao.gov/new.items/d01750t.pdf](http://www.gao.gov/new.items/d01750t.pdf))

Final Report details a pilot program of direct care worker interventions (including training on conflict resolution, workshops in communication and team building and a mentor training program) implemented to address CNAs' top concerns:

- 1) Short-staffing
- 2) Poor wages and benefits
- 3) Relationships (supervisors) and lack of respect from public
- 4) Inadequate job orientation and levels of training

CNAs reported the need for:

- 1) Better orientation programs
- 2) Better communication, teamwork, and improved relationships with co-workers, especially supervisors.
- 3) More training on the disease processes and in caring for dementia clients.

### **Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of Local Long Term Care Ombudsmen, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

### **Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, American Seniors Housing Association, National Center for Assisted Living

### **Organizations Abstaining From the Vote on This Recommendation**

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None

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**Supplemental Positions for S.12**

1) We dissent. Recommendation is focused on instructing the ALR to implement operational and staffing processes, rather than focusing a quality monitoring component from the perspective of the consumer and determining the resident's views and opinions on the quality of life in the ALR.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*



**Staffing**

**S.13 Recruitment and Retention: Human Resource Practices**

**Recommendation**

Management shall implement human resource practices to promote the recruitment, professional development, and retention of direct and indirect care staff. Management shall consider short and long-term strategies and professional and personal support services that would be deemed most meaningful to their specific staffing populations including:

- a. Effective leadership and supervision offering strong, respectful organizational culture support all staff so that staff can be effective, supportive caregivers;
- b. Living wages and benefits;
- c. Consistent resident assignments, with input from residents and staff;
- d. No mandatory overtime;
- e. Skills development (training including advanced skills, mentoring, train-the-trainer) and;
- f. Career advancement (career ladders, peer mentors).

Management shall develop, implement, monitor, and evaluate the recruitment, development, and retention of direct care staff.

**Implementation**

Guideline for State Regulation

**Rationale**

Effective recruitment, staff development and retention practices lead to enhanced quality of life for both residents and staff members of the ALR. They have direct and significant implications for residents with respect to quality of care and services provided them; for staff with respect to job effectiveness and job satisfaction; and for providers with respect operating costs associated with high staff turnover. Indeed, high turnover in the LTC workforce has long been associated with poorer resident outcomes--as it places greater, often unrealistic and unmanageable, workload demands on remaining staff. Decreased worker effectiveness, increased levels of stress, and increased job dissatisfaction have all been cited as negative outcomes of, and potential triggers for more, staff turnover. As Susan Eaton notes in her research paper "Keeping Caring Caregivers": "From the research literature in organizational behavior, management, sociology and human resources, it is known that supervisory relationships, staffing levels, wage levels, benefit levels, and even the organizational culture of care could make working in two apparently similar facilities very different experience (Herzenberg et al 1999)." Indeed, her findings indicate that a well-managed organization that respects and develops caregivers and utilizes thoughtful work structures, implements positive and flexible human resource policies that build on workers intrinsic motivation, and maintains adequate staffing levels can do much to ameliorate staffing and quality care issues.

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the working conditions in the higher quality nursing homes was that the facilities were n understaffed....Work organization also differed. Nurse aides often worked in teams, or "care partners", so they could assist each other Information on resident health status was freely shared by nurse supervisors, often in a "team meeting" at the beginning of a shift."

Susan Eaton in "Keeping Caring Caregivers: How Managerial Practices Affect Turnover among Front-line Nursing Assistants": "...five areas stand out as distinguishing facilities with low nursing staff turnover:

- (1) High quality leadership and management, offering recognition, meaning, and feedback as well as the opportunity to see one's work as valued and valuable; Managers who built c the intrinsic motivation of workers in this field
- (2) An organizational culture, communicated by managers, families, supervisors, and nurses themselves, of valuing and respecting the nursing caregivers themselves as well a: residents
- (3) Basic positive or 'high performance' Human Resource policies, including wages and benefits but also in the areas of 'soft' skills and flexibility, training, and career ladders, scheduling, realistic job previews, etc.
- (4) Thoughtful and effective, motivational work organization and care practices
- (5) Adequate staffing ratios and support for high quality care."

Iowa Caregivers CNA Recruitment/Retention Project

([www.gao.gov/new.items/d01750t.pdf](http://www.gao.gov/new.items/d01750t.pdf)) Final Report details a pilot program of direct care worker interventions (including training on conflict resolution, workshops in communication and team building and a mentor training program) implemented to address CNAs' top concerns:

- 1) Short-staffing
- 2) Poor wages and benefits
- 3) Relationships (supervisors) and lack of respect from public
- 4) Inadequate job orientation and levels of training

CNAs reported the need for:

- 1) Better orientation programs
- 2) Better communication, teamwork, and improved relationships with co-workers, especially supervisors.
- 3) More training on the disease processes and in caring for dementia clients.

### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple

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Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of Local Long Term Care Ombudsmen, National Adult Family Care Organization, National Hospice and Palliative Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

American Association of Homes and Services for the Aging, Assisted Living Federation of America, American Seniors Housing Association, Catholic Health Association of the United States, National Center for Assisted Living

**Organizations Abstaining From the Vote on This Recommendation**

None

**Supplemental Positions for S.13**

1) We dissent. Recommendation is focused on instructing the ALR to implement certain human resources practices rather than focusing a quality monitoring component from the perspective of the consumer and determining the resident's views and opinions on the quality of life in the ALR.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

## Staffing

### S.14 Orientation for All ALR Staff

#### Recommendation

Within 14 days of employment, all ALR staff shall successfully complete an orientation program designed by the ALR to provide information on:

- the care philosophy of the ALR,
- understanding of dementia;
- understanding of the common characteristics and conditions of the resident population served;
- appropriate interaction with residents and family members,
- customer service policies, including resident rights and recognizing and reporting of signs of abuse and neglect;
- ALR fire, life safety, emergency disaster plans, and emergency call systems and use of ALR equipment required for job performance; and
- the ALR's employment/human resource policies and procedures.

All staff shall have specific orientation relevant to their specific job assignments and responsibilities.

Contract staff should receive an orientation on topics relevant to their job tasks, including orientation to ALR fire, life safety, emergency disaster plans, and emergency call systems.

#### Implementation

Guidelines for Operations

#### Rationale

Practice and research on long term care and health care staffing and training have documented the need for these requirements, which can be presumed to extend to staffing and training for the assisted living workforce. Information and research is cited from studies conducted in nursing facilities as they provide the closest parallels to assisted living.

Research documents the frailty of residents in assisted living (Haas, 2002). Therefore ALR staff responsible for direct care of residents need a basic level of training and skills and ongoing training and skill development to ensure that the residents receive required care and services that meet generally accepted standards of care for the specific conditions of each resident. Research also suggests that staff training should cover ethical and interpersonal aspects of care as well as technical skills development (Feldman, 1994).

The Abt Associates, Inc. Phase II study on nursing staffing and training in nursing facilities conducted for the U.S. Department of Health and Human Services found that most of the nursing assistants and educators agreed that the federally mandated 75 hours of training was not enough to cover all the material that they needed to learn. A number of states require twice that amount. Since the care requirements of residents in assisted living generally are not as high as those of nursing home residents, the recommendation for 75 hours of training is reasonable.

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The medical profession has long practiced a successful training tool - learn a skill, do the skill, teach the skill. The paraprofessional workforce could benefit significantly from this learning method that focuses on competency. A study conducted by the Iowa Caregivers Association in 2000 found this axiom to be true.

Research shows that a high percentage of certified nursing assistant turnover occurs within the first three to six months of hiring (Institute of Medicine 2001). Lack of good orientation or mentoring appeared to increase early turnover among high-turnover facilities (Eaton, "Keeping Caring Caregivers"). The Iowa Caregivers 2000 study found that nursing assistants identified inadequate levels of education, training and orientation as one of the major reasons why they do not stay in the field. Careful attention therefore to direct care staff education, orientation, mentoring, and on-the-job training are essential to ensure a stable workforce.

On-the-job injuries are also high for this category of worker (OSHA). Good training and job preparation will help reduce injuries both to workers and to residents.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Center for Assisted Living, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of Local Long Term Care Ombudsmen, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

None

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**Supplemental Positions for S.14**

1) We dissent. The primary issue related to quality of care is if there is evidence of care needs not being met. States can determine this through substantiated complaints; comparison of assessed need with the service plan, accuracy of the resident's existing service plan relative to observed need; and measures of consumer satisfaction.

Absent data that correlates the ALW's prescribed requirements for orientation programs state

**Staffing**

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agencies and ALRs should retain the flexibility to decide the best combination of staff training requirements and care monitoring that will result in high standards of care.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

**Staffing**

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**S.15 Staff Performance Evaluations**

**Recommendation**

All staff shall have performance evaluations conducted at least annually. The evaluation is prepared by a direct supervisor, based on established performance and competency standards for the employee's level of staff responsibility. The evaluation shall include measurable performance objectives for the next evaluation period and a plan for training or other activity to assist the employee to achieve these objectives. Copies of the evaluation and performance objectives and achievement plan shall be placed in the employee's personnel record. A copy of the evaluation shall be given to the employee and the employee provided an opportunity to discuss the evaluation with the supervisor and respond to unfavorable evaluations as part of employee grievance processes.

**Implementation**

Guideline for Operations

**Rationale**

It is appropriate that employers and employees understand the standards of performance and competency upon which the employee will be evaluated. Positive employment practices use evaluations as a method of assisting employees to improve their performance therefore evaluations should be tied to a plan which will assist the employee, by training otherwise, to achieve performance objectives. Employees should have a right to dispute unfavorable evaluations as part of employee grievance practices.

**Organizations Supporting This Recommendation**

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Medical Directors Association, American Seniors Housing Association, American Society of Consultant Pharmacists, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Catholic Health Association of the United States, Center for Medicare Advocacy, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Academy of Elder Law Attorneys, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association for Regulatory Administration, National Association of Social Workers, National Association of State Ombudsman Programs, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Association of Local Long Term Care Ombudsmen, National Hospice and Palliative Care Organization, National Adult Family Care Organization, National Senior Citizens Law Center, Paralyzed Veterans of America, Pioneer Network

**Organizations Opposing This Recommendation**

Assisted Living Federation of America

**Organizations Abstaining From the Vote on This Recommendation**

National Center for Assisted Living

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**Supplemental Positions for S.15**

**Staffing**

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1) We dissent. This recommendation attempts to micromanage administrative personnel functions of the ALR. Beyond the mandate of the ALW.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*



**Topic Group Recommendations  
That Did Not Reach Two-Thirds Majority  
Staffing**

*The following recommendations did not reach a two-thirds majority of the ALW. The recommendations showing a voting record were unable to reach two-thirds majority at the final vote. The recommendations that do not have a voting record were unable to reach two-thirds majority during the development process.*

## Staffing

### S.16 Personal Care Assistant (PCA) Training

2/3 Maj. Not Reached

#### Recommendation

Personal Care Assistants (PCAs) are any staff providing direct care services. All staff providing direct care shall:

1. Be at least 18 years old unless enrolled in a state-accredited high school vocational education program; and
2. Successfully complete a state-approved training program including both classroom and clinical skills practicum and pass a written examination and skills competency test administered by a state-approved examiner prior to or within 4 months of hire. The learning and performance objectives for the personal care assistant training program shall include all of the following:
  - a. Demonstrate understanding of the philosophy and concepts of assisted living and how they guide caregiving
  - b. Successfully demonstrate the understanding of resident rights (e.g., privacy, freedom of choice, preserving dignity, encouraging independence, personalizing services, etc.)
  - c. Involve and support family caregivers
  - d. Demonstrate cultural competency
  - e. Successfully demonstrate ADL care techniques for dressing, grooming, bathing, oral hygiene, toileting, perineal care for incontinent residents, eating, and assistance with ambulation
  - f. Demonstrate understanding of the normal aging process, sensory changes in older adults, and common geriatric conditions
  - g. Recognize the signs and symptoms of depression and other common mental health conditions
  - h. Successfully demonstrate appropriate techniques for assisting residents with functional disabilities, physical frailties, and mental health issues
  - i. Successfully complete a CPR and First Aid program
  - j. Demonstrate understanding of quality of life needs in the four domains: physical, psychological, social, and spiritual
  - k. Demonstrate understanding of how to respond to emergencies, including falls
  - l. Demonstrate understanding of and demonstrate appropriate infection control measures
  - m. Demonstrate ability to measure, report, and document all vital signs (temperature, pulse, blood pressure, respiration, and pain) including appropriate techniques
  - n. Document tasks associated with the care needs of residents
  - o. Identify and report changes in health conditions
  - p. Document and report adverse outcomes (e.g., resident falls, elopement, lost teeth/hearing aid, etc.)
  - q. Use resources/references related to the care needs of residents
  - r. Demonstrate understanding of responsibilities under state regulatory requirements related to providing care
  - s. Successfully demonstrate the understanding of care needs for individuals with dementia including: overview of Alzheimer's disease and related dementias, communicating with individuals with dementia, challenging behaviors, environment and safety, late stage care

## Staffing

- assistance with ADLs, and integration of activities in daily life,
- t. Demonstrate understanding of the use of advanced directives and DNR orders
  - u. Demonstrate understanding of the principles of palliative and end-of-life care

Current state-approved certification or licensure (e.g., certified nursing assistant, Medical certified home health aide, licensed practical nurse, registered nurse) may be exempt from the above requirement. States will determine which certifications/licensures will exempt person from participating in the PCA training. Training for the care of persons with dementia will be provided at the orientation in each ALR.

3. Work under the direct supervision of an experienced mentor who has passed the state-approved certification or licensure training program until they have completed and passed their certification or licensure program.

4. Receive annually at least 12 hours of relevant training and skills development to include at least 4 hours of specific training related to special needs of residents for whom care is provided (e.g., dementia-specific care needs). Completed training should be outlined in each individual's staff performance and training plan and be provided by a state-approved or accredited training source.

Contract staff shall meet the same qualifications as permanent staff, and there shall be a written contract between the ALR and the agency.

### Implementation

Guideline for State Regulation

### Rationale

This recommendation specifies performance objectives to be achieved, rather than specifying a minimum number of hours of training that shall be completed. The consensus of the ALW was that specifying performance objectives was a better approach than specifying number of hours.

See additional discussion/rationale after S.16 – Orientation for All ALR Staff.

### Organizations Supporting This Recommendation

AARP, Alzheimer's Association, American Assisted Living Nurses Association, American College of Health Care Administrators, American Medical Directors Association, American Society of Consultant Pharmacists, Catholic Health Association of the United States, Consumer Consortium on Assisted Living, Joint Commission on Accreditation of Health Care Organizations, National Multiple Sclerosis Society, NCB Development Corporation, National Association of Activity Professionals, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Hospice and Palliative Care Organization, Paralyzed Veterans of America, Pioneer Network

### Organizations Opposing This Recommendation

American Association of Homes and Services for the Aging, American Seniors Housing Association, Assisted Living Federation of America, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, Center for Medicare Advocacy, National Academy of Elder

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Law Attorneys, National Association for Regulatory Administration, National Association of State Ombudsman Programs, National Center for Assisted Living, National Association of Local Long Term Care Ombudsmen, National Citizens' Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Senior Citizens Law Center

**Organizations Abstaining From the Vote on This Recommendation**

American Bar Association

**Supplemental Positions for S.16**

1) The need for appropriate staff training is imperative in order to meet the needs of ALR residents. A national study of assisted living found, "most staff members were not knowledgeable about what constituted normal aging."\* Because of the increasingly higher functional and health care needs of assisted living residents, personal care assistants need a thorough training program to adequately prepare them for working in assisted living. Additionally, because of the significant number of residents in assisted living that have dementia, staff need to receive specialized training in this area as well.

S. 16 carefully and thoroughly details the learning and performance objectives for personal care assistant training as well as conditions under which they are tested and supervised. This recommendation importantly addresses the need for contract staff to meet the same qualifications as permanent staff. The undersigned strongly support the importance and value of S. 16.

\* Catherine Hawes, Charles D. Phillips, and Miriam Rose. High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey (Washington, D.C., U.S. Department of Health and Human Services, November 2000), <http://aspe.hhs.gov/daltcp/reports/hshp.htm>.

*AARP, American College of Health Care Administrators, Consumer Consortium on Assisted Living, NCB Development Corporation, National Association of Professional Geriatric Care Managers, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

2) We oppose this failed recommendation because no length of training is required. The federal minimum requirement for certified nurse aide training is 75 hours, and a number of states require more. The suggested personal care assistant curriculum would have little meaning in practice if training time is too minimal to assure staff competence.

*National Committee to Preserve Social Security and Medicare, Center for Medicare Advocacy, National Association for Regulatory Administration, National Citizens' Coalition for Nursing Home Reform, Association of Health Facility Survey Agencies, National Network of Career Nursing Assistants, National Senior Citizens Law Center, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs*

3) We dissent. Requires states to adopt a state-approved training program for PCA's, and specifies the learning and performance objectives that the state must include. Infringes on state authority and flexibility to decide how it will meet the intent of an appropriate recommendation.

The primary issue related to quality of care is not whether the PCA has passed an examination, but rather is there evidence of care needs that are not being met. States can determine this through

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substantiated complaints; comparison of assessed need with the service plan, accuracy of the resident's existing service plan relative to observed need; and measures of consumer satisfaction.

Absent data that correlates the ALW's prescribed requirements with an improved level of quality of care, states should retain the flexibility to decide the best combination of Direct care staff training requirements and care monitoring that will result in high standards of care.

*Assisted Living Federation of America, National Association for Home Care, Joint Commission on Accreditation of Health Care Organizations*

4) We believe by limiting employees to a minimum age of 18, that providers are losing a valuable and proven population within the workforce. The minimum age should be 16 years. This is critical at a time when the labor pool in our country is tight and long term care workers are in such high demand.

In addition, we believe PCAs should successfully complete a state-approved training program including both classroom and clinical skills practicum that could be offered at the facility level. Finally, we also believe the list of learning and performance objectives is too extensive for front line caregivers. States should determine what subject matter PCAs are trained in initially and should also be able to identify ongoing training needs.

*National Center for Assisted Living, American Seniors Housing Association*

## Staffing

### S.17 Staffing Workload

2/3 Maj. Not Reached

#### Recommendation

The ALR shall ensure sufficient staff are on duty on each shift and manage staff activities in a manner that meets the needs of all residents and maintains a clean and safe environment at all times. Management shall implement practices for achieving realistic and reasonable workload levels based upon specific levels of assistance and care needed by residents and the staff time needed on each shift to provide required assistance to all residents assigned for care in a safe, competent, and caring manner.

The elements from the pre-move in screening process, initial assessment, on-going assessments and service plan, in addition to reviewing any change of condition residents may be experiencing shall be considered in determining staffing patterns for direct and indirect care staff.

State regulatory agencies shall develop or adopt a tool for use by surveyors to determine the adequacy of staffing levels to perform tasks specified in the ALR's resident service plans. This tool shall be freely shared with and may be used by ALRs, as well as ombudsmen and consumers.

Chronic understaffing should be cited as a serious deficient practice requiring imposition immediate and meaningful penalties without the opportunity to be relieved of penalty.

To facilitate workload planning and compliance, states shall develop or adopt a standard curriculum for training personnel with decision-making authority for admission of prospective residents that will enable these employees to adequately assess whether a potential resident's care needs exceed what an ALR can provide, given its staffing level. All personnel involved in admission decisions shall complete this curriculum, and shall be regularly in-serviced with refresher material after completing the curriculum. The ALR will train the marketer on what is appropriate to disclose in the admission process.

Based on the needs of the residents, the assisted living residence shall assure that the resident receives health care services under the direction of a registered nurse and shall:

- Have at least one registered nurse available at all times, meaning at least on call and capable of being reached by telephone;
- Develop nursing practice policies and procedures and coordination of all health care services.

#### Implementation

Guidelines for State Regulations

#### Rationale

Because understaffing creates great potential for harm to residents, state regulatory agencies should consider chronic understaffing as a deficient practice in and of itself, irrespective of whether other care-related deficient practices are identified.

Research in nursing homes has shown that quality of resident care is contingent upon



## Staffing

staffing standards to assure the presence of qualified licensed or certified staffs to provide necessary services at all hours.

Robust minimum staffing requirements should be developed in accordance with the numbers of residents, the extent of their care needs and dependency, and, where applicable, the level of licensure. Where there is no specified level of licensure or restriction on the facility's resident admission and retention practices, and/or where a facility is Medicaid certified to serve nursing home eligible residents, the facility must be staffed to provide the highest level of care and health-care oversight.

In developing its method to calculate the minimum staff required per shift, the state must address:

- A baseline staffing level necessary to carry out the facility's emergency plan and routine services applicable to all residents, commensurate with the general acuity level of the population in care or potentially in care according to its licensure level/restrictions or lack thereof;
- Staffs needed to perform the care and service plans for each resident; and
- The extent of nursing care and oversight needed for residents in care or potentially in care for purposes of (a) overseeing the adequate performance of care plans, (b) monitoring all residents for health status changes, and (c) serving residents with significant disabilities and dependencies, including nursing home-eligible residents, residents needing support technology, and those receiving hospice care.

Assisted living healthcare services must be planned and directed by a Registered Nurse (RN), who may delegate responsibilities to qualified staff but must oversee and is accountable for the care provided. Research by Philips, Hawes, and Rose for the U. S. Department of Health and Human Services (2000) "has shown the positive impact of RN care in facilitating 'aging in place' and preventing or delaying transfer from assisted living to a nursing home . . . Residents in facilities with a full time RN involved in direct care were half as likely to move to a nursing home." (Catherine Hawes, telephone conversation, 3-16-2003.) Indeed, at least one state, Alabama, has extensive requirements for RN involvement in Specialty Care dementia units (Ala. Admin. Code section 420-5-20-.06(2)).

*National Citizens' Coalition for Nursing Home Reform, Association of Health Facility Survey Agencies, Center for Medicare Advocacy, National Association of Local Long Term Care Ombudsmen, National Association of State Ombudsman Programs, National Association for Regulatory Administration, National Committee to Preserve Social Security and Medicare, National Network of Career Nursing Assistants, National Senior Citizens Law Center*

2) The need for appropriate staffing workloads in ALRs is extremely important. Understaffing creates great potential for harm to residents and at minimum unmet personal care needs. Additionally, research shows that insufficient staffing workload leads to increased staff injuries and is a significant reason why staff resign.

Advocates for nursing home reform have supported using a 'fixed ratio' system to determine appropriate staffing workloads, e.g., a minimum of 3.5 direct care staff hours per resident per day. The shortfall of this approach is that there is no research basis (as in nursing homes) for determining minimum staffing ratios for ALRs. Also, the 'fixed ratio' approach does not ensure that the actual needs of the residents are taken into account. Therefore, a 'fixed ratio' system might either provide too few staff if resident acuity needs were very high or too much staff if the resident care needs were quite low. The disparity in resident care needs is prominent in assisted living.

S.17 recommends an 'acuity-based' system that ALRs shall follow to ensure that direct care staffing



**Staffing**

is based on the actual needs of residents. Many researchers and experts in long-term care promote the use of a resident acuity-based approach to determining appropriate staffing workload. This approach focuses on the scheduled and unscheduled functional dependencies and care and service needs of the residents within each ALR - not state-by-state or chain-by-chain, etc. Acuity-based staffing models have been used by hospitals, but have not been widely developed or evaluated in assisted living. Additional research needs to be conducted on developing an effective system for determining appropriate staffing workloads in ALRs.

S. 17 also addresses the need for each ALR to consider the needs of their residents to determine how much time would need to be provided by a registered nurse (RN) to support the health care needs of their residents. The core requirement for an RN is - Based on the needs of the residents, the ALR shall assure that at least one registered nurse is available at all times, meaning at least on call and capable of being reached by telephone. Each facility shall make individual determinations based on the needs of their residents about how many RNs are needed and whether they are staff or contracted professionals.

*AARP, American College of Health Care Administrators, American Seniors Housing Association, Consumer Consortium on Assisted Living, NCB Development Corporation, National Multiple Sclerosis Society, Paralyzed Veterans of America, Pioneer Network*

3) The use of healthcare professionals should be based on the needs of the residents. We would recommend keeping the first two paragraphs which are listed below and suggest deleting the rest of the recommendation. Therefore this recommendation should read:

The ALR shall ensure sufficient staff are on duty on each shift and manage staff activities in a manner that meets the needs of all residents and maintains a clean and safe environment at all times. Management shall implement practices for achieving realistic and reasonable workload levels based upon specific levels of assistance and care needed by residents and the staff time needed on each shift to provide required assistance to all residents assigned for care in a safe, competent, and caring manner.

The elements from the pre-move in screening process, initial assessment, on-going assessments and service plan, in addition to reviewing any change of condition residents may be experiencing must be considered in determining staffing patterns for direct and indirect care staff.

*National Center for Assisted Living, American Seniors Housing Association*

# *Appendix A*

## **Best Practices / Operational Models**

**Accountability and Oversight**

**Operational Model**

**AO.0 Components of a State Accountability and Oversight System**

In addition to the traditional methods of survey and enforcement some states are using or introducing new programs of technical assistance for ALRs:

California

California's Technical Support Program is an example of a consultative approach that emphasizes prevention through education. TSP staff offer consultation in individual ALRs and provide group-training sessions for providers. TSP services are provided free of charge and on a voluntary basis. Attached is a detailed description of the TSP operated by the Community Care Licensing Division under the California Department of Social Services.

North Carolina

North Carolina enacted House Bill 1068, which directed the Department of Health and Human Services to establish a quality improvement consultation program. The purpose of the program is to assist providers in the development of quality improvement plans for each assisted living community. The NC legislature came to recognize that the imposition of penalties for deficiencies in meeting licensure requirements is not the exclusive method for ensuring quality of care in licensed adult care homes (the licensure term for assisted living in North Carolina).

House Bill 1068 will allow incentives toward the provision of quality, including, but not limited to: 1) amending current law to allow an extension of the licensure period and survey period for Adult Care Homes with a good record of compliance and in the absence of consumer complaints; 2) review aspects of the quality assessment/monitoring process that should be changed or modified under state law; and 3) the Department of Health and Human Services will offer joint training of Facility Services Consultants, county DSS adult home specialists and Adult Care Home Providers.

The bill also calls for the identification of rules that impede direct care of residents or prohibit resident choice, and allows for the development of proposals to repeal those rules as necessary.

**Direct Care**

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**Operational Model**

**D.10 Identification of Cognitive Impairment/Dementia**

To train staff to be aware of the signs and symptoms of cognitive impairment/dementia, assisted living facilities should use the Alzheimer's Association's 10 Warning Signs and the six symptoms listed in the Agency for Health Care Policy and Research (AHCPR) 1996 Clinical Practice Guideline, "Early Identification of Alzheimer's Disease and Related Dementias." The presence of these sign and symptoms does not show that the person has dementia, but rather that he/she needs a diagnostic assessment by an appropriately trained and qualified professional. (AHCPR, the Alzheimer's Association, and the other two consensus groups that have considered procedures for identifying people with possible dementia have recommended staff training about these signs and symptoms rather than formal screening with instruments, such as the MMSE.)

Once cognitive impairment/dementia has been recognized in a resident, assisted living staff may find it valuable to evaluate the person's level of impairment by using one of the available rating instruments. These instruments include the Global Deterioration Scale (Reisberg et al., 1982) and the Clinical Dementia Rating Scale (Hughes et al., 1982).

## Operations

### Operational Model

#### O.04 Emergency and Disaster Preparedness Plans

The following should be considered when developing Emergency and Disaster Preparedness Plans:

- The means by which residents or their families or representatives are notified of the evacuation plan;
- The training that staff will receive related to the plan, specifically execution of the plan, how soon after hiring the training will occur, and how frequently review of the plan with staff will occur;
- The manner in which staff, residents and their families or representatives will be educated about changes to the evacuation plan;
- Specific responsibilities for staff members related to evacuation of residents;
- Current list of each resident who will need physical assistance or specialized equipment in order to evacuate the building and a designated location, known to all staff, as to where this list is kept;
- Identification of the staff member responsible for at a minimum each of the following:
  - Ensuring all residents are accounted for;
  - When time permits, ensuring medications for all residents for whom medications are centrally stored are taken from the building; and
  - When time permits, ensuring the residents' medical records are taken from the building.
- When time does not allow for gathering of medications and residents' medical records, a back-up plan shall be in place for obtaining medications and pertinent medical information following the evacuation.
- The method for notifying families or representatives of residents when an evacuation has occurred;
- The frequency with which execution of the plan will be practiced by staff, by residents and by both following these guidelines:
  - Every six months each shift shall evacuate the building;
  - When this occurs between 9 pm and 6 am, a coded announcement may be used instead of normal audible alarm signals. These practice executions of the plan may be conducted without disturbing sleeping residents by using simulated residents or empty wheelchairs.
- Every month, on alternating shifts, tabletop evacuation practices should take place.
- A method for evaluation of the effectiveness of the plan.

An additional consideration for providers is to have a written agreement updated annually, which has been signed by all parties, with another location (e.g., hospital, nursing facility, community center, hotel, church, school) in case of the need to relocate residents during an emergency.

## Operations

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### Operational Model

#### O.05 Contingency Plan

Factors to be considered when developing the contingency plan include:

- Where the residents will be housed until the facility can again be occupied;
- How the residents will be transported to the alternate location;
- The method for notifying residents' families or representatives that the resident is in an "emergency" location;
- The manner in which adequate and appropriate materials and equipment consistent with the needs of the residents and the contingency location will be identified, gathered and transported;
- How the facility will ensure that there is adequate staff for assistance and transporting of residents and for providing the required care for the residents when they are residing at the contingency location.

All staff should be informed of the most current contingency plan and each individual's role in executing the plan. This should occur annually at a minimum.

## Operations

### Operational Model

#### O.06 Food Storage, Preparation and Transporting

To ensure that food is safely stored, prepared and handled, assisted living residences should follow related guidelines from the Food and Drug Administration. This includes but is not limited to: storing, reheating, and serving food at appropriate temperatures; protecting food from contamination; preventing the growth of food borne pathogens; controlling lighting, ventilation and humidity to prevent moisture condensation and mold growth; thoroughly cleaning and sanitizing work surfaces, supplies and equipment after use; and requiring appropriate hand washing before transporting food and before and during food preparation.

A food service supervisor, who need not be a registered dietitian, should oversee general kitchen management, including ordering of food and supplies; receiving, storing and preparing foods; providing safe and sanitary kitchen areas and equipment; providing staff in-service training of food safety practices; and establishing and updating written food safety and food handling policies and procedures.

Staff involved in the storage, handling and preparation of food should be free of signs and symptoms of communicable disease. Smoking and the use of tobacco products should be prohibited in food preparation and service areas. Food preparation methods that retain nutrient values should be encouraged. The assisted living residences should segregate food from non-consumable supplies such as medical equipment and supplies, medications, cleaning supplies and poisons.

Soiled linen should be handled and transported so that there is no cross-contamination of food preparation, service and storage areas. In instances where this is problematic because of physical plant, soiled linens should be placed in bags for transportation to laundry areas.

## Operations

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### Operational Model

#### 0.08 Smoking

If the assisted living residence permits smoking, the assisted living residence must have a written smoking policy which addresses: who may and may not smoke; when and where smoking may occur; appropriate signage in designated smoking areas; what information is relayed to residents regarding the impact of smoking on themselves and others and smoking related safety; what information is relayed to staff regarding the impact of smoking on themselves and others, smoking safety and handling smoking related emergencies; how smoking policies will be communicated and enforced throughout the assisted living residence, including smoking related move out criteria; what documentation is required to support individual resident smoking including intake, periodic screening, evaluation, education and informed consent; how and how often residents who wish to smoke will be screened for their ability to smoke independently or with assistance, with the components of a smoking screening process including the following risk factors at a minimum- level of cognition, ability to smoke unsupervised, medication use in relation to smoking, and safety issues (e.g. smoking and oxygen use); and maintenance of ventilation and fire protection systems.



**Operations**

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**Operational Model**

**O.09 Activities**

Staff, volunteers, family members, and students involved in planning or implementing activities must receive training that includes but is not limited to: the philosophy, intent and importance of activity services; the diversity of residents' learning styles; preparation and set-up of environment and materials; and how to provide positive interaction and communication.

Activity calendars must be current, understandable and accessible to resident, families, staff and volunteers. Repeated oral communication with residents must be utilized so that residents can be comfortable knowing what will be available during that month / week / day and have the opportunity to choose accordingly.

## Operations

### **Operational Model**

#### **O.10 Activities for Special Care Residents**

The Alzheimers Association with input from National Association of Activity Professionals offer a course entitled "Activity Based Alzheimer Care: Building a Therapeutic Program" which encompasses philosophy, activity domains, and categories that can be incorporated into an ALR program for special care residents. The Alzheimers Association also has a course for staff training entitled "Alzheimers Care Enrichment Philosophy: Building a Caregiving Team." For further information, contact your local Alzheimer's Association Chapter.

**Operations**

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**Operational Model**

**O.13 Assisted Living Residence Councils**

Resident Council can find many worthwhile activities and projects in which to participate, including welcoming committees, get well committees, residence newsletters, recognizing individuals for special efforts, and employee of the month awards.

**Resident Rights**

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**Operational Model**

**R.09 Pre-Admission Disclosure on Advance Directives**

As part of the ALR's pre-move in screening process, the facility should provide to residents\* information about their rights under state law to execute advance directives, which may include a booklet or statement provided by the State or other respected source outlining its advance directive legislation. The explanation approved for hospitals, nursing facilities, hospices and home health agencies by the state's medical assistance program under the federal Patient Self-Determination Act may be used as a model.

**Resident Rights**

**Operational Model**

**R.10 Pre-Admission Disclosure on End-of-Life Care**

Operational Model

The ALR's pre-move in screening process should provide to residents information about any state laws or regulations which will limit its ability to provide certain types of end of life care and support. The ALR should state its philosophy about the provision of end of life care in the ALR including, but not limited to, access to palliative care or hospice services from outside providers. The ALR should provide a written statement (either separate or as part of other materials) of its philosophy and policies concerning limitations on delivery of medical services, food, or hydration as part of a palliative or hospice plan of care. In addition, the ALR should disclose how it implements or assists end of life care plans, including pain management, palliative symptom management, and the provision of psychosocial and spiritual support. Information and regulations affecting operational models include: Medicare Regulations, Publications of the Last Acts Campaign, Policies/procedures recommended by the National Hospice and Palliative Care Organization.

## Staffing

### Operational Model

#### S.11 Qualifications for Administrators

This is an operational model of a course to prepare individuals to take the AL certification or licensure exam.

#### Required Knowledge & Skill Areas for Each Domain

##### Organizational Management and Governance

- Governing body's mission, philosophy, goals, and ethics
- Equal Employment Opportunity Commission, Americans with Disabilities Act and immigration laws and regulations
- Area agencies on aging, assisted living, ombudsman programs
- Communication methods for disseminating goals and objectives
- Goal-setting and implementation
- Professional ethics
- Management – science, art, and practice
- Needs assessment
- Risk management principles
- Public relations and marketing of assisted living residences
- Planning, implementation, evaluation of strategies, methods, and outcomes
- Problem-solving and decision-making
- Resource allocation and management
- Forecasting techniques to anticipate demand for assisted living services
- Partnership development with health care providers in the community
- Information dissemination techniques for community awareness of the residence and its services
- Outreach services – their cost and impact on referrals and community opinion
- Federal, state, and local government regulations, standards, and guidelines that effect residence operation and methods of compliance
- Legislative process
- Requirements for the participation in experimental research
- Methods of estimating, and the uses for, resident turnover data
- Records systems, including automation, retention, security, and applicable laws and regulation
- Family, resident, and staff satisfaction procedures to monitor and improve quality of services

##### Resident Services

- Communication methods for disseminating and providing resident care services
- Resident assessments and implementation of care services
- Implementation of quality improvement program to insure quality and timely care to residents
- Move-out planning, discharge resources and associated liability issues
- Legal rights of resident including privacy, right to information, informed consent, self-determination, and advance directives

## Staffing

### Operational Model

- Planning, implementation and evaluation of food service program that meets the nutritional needs of the residents and promotes socialization
- Medical and psychosocial needs of the elderly and chronically ill
- Social services, activities, food services, residents records and pharmacology
- Determination and assessment of resident care goals and appropriate documentation
- Residents' Bill of Rights and Responsibilities
- Development of resident rules, regulations and policies
- Needs assessment and implementation of staffing patterns necessary for quality services and residence requirements

### Clinical Services for Specialty Residences

- Basic requirements for special diets and administration protocols
- Rehabilitation Services
- Respiratory Services
- Procedures for teaching individuals about illness and care needs
- Basic disease processes, appropriate clinical care, infection control, and acuity requirements
- Development and implementation of systems for handling, administering, labeling, and destroying drugs
- Role of pharmacist and/or consulting pharmacist
- Process for medication management
- Infection control techniques and protocols related to care and services
- Basic medical terminology
- Medical services and their role in the organization
- Techniques to gather and utilize necessary information for resident and organizational outcomes

### Environmental Management

- Architectural and environmental design to accommodate all age groups and those physically challenged
- Building code rules and regulations
- Community emergency resources
- Effective training for emergencies
- Evaluation procedures for housekeeping and physical plant
- Sanitation and infection control
- Materials management
- Preventative maintenance
- Procedures for designating responsibility in emergency planning
- Pest control
- Safety, fire, and disaster guidelines of the National Fire Protection Association and the Life Safety Codes as well as local ordinances
- Security measures

### Financial Management

- Ancillary and other revenue producing sources

## Staffing

### Operational Model

- Capital budgeting
- Computer management information systems for financial management
- Cost components for services, programs, renovation/expansion of residence and new construction
- Financial analyses
- Generally accepted accounting practices (e.g., budgeting, cash flow, inventory, banking, auditing procedures, fixed costs, variable costs, investments, collection, billing, purchasing, etc.)
- Interpreting financial results
- Insurance needs for residence
- Loan acquisition
- Materials management, including inventory and purchasing
- Resident financial evaluations, banking procedures and account management
- Resident fund and petty cash management and liability
- Payroll procedures
- Regulatory requirements for budgeting
- Reimbursement regulations
- Tax laws and reporting (proprietary and nonprofit)
- Techniques for determining reasonable costs/pricing
- CPA audit reports

### Personnel Management

- Labor laws
- Development of personnel policies, regulations and laws including grievance procedures; job descriptions, labor, tax, minimum wage and federal/state/local regulations; worker's compensation; benefits and wages; current market value of labor; employee recruitment, assessment, motivation and recognition methods; information, communication and counseling channels with the residence; in-service/training needs assessment, program planning, costs, implementation, and evaluation; analysis of absenteeism and turnover rate; organization theory, lines of authority and responsibility; job description development and maintenance
- Recruitment and interviewing
- Staffing methods and patterns, including job analysis
- Written and oral communication skills for effective employee relations



## Staffing

### Operational Model

#### S.12 Recruitment and Retention: Management Practices

The complex issues regarding recruitment, development, and retention of staff throughout the LTC industry in the present, and into the future, may best be addressed by all sectors combining their resources and talents to create public/private collaborations that promote the creation, testing, implementation, and evaluation of new initiatives.

Such efforts may include, but not be limited to collaborations with public agencies, educational institutions, community-based initiatives, and/or other providers.

The report to the Pennsylvania Intra-Governmental Council on Long Term Care entitled "Pennsylvania's Frontline Workers in Long Term Care" (Polisher Research Institute at the Philadelphia Geriatric Center; Feb. 2001) represents one state-wide examination of these issues across the entire long term care continuum of facility-based and community-based providers, advocating public/private partnerships and "... close cooperation between various government departments and agencies and between the different provider segments within the long term care industry" as guiding principles for designing new statewide initiatives.

Massachusetts has established the Direct Care Workers Initiative, "...a coalition of consumer advocates, providers, labor unions and worker advocates that seeks to improve the quality of long-term care by improving the quality of jobs for direct care workers."

Effective structures and practices may include, but not be limited to:

- quality improvement teams to assist in developing, implementing, monitoring, and evaluating ALR practices
- interdepartmental and across-shifts information and communication practices
- interdisciplinary teams for collaborative resident care planning, implementation, and evaluation.

Susan Eaton in "Beyond 'Unloving Care: Linking Human Resource Management and Patient Care Quality in Nursing Homes" (text at <http://www.ksg.harvard.edu/socpol/eatonpaper.htm>) describes a regenerative community model. "This study examines the link between human resource management, work organization, and patient care quality in U.S. long-term care settings, proposing a key role for both management philosophy and improved front line staffing arrangements in delivering consistently higher quality care, defined to include both physical and psychological outcomes.... The original research includes case studies conducted in 20 facilities in California and Pennsylvania, USA." "The 'high quality' homes are distinguished by more nurses working on each shift at the RN, LVN, and NA levels, more gerontological training for all staff, greater information-sharing, more team-work and more continuity of care."

## Staffing

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### Operational Model

In "Recruiting and Retaining Frontline Workers in Long-Term Care: Organizational Practices in Ohio" Scripps Gerontology Center Miami University Oxford, OH, June 1999 (Full report at [www.scripps.muohio.edu](http://www.scripps.muohio.edu) - under Publications section, ) Jane Karnes Straker & Robert C. Atchley delineate "...conditions and management practices that differentiated organizations reporting minimal problems in recruiting and retaining staff in frontline positions from those that reported serious problems" in LTC facilities and home health care programs. "To keep employees once they are hired employers must provide adequate training to inspire confidence on the job, adequate staff to prevent overload and burnout, and time to maximize relationships with care recipients. Strategies used by low turnover organizations provide ideas of where other organizations can begin." "Only low turnover nursing homes were interested in offering additional opportunities for employee input, although at least one study has shown that the only factor that had a significant impact on nursing home turnover was the degree to which aides were able to contribute their own opinions about resident care. Where aides participated in care planning meetings, turnover was even lower (Wilner & Wyatt, 1999)."

**Staffing**

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**Operational Model**

**S.13 Recruitment and Retention: Human Resource Practices**

The complex issues regarding recruitment, development, and retention of staff throughout the LTC industry in the present, and into the future, may best be addressed by all sectors combining their resources and talents to create public/private collaborations that promote the creation, testing, implementation, and evaluation of new initiatives.

Such efforts may include, but not be limited to collaborations with public agencies, educational institutions, community-based initiatives, and/or other providers.

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#### S.16 Personal Care Assistant (PCA) Training

Dementia Care in Assisted Living: Resources for Staff Training

Note: In addition to the materials and programs listed, many local Alzheimer's Association chapters have programs to assist with staff training. Contact information for local Alzheimer's Association chapters is at [www.alz.org/findchapter.asp](http://www.alz.org/findchapter.asp).

Alzheimer's Association, Activity Programming for Persons with Dementia, 1995, 138-page guide, available from the Alzheimer's Association, 800-223-4405.

Alzheimer's Association, Key Elements of Dementia Care, 1997, 90-page guide for residential care settings, available from the Alzheimer's Association, 800-223-4405, \$25.

Alzheimer's Association, Solving Bathing Problems, 1999, 22-minute video and 68-page instruction book, available from the Alzheimer's Association, 800-223-4405 or from Health Professions Press, 888-337-8808, \$139.

American Association of Homes and Services for the Aging, Assisted Living Needs, Practices, and Policies in Residential Care for the Elderly, 2001, 344-page book, available from AAHSA, 1-800-508-9442, \$53.

American Psychiatric Nurses Association, Choice and Challenge: Caring for Aggressive Older Adults, training program for nurses and nursing assistants, 22-minute video, available from Terra Nova Films, [tnf@terranova.org](mailto:tnf@terranova.org), \$139.

Assisted Living Federation of America, Alzheimer's Care Series (Wandering: Is it a Problem? Resisting Care...Putting Yourself in Their Shoes, Agitation...It's a Sign), three 14-minute videos with study guides, available from Fanlight Productions, [www.fanlight.com](http://www.fanlight.com), \$169 each or \$400 for all three.

Assisted Living Federation of America, Alzheimer's/Dementia Care, a training program including participant manuals, final exams, instructor guides, and 5 videos for 10 CEU hours, available at 800-258-7030, cost varies according to materials selected.

Bell, V. & Troxel, D., The Best Friends Staff, 2001, 296-page book, available from Health Professions Press, 888-337-8808, \$32.95.

Caring for the Cognitively Impaired Patient, Lexington, KY: Alzheimer's Disease Research Center & College of Nursing, University of Kentucky, 1990.

Communicating with Moderately Confused Older Adults, 1997, video, available from Terra Nova Films, 800-779-8491, \$129.

Communicating with Severely Confused Older Adults, 1997, video, available from Terra

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Nova Films, 800-779-8491, \$129.

Coons, D.H. & Metzlar, L., Manual for trainers of Direct Service Staff in Special Dementia Units. Ann Arbor, MI: University of Michigan Press, 1990.

Greater Austin Alzheimer's Association Chapter, Alzheimer's Disease Education Program: Training Program for Health Care Staff, 1999, available from the Greater Austin Chapter, 512-454-5476, \$50.

Greater Washington Alzheimer's Association Chapter, Person Centered Care: Skill Building for Caregivers of People with Dementia, a 12-hour training program provided by the chapter with subsidies from the State of Virginia.

Los Angeles Alzheimer's Association Chapter, How to Work with the Confused Older Adult: a Program for Certified Nurses Aids, Homecare Workers, and Caregiving Professionals, 1998, 200-page manual, available from the Los Angeles Chapter, 323-938-3379, \$50.

Miami Valley Alzheimer's Association Chapter, Dress Him While He Walks: Management in Caring for Residents With Alzheimer's, 1993, video, available from Terra Nova Films, 800-779-8491, \$139.

Gwyther, Lisa P., Caring for People With Alzheimer's Disease: A Manual for Facility Staff, 2nd Edition, Washington DC: American Health Care Association, and Chicago, IL: Alzheimer's Association, 2001, 116-page book, available from the Alzheimer's Association, 800-223-4405.

Kuhn, D., Ortigara, A., & Lindeman, D. The Growing Challenge of Alzheimer's Disease in Residential Settings, Rush Alzheimer's Disease Center, 1999, 3-part training program with slides and a 100-page manual, available from the ADEAR Center, www.alzheimers.org, \$40.

Middleton, L., Johnson, K., & Alexander, L. Long-term care of the Alzheimer's Patient: A Curriculum Guide. Tampa, FL: Suncoast Gerontology Center, University of South Florida, 1990.

Optimum Care of the Nursing Home Resident with Alzheimer's Disease: "Giving a Little Extra." Durham, NC: Duke Family Support Program.

Philadelphia Geriatric Center, Recognizing and Responding to Emotion in Persons with Dementia, 22-minute video and instructors guide, available from Health Professions Press, 888-337-8808, \$139.

Rabins, P.V., Alzheimer's Care Kit, University of Maryland School of Medicine, 3 videos (Signs and Symptoms of Alzheimer's Disease, 33 minutes, Responsive Care Plans, 21

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minutes, and Minimizing Care Problems, 35 minutes), available from [www.videopress.org](http://www.videopress.org), \$400.

Rabins, P.V., Assessing the Mental Status of the Older Person, University of Maryland School of Medicine, 34-minute video demonstrating assessment of persons with Alzheimer's disease for students and nursing assistants, available from [www.videopress.org](http://www.videopress.org), \$150.

Ricker, B., Providing Dementia Care: A Teaching Manual for Educators, 1997, 280-page manual, available from the Western and Central Washington State Alzheimer's Association Chapter, 206-363-5500, \$95.

Santo Pietro, M. & Ostuni, E. Successful Communication with Alzheimer's Disease Patients: An In-service Training Manual, 1997, Boston, MA: Butterworth-Heinemann..

Siciliano, P. Alzheimer's Disease & Related Dementias: Training Manual for Health Professionals, 2000, 150-page manual, available from the Utah Alzheimer's Association Chapter, 801-274-1944.

St. Louis Alzheimer's Association Chapter, Training the Trainer: Building Creative Caregivers, 1997, curriculum and manual for an 8-module training program, available from the St. Louis Chapter, 314-432-3422, \$40.

University of Arizona, Alzheimer's Disease: Pieces of the Puzzle, 1990, include 5 videos, available from Terra Nova Films, 800-779-8491, \$199.

University of Kentucky, For Those Who Take Care: An Alzheimer's Disease Training Program for Nursing Assistants, Lexington, KY, 1996, includes a 264-page manual in a binder with text for overhead projection and student handouts for 8 1-hour sessions, available from ADEAR, 1-800-438-4380.

University of Michigan, Helping People with Dementia with Activities of Daily Living, Institute of Gerontology, 22-minute video, available from Health Professions Press, 888-337-8808, \$110.

University of Texas Southwestern Medical Center, Nurses' Aides—Making a Difference: Skills for Managing Difficult Behaviors in Dementia Victims, includes a 31-minute video and 16-page manual, available from ADEAR, 1-800-438-4380.

University of Washington, Managing and Understanding Behavior Problems in Alzheimer's Disease and Related Disorders, Seattle, WA, Alzheimer's Research Center, includes 10 videos and an 84-page manual, available from Health Professions Press, 888-337-8808, \$295.

University of Washington, STAR: Staff Training in Assisted Living Residences, Seattle,

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WA, program to reduce problems and enhance care, (more information to be provided by 2/11/03).

**Accountability and Oversight**

<b>AO.01</b>	<b>Center for Excellence in Assisted Living</b>	Pass
<b>AO.02</b>	<b>Increased Funding for Long Term Care Ombudsmen</b>	Pass
<b>AO.03</b>	<b>State-level Public Meetings to Review ALW Recommendations</b>	Pass
<b>AO.04</b>	<b>Pre-licensure Review</b>	Pass
<b>AO.05</b>	<b>Supply Constraints</b>	Pass
<b>AO.06</b>	<b>Components of a State Accountability and Oversight System</b>	Pass
<b>AO.07</b>	<b>Public Access to Statutes, Regulations, Survey and Inspection Reports</b>	Pass
<b>AO.08</b>	<b>Federal Jurisdiction Over Assisted Living</b>	Pass
<b>AO.09</b>	<b>Licensure of Assisted Living</b>	Pass
<b>AO.10</b>	<b>Stakeholder Involvement in Federal Actions</b>	Pass
<b>AO.11</b>	<b>Measure of Resident Outcomes</b>	2/3 Maj. Not Reached
<b>AO.12</b>	<b>Consumer Reports</b>	2/3 Maj. Not Reached



**Affordability**

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<b>A.01</b>	<b>Consumer Directed Long-Term Care Benefit</b>	Pass
<b>A.02</b>	<b>Home and Community Based Waiver</b>	Pass
<b>A.03</b>	<b>Additional Federal and State Funding for Affordable Assisted Living</b>	Pass
<b>A.04</b>	<b>SSI Payment for Assisted Living</b>	Pass
<b>A.05</b>	<b>Government Reimbursement for Services and the Cost of Care</b>	Pass
<b>A.06</b>	<b>Medicaid Assisted Living Rate Setting Tool</b>	Pass
<b>A.07</b>	<b>Retroactive Medicaid Payments in Assisted Living</b>	Pass
<b>A.08</b>	<b>Governmental Subsidies and Resident Income Calculation</b>	Pass
<b>A.09</b>	<b>Tenant Service Payment and Housing Subsidy Income Calculations</b>	Pass
<b>A.10</b>	<b>Medicaid Program Rules: Family Contributions and Room and Board Maximums</b>	Pass
<b>A.11</b>	<b>Third Party Service Payments and Housing Subsidy Income Calculations</b>	Pass
<b>A.12</b>	<b>Medicare &amp; Medicaid Physician House Call Payments in Assisted Living</b>	Pass
<b>A.13</b>	<b>Transportation</b>	Pass
<b>A.14</b>	<b>HUD and HHS Collaboration to Deliver Affordable Assisted Living</b>	Pass
<b>A.15</b>	<b>Federal Housing Subsidy Programs and Assisted Living</b>	Pass
<b>A.16</b>	<b>Federal Housing Subsidies and the Cost of Common Facilities in Assisted Living</b>	Pass
<b>A.17</b>	<b>HUD Assisted Living Conversion Program</b>	Pass
<b>A.18</b>	<b>Assisted Living Conversion Program for Public Housing</b>	Pass
<b>A.19</b>	<b>Affordable Assisted Living Demonstrations in Subsidized Housing</b>	Pass
<b>A.20</b>	<b>HUD Housing Choice Voucher Rules in Assisted Living</b>	Pass
<b>A.21</b>	<b>LIHTC QAP &amp; Set Aside for Affordable Assisted Living</b>	Pass
<b>A.22</b>	<b>Assisted Living Tax Credit</b>	Pass
<b>A.23</b>	<b>Advisory Boards for Government Initiative in Affordable Assisted Living</b>	Pass

**Assisted Living Workgroup Report to the U.S. Senate Special Committee on Aging**

<b>A.24</b>	<b>Aging Network Funding for Training</b>	Pass
<b>A.25</b>	<b>Paper Work Burden of Governmental Programs in Assisted Living</b>	Pass
<b>A.26</b>	<b>Food Stamps Usage in Assisted Living</b>	Pass
<b>A.27</b>	<b>Federal Development Subsidies and Private Units</b>	2/3 Maj. Not Reached
<b>A.28</b>	<b>Affordable Assisted Living Liability Insurance</b>	2/3 Maj. Not Reached
<b>A.29</b>	<b>Unit Hold</b>	2/3 Maj. Not Reached

**Direct Care**

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D.01	Pre-Move In Screening Process	Pass
D.02	Initial Assessment	Pass
D.03	Service Plan	Pass
D.04	Reasons for Resident Transfer or Move-out from an Assisted Living Residence	Pass
D.05	Protocols for Resident Transfer or Move-out from an Assisted Living Residence	Pass
D.06	Palliative Care	Pass
D.07	Hospice Care	Pass
D.08	Advance Directives	Pass
D.09	Do Not Resuscitate Orders (DNR)	Pass
D.10	Identification of Cognitive Impairment/Dementia	Pass
D.11	Care for People with Cognitive Impairment/Dementia and Dementia Special Care Units and Facilities	Pass
D.12	Senior Wellness Programs in ALRs	Pass
D.13	Shared Responsibility Agreement	2/3 Maj. Not Reached
D.14	Access to ALR's for Individuals with Personal Healthcare Needs	2/3 Maj. Not Reached
D.15	External Professional Consultant	2/3 Maj. Not Reached

**Medication Management**

<b>M.01</b>	<b>Policies and Procedures</b>	Pass
<b>M.02</b>	<b>Policies and Procedures</b>	Pass
<b>M.03</b>	<b>Resident Assessment and Management of Medication</b>	Pass
<b>M.04</b>	<b>Resident Assessment and Management of Medication</b>	Pass
<b>M.05</b>	<b>Resident Assessment and Management of Medication</b>	Pass
<b>M.06</b>	<b>Medication Administration by Medication Assistive Personnel</b>	Pass
<b>M.07</b>	<b>Medication Assistive Personnel Job Description</b>	Pass
<b>M.08</b>	<b>Curriculum for MAP Training Program</b>	Pass
<b>M.09</b>	<b>Ongoing MAP Training</b>	Pass
<b>M.10</b>	<b>MAP Activities Related to Medication Administration</b>	Pass
<b>M.11</b>	<b>Medication Packaging</b>	Pass
<b>M.12</b>	<b>Medication Packaging</b>	Pass
<b>M.13</b>	<b>Storage</b>	Pass
<b>M.14</b>	<b>Medication Records</b>	Pass
<b>M.15</b>	<b>Definitions</b>	2/3 Maj. Not Reached
<b>M.16</b>	<b>Supervision of Medication Assistive Personnel</b>	2/3 Maj. Not Reached
<b>M.17</b>	<b>MAP and PRN Medications</b>	2/3 Maj. Not Reached
<b>M.18</b>	<b>MAP and Insulin Injections</b>	2/3 Maj. Not Reached
<b>M.19</b>	<b>MAP and Enteral Medication Administration</b>	2/3 Maj. Not Reached
<b>M.20</b>	<b>Telephone Orders</b>	2/3 Maj. Not Reached
<b>M.21</b>	<b>Quality Improvement</b>	2/3 Maj. Not Reached
<b>M.22</b>	<b>Consultant Pharmacist Role</b>	2/3 Maj. Not Reached

**Operations**

<b>O.01</b>	<b>Building Codes</b>	Pass
<b>O.02</b>	<b>Life Safety Compliance</b>	Pass
<b>O.03</b>	<b>Communication of Life Safety Standards</b>	Pass
<b>O.04</b>	<b>Emergency and Disaster Preparedness Plans</b>	Pass
<b>O.05</b>	<b>Contingency Plan</b>	Pass
<b>O.06</b>	<b>Food Storage, Preparation and Transporting</b>	Pass
<b>O.07</b>	<b>Food &amp; Nutrition</b>	Pass
<b>O.08</b>	<b>Smoking</b>	Pass
<b>O.09</b>	<b>Activities</b>	Pass
<b>O.10</b>	<b>Activities for Special Care Residents</b>	Pass
<b>O.11</b>	<b>Transportation</b>	Pass
<b>O.12</b>	<b>Environmental Management</b>	Pass
<b>O.13</b>	<b>Assisted Living Residence Councils</b>	Pass
<b>O.14</b>	<b>Community Environment &amp; Standards</b>	Pass
<b>O.15</b>	<b>Security for Wandering Residents</b>	Pass
<b>O.16</b>	<b>Restraints</b>	2/3 Maj. Not Reached

**Resident Rights**

R.01	Consistency in Contracts and Marketing	Pass
R.02	Contracts and Agreements: Consistency with Applicable Law	Pass
R.03	Contracts and Agreements: Readability and Pre-Signing Review	Pass
R.04	Contracts and Agreements: Required Elements	Pass
R.05	Contracts and Agreements: Prohibition on Waiver of Right to Sue	Pass
R.06	Posting Contact Information	Pass
R.07	Pre-Admission Disclosure for Specialized Programs of Care	Pass
R.08	Contracts and Agreements: Third Party Responsibility	Pass
R.09	Pre-Admission Disclosure on Advance Directives	Pass
R.10	Pre-Admission Disclosure on End-of-Life Care	Pass
R.11	Resident Rights and Provider Responsibilities	Pass
R.12	Ethics Committee/Consultation	Pass
R.13	Room/Unit Hold During Resident Absence	Pass
R.14	Acceptance of Public Funds: ALR Policy and Information for Residents	Pass
R.15	Fee Increases, Security Deposits and Resident Finances	Pass
R.16	Resident Rights Upon Transfer or Discharge	Pass
R.17	Access to State Survey/Inspection Reports	Pass
R.18	Disclosure of Staffing Levels	Pass
R.19	Lost and Stolen Property	2/3 Maj. Not Reached
R.20	Medicaid Reimbursement	2/3 Maj. Not Reached

**Staffing**

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<b>S.01</b>	<b>Staffing Qualifications: Communication</b>	Pass
<b>S.02</b>	<b>Federal Criminal Background Checks</b>	Pass
<b>S.03</b>	<b>Staff Qualifications: Use of Information from Criminal Background Checks</b>	Pass
<b>S.04</b>	<b>Federal Abuse Registry</b>	Pass
<b>S.05</b>	<b>Verification of Employment History</b>	Pass
<b>S.06</b>	<b>Compliance with Federal Employment Laws</b>	Pass
<b>S.07</b>	<b>24-Hour Awake Staff</b>	Pass
<b>S.08</b>	<b>Authorized Acting Administrator</b>	Pass
<b>S.09</b>	<b>Vaccinations</b>	Pass
<b>S.10</b>	<b>Discussion of Job Descriptions with Potential Employees</b>	Pass
<b>S.11</b>	<b>Qualifications for Administrators</b>	Pass
<b>S.12</b>	<b>Recruitment and Retention: Management Practices</b>	Pass
<b>S.13</b>	<b>Recruitment and Retention: Human Resource Practices</b>	Pass
<b>S.14</b>	<b>Orientation for All ALR Staff</b>	Pass
<b>S.15</b>	<b>Staff Performance Evaluations</b>	Pass
<b>S.16</b>	<b>Personal Care Assistant (PCA) Training</b>	2/3 Maj. Not Reached
<b>S.17</b>	<b>Staffing Workload</b>	2/3 Maj. Not Reached

**Activities of Daily Living (ADL)** – Physical functions that a person performs every day that typically include dressing, eating, bathing, toileting and transferring. Disability is often measured by limitations in activities of daily living. See also Instrumental Activities of Daily Living (IADL).

**Acuity-Based Staffing** – A model in which the number of staff is determined by the health care needs and functional dependencies “acuity” of the residents, as well as the number of residents with significant needs requiring hands-on care.

**Advance Directives** – The process of deciding in advance what course of action or approaches to care an individual would like to be followed in the event that he or she is incapable of making such decisions. Written forms of such directives would be living wills and durable powers of attorney.

**Adverse Drug Reaction** – In pharmacology, an adverse event is any unexpected or dangerous reaction to a drug.

**Americans with Disabilities Act** – A federal civil rights law enacted in 1991 to protect the rights of persons with disabilities regarding employment, transportation, public accommodations, and public programs.

**Ancillary Services** – Services beyond the basic package of everyday supportive services that are rendered to a resident on site. These services may be provided by the assisted living operator or by third party providers. Costs for such services are typically paid in addition to the basic monthly or daily fee.

**Assisted Living Quality Coalition** – A group of four provider organizations (American Association of Homes and Services for the Aging, American Health Care Association, American Seniors Housing Association, and Assisted Living Federation of America) and two consumer organizations (AARP and Alzheimer’s Association) that issued a final report on a quality initiative in August 1998.

**Assisted Living Residence (ALR)** – A setting that meets the ALW definition of assisted living, where residents live and receive services, used in preference to “facility” in the ALW report because the emphasis is on the housing and residential aspects of living rather than the more institutional aspects.

**Assisted Living Workgroup (ALW)** – A group of roughly fifty national organizations with interests in assisted living assembled to address the request of the U.S. Senate Special Committee on Aging for recommendations to promote quality.

**Authorized Prescriber** – A licensed health professional that meets the federal and state requirements for prescribing medications and treatments.

**Board and Care Homes** – Group living arrangements (sometimes called group homes, domiciliary care homes, or personal care homes) that provide limited services to persons with disabilities. Many board and care homes serve persons with very low incomes who receive funding through the Supplemental Security Income program along with state supplements where available. Board and care homes do not typically offer the level of



services or privacy provided in assisted living, though some states continue to use the same licensure category for both types of residential care.

**Certificates of Need** – A certificate of need is allocated to a provider permitting that provider to enter a market area and open an ALR. A state will describe a process that must be followed and criteria that must be met in order to award the certificate of need. For example, a state may require that an applicant ALR prove, through a specified methodology, that there is a need for the service being offered in the particular area where the ALR proposes to operate.

**Clinical Skills Practicum** – That component of a training program that provides training in and demonstration of the clinical skills that are required for personal care job responsibilities.

**Colostomy** – An alternative exit from the colon created to divert waste through a hole in the colon and through the wall of the abdomen. A colostomy is commonly performed by severing the colon to attach the end leading to the stomach to the skin through the wall of the abdomen. The end of the colon that leads to the rectum is closed off and becomes dormant.

**Continuing Care Retirement Community (CCRC)** – A community that provides more than one living and services option on the same campus. Typically these levels include independent living apartments, assisted living, and skilled nursing.

**Contract Staff** – All individuals who provide services to residents or within the assisted living residence based upon a written agreement between the ALR and the individual or an agency employing that individual.

**Controlled Drug** – means a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V. The Controlled Substances Act places all substances that are regulated under existing federal law into one of five schedules. This placement is based upon the substance's medicinal value, harmfulness, and potential for abuse or addiction. Schedule I is reserved for the most dangerous drugs that have no recognized medical use, while Schedule V is the classification used for the least dangerous drugs. (DEA)

**Dementia** – A decline in cognitive functioning measured by impairment of memory, orientation, judgment, learning, and calculation. Often accompanied by emotional and behavioral manifestations, dementia is a group of symptoms caused by some underlying disease state such as Alzheimer's disease, Parkinson's disease, or stroke.

**Direct Service Staff** – All staff, paraprofessional (e.g., personal care assistants, medication assistive personnel) or professional (e.g., nurses or other health care professionals), who provide hands-on or direct services to residents and have most direct contact with families at any time. Also referred to as direct care staff.

**Elopement** – Inappropriate wandering from an ALR by a resident, usually by a resident with cognitive impairments to their judgment.

**Full Disclosure** – Complete and accurate written and verbal information presented by a residence that describes services, fees, conditions for move in and move out, and other information about a residence.

**Home and Community-Based Services** – Long-term supportive services provided to persons with disabilities outside of institutional settings.

**Home and Community-Based Waivers** -- Funding for home and community-based services provided under the Medicaid program. States can receive waivers from certain Medicaid requirements in order to provide targeted assistance to different populations in different settings. Forty-one states now provide some Medicaid funding to assisted living, most frequently through home and community-based waivers.

**Hospice** – Programs that provide palliative and supportive services to persons who are terminally ill and their families.

**Ileostomy** – An opening into the ileum, part of the small intestine, from the outside of the body. An ileostomy provides a new path for waste material to leave the body after part of the intestine has been removed.

**Indirect Service Staff** – Staff who assist in providing services within the ALR or to residents but whose primary responsibilities do not include resident contact. Examples include maintenance, housekeepers, and food service personnel.

**Instrumental Activities of Daily Living (IADL)** – Functions that involve managing one's affairs and performing tasks of everyday living, such as preparing meals, taking medications, walking outside, using the telephone, managing money, shopping, and housekeeping. The amount of help a person needs in performing these tasks is frequently used as one measure of disability. See also Activities of Daily Living (ADL).

**Licensed administrator** – Administrator meeting the required qualification, completing and passing a state-approved licensure or certification exam of proficiency assessed and monitored by a recognized testing organization or board.

**Long-Term Supportive Services** – Personal care and health-related services provided to persons with disabilities or illnesses. The ALW uses "supportive services" in preference to "care" to stress a less paternalistic and institutional model of supporting people with disabilities.

**Measures of Clinical Outcomes** – Measures associated with the implementation of clinical activities such as resident assessment, service planning, medication management, and wellness/preventive programs.

**Measures of Functional Outcomes** – The measurement of an individual's ability to perform activities of daily living such as bathing, dressing or walking independently, and the degree to which that ability has improved, declined or been maintained with or without intervention.

**Medicaid** – A joint federal and state-funded program, administered by the states, that provides a broad array of health and personal care services to individuals with low incomes or to persons whose health-related needs have exhausted their financial resources.

**Medicaid Waiver** – See Home and Community-Based Waiver.

**Medicare** – Federally funded and administered health insurance program for persons aged 65 and older and for persons who have been eligible for Social Security disability payments for two years or more.

**Medication Administration** – Involves opening a container of medications, removing a proscribed dosage and giving the medication by injection, insertion in the mouth, eye, ear, or body cavity, or applying it to the skin. In most cases, only a nurse or specially trained assistant can administer medications.

**Medication Management** – Involves storing medications, opening medications for a resident, reminding residents to take medications and other assistance not involving the administration of medications.

**Nebulizer** – A device for administering a medication by spraying a fine mist into the mouth, nose or both. Also known as an atomizer.

**Negotiated Risk Agreement** – See Shared Responsibility Agreement.

**Occupancy Agreement** – An agreement between a resident and the assisted living residence that outlines the conditions for living in the residence and the conditions under which a resident will no longer be able to remain.

**Over-the-Counter Medication** – A drug for which a prescription is not needed.

**Palliative Services** – Services to relieve pain and suffering without the goal of curing the disease. Palliative services are most often given to people with a terminal diagnosis.

**Performance Measures** – A quantitative tool such as a ratio, rate, index or percentage that provides an indication of an ALR's performance in relation to a specific process or outcome.

**Personal Care** – Assistance provided by another person to help with walking, bathing, grooming, dressing, eating and other routine daily tasks.

**Prescribed Medication** – A drug requiring a prescription from an authorized prescriber, as opposed to an over-the-counter drug, which can be purchased without one.

**PRN Medication** – Abbreviation meaning "when necessary" (from the Latin "pro re nata", for an occasion that has arisen, as circumstances require, as needed). Used to refer to a medication that is taken when needed, rather than on a fixed schedule.

**Provider Capacity** – The ability of an ALR to meet minimum standards as defined by the state, both operational and financial.

**Receivership** – A legal proceeding in which a person is appointed to take charge of the funds or property of an ALR when there is danger that, in the absence of this appointment, the property will be lost, removed or injured.

**Resident(\*)** – Consumers who live in assisted living residences. In the ALW report, the term resident often is followed by an asterisk (\*) to indicate that the term implies family or other surrogate decision-makers where appropriate.

**Residential Care** – A term that often includes assisted living, board and care, adult foster care, and other types of supportive housing not licensed as nursing homes.

**Responsive Complaint Investigation Process** – This process would include the following elements:

- A state-adopted process for receiving complaints from residents\* of ALRs; and
- A method for promptly tracking, responding to and resolving complaints.

**Shared Responsibility** -- A shared responsibility agreement is a written agreement between the resident and the assisted living residence that memorializes the parties' discussions and agreements regarding preferences and how they will be accommodated in the community. Shared responsibility agreements, sometimes known as negotiated risk agreements, are generally used when the resident's preferences require a deviance from accepted standards or rules where the risk of an adverse outcome is substantial.

**Significant Change** – A new or markedly different physical, functional, cognitive or psychosocial condition in a resident that impacts the service delivery of the resident's individual service plan, to include:

- Deterioration or improvement in an individual's health status or ability to perform activities of daily living;
- A deterioration or improvement in an individual's behavioral or mood status.

**Special Care Units** – A section within an assisted living residence or nursing home with a specified number of units devoted to residents with specific needs. The most common type of special care unit is for residents with dementia.

**Specialized Medication Packaging** – Refers to medication packaging other than the traditional vial or bottle system.

**State Plan Services** – Those services that a state must provide to Medicaid recipients because they are identified in the state Medicaid plan submitted to CMS. Federal law requires some of those services and some are included at the option of the state. State plan services are an entitlement, which means that all beneficiaries who meet the eligibility criteria must be served.

**Stomal** – Refers to administering medications through an opening into the body from the outside created by a surgeon. Typically used in reference to a colostomy or ileostomy. (see *colostomy*)

**Sublingual** – Underneath the tongue. A sublingual medication is dissolved under the tongue.

**Supplemental Security Income** – Federal program under the Social Security program that guarantees a minimum monthly income to every person who is age 65 or older, disabled or blind and meets income and asset requirements.

**The Aging Network** – An organizational structure that includes the U.S. Administration on Aging at the federal level, the State Units on Aging at the state level, and the Area Agencies on Aging at the local level. The Aging Network also extends to public and private service providers such as social service agencies, senior centers, and advocacy groups. Each part of the network operates from a different perspective, but all have the common goal of improving the quality of life for older people and their caregivers.

**Topical** – A medication that is applied to the surface of the skin, often in the form of an ointment or cream.

**Unit Dose** – Unit-dose packaging means an individual drug product container, usually consisting of foil, molded plastic or laminate with indentations into which a single solid oral dosage form is placed, with any accompanying materials or components including labeling. Each individual container is fully identifiable and protects the integrity of the dosage form (Massachusetts Department of Public Health).