



**Assisted Living Regulations
Public Forum – Session Two
October 1, 2015 at 2:00 p.m. 4:30 p.m.
Meeting Minutes**

Regulation Review for COMAR 10.07.14 (Sections .28 - .42)

OHCQ Staff: Amanda Thomas (Organizer), Regulatory Affairs Analyst
Gwen Winston, Quality Initiatives Coordinator
Carol Fenderson, Deputy Director of State Programs

Date: October 1, 2015

Time: 2:00 p.m. – 4:30 p.m.

Location: Rice Auditorium, 55 Wade Ave, Catonsville, MD 21228

Welcome and Introductions:

- Opening remarks and welcome – Carol Fenderson
- Review of Ground Rules – Amanda Thomas
 - Please note that this session is being recorded for note taking purposes.
 - Please be respectful during this session. Everyone’s comment is important.
 - 2 minute time limit for comments.
 - Those in the room will provide comments first and those on the phone will follow.

Attendees:

- 38 attendees participated in person
- 35 attendees participated by phone

Arrington, Anne	Kotanko, Jeralyn
B, Faith	Leppado, Lisa
Bennett, Eileen	McCamie, Lynn
Boettger, Susan	Mikem, Debra
Brunson, Monica	Neville, Kristen
Chales, Erica	Patterson, Ann
Davamony, Neena	Rana, Theresa
Davamony, Peter	Rich, Ruth
Dean-Crabtree, Beverly	Silverio, German
Dunn, Sister Irene	Simms, Mae
Funderlourke, Nikia	Sollins, Howard
Gardiner, Kristen	Sraver, Warren



Haley, Linda	Taneur, Roger
Hardy, Queene	Taweussr, Roger
Hirsch, Barbara	Willis, Michael
Hurley, Anne	Woodson, Michelle
Janeus, Margaus	Zick, Rebecca
Johnson-Plato, Patricia	
Jones, Erica	
Kennedy, Julie	
King, Elizabeth	

Regulation Comments

.28 Incident Reports

Eileen Bennet (Long-term Care Ombudsman program in Montgomery County) – The incident report should be made available to the local ombudsman.

Howard Sollins (Private Citizen) – Question about 24 hours about a death report. Is that a death in facility. If someone goes to hospital and dies, is their certainty that the Assisted Living facility would know and report the death if it occurred off-site. Is this requirement for onsite or offsite?

David Jones (Board of Pharmacy) – Resolution of the incident report question from Howard Sollins.

.32 Records- (Regulation removed, however comments still accepted.)

No comment.

.29 Relocation and Discharge.

Anne Hurley (Maryland LegalAid) – New regulations are continuing historical lack of discharge protections in assisted living facilities for residents. The only requirement that is present is that a person receives 30 days notice when and that the reason is agreed upon in the original resident agreement. This supposes that everyone signing the agreement is operating with the same bargaining power. Large differential between bargaining power of residents and providers. No prohibited reason for discharge. They could be discharged for retaliation for reporting to OHCCQ. No right to appeal, if they disagree with discharge. Resident would need to intervene with a lawyer to avoid or prevent discharge. There isn't a right to a safe and secure discharge. Receives calls from being put and their things are out on the lawn. They are told that they have to leave and find a place to go. Residents have been left in hospitals; Assisted Living refuses to take them back. Regulation sections B and C(3) requires that discharge



planning is done when transferred to another facility. However, there are people with medical needs that are not being transferred to another facility, they are not covered by this provision. We suggest that discharge planning be done for any person with continuing medical needs. Federal government through CMS, will begin requiring by 2019 that Assisted Living facilities that accept Medicaid waiver, offer the same protections to residents as landlord tenant leases and agreements. All Assisted Living residents using Medicaid waiver will only be removed through landlord tenant proceedings. Facilities would be required to provide notice and opportunity to go to court. The current proposed regulations don't include those same protections for all Assisted Living residents. If the federal guidelines are left out of the proposed regulation, we will end up with a two tiered system of private pay and Medicaid waiver. Medicaid waiver residents will be entitled to the landlord tenant protections as well as other protections. The residents who are not paying through Medicaid waiver will not have any rights beyond 30 days notice of discharge. There has to be coordination and deliberate decision making on the part of OHCC, that they are currently making the decision to not include the same discharge protections as the Medicaid waiver participants. There is a concern that providers may not want to provide services to Medicaid waiver residents due to the additional requirements. This is a serious concern as there are a lot of nursing home, CFC, and Community Based Options Waiver residents and there are not a lot of housing options. They are going to Assisted Living facilities. People are dropping out of being Medicaid Providers as a result of this discrepancy. This is a huge problem. We recommend right to safe and secure discharge regardless of reason for discharge and right to discharge planning. Recommend same discharge protections required of HCBS (Community Based Settings) rule be incorporated into the Assisted Living regulations, including landlord tenant protections as well as other protections. Prohibition against retaliatory discharges and other discharges against public interest.

Eileen Bennet (Long-term Care Ombudsman program in Montgomery County) - Ditto to Anne. Suggesting we look to language of CCRC for developing a course of consistent language for behavioral issues to be addressed. Where does it rise to the level of needing necessary discharge. Any discharge safe and secure language needs to truly include discharge planning and what that means, not just a 30 days notice. Meeting the standards of the highest level of care. Knowing that the level of care is up for discussion, but recognizing that whenever an Assisted Living is agreeing to take an individual that they need to develop standards for working with that individual and language equal to the Medicaid waiver guidance. Section B(2) should say, "not less than 30 days". D(1), we don't see why a social security number is required, were way past those types of identifications. Identity theft being a big deal, we should protect residents by not using social security number as identification when not necessary.



Sister Irene (Victory Housing) – Letter D talks about the data sheet that goes with resident. Regulations say it should include current medications taken by residents. Most of our residents take more than one medication and it would be difficult to fit them all on the emergency data sheet. We send a copy of the POS with it, so that the medications and their diagnosis are available. My question is it necessary to have the medications and the diagnosis on the emergency data sheet or is the attached POS sufficient.

David Jones (Board of Pharmacy) – D(4), language should be changed from “current medications taken by patient” to “current medications ordered for the patients” to include maybe DRN. Not reflected by words taken by.

Pat Younger (Sagepoint Gardens) - Landlord tenant protections is far too stringent for the private sector and not necessary. I agree we could put in more protections on discharge, but landlord tenant is not appropriate in my opinion because of the medical situations that we deal with. It's not straight forward, as it is in the regular community. There are more complicated medical issues to deal with. I think it's inappropriate in this context.

Kim Burton (Mental Health Association of Maryland) – Would like to echo what Anne Hurley has discussed. We would like to see some protections exercised in the regulations including: discharge planning, safe discharge, and application of Home and Community Based Services rule that provides protection (cite their source). Also if an individual is discharged, we would like to see information having to do with treating professionals, specifically behavioral health providers. Our concern is that discharge issues disproportionately affects residents with behavioral health needs. People with mental illness and substance use disorders are disproportionately the folks who are dumped/ discharged without the resources they need.

Debby (Provider) – Agree with Pat about the private sector with landlord tenant statement. Residents are paying for their service. There is a difference between property and a service. Whether it's private pay or Medicaid waiver they are not signing a contract for the building itself, it's the services.

Howard Sollins – I'm not sure if the agency has the statutory authority to impose a landlord tenant law. The landlord tenant law may not apply to Assisted Living facilities as they are providing a service. There may be official documentation from the Attorney General on this. If OHCC is looking at this, it should be looked at broadly. Also, when considering discharge, the residents that remain after someone is discharged should be considered. Sometimes there are resident issues, especially in smaller homes, where a resident may pose a safety issue to other residents. We don't want to be in a position



where there are other residents at risk due to the inability to discharge a resident. This issue requires additional discussion. One size fits all may not work for this situation.

.30 Resident's Representative.

Kim Burton (Mental Health Association) – Would like to see language that ensures that providers or owners of Assisted Livings do not become their representative for financial or health decisions.

.31 Resident's Rights.

Eileen Bennet –Rights of appeals should be included in the regulation.

Anne Hurley – Section A(25) talks about residents returning from a hospital stay after 15 days, with the following exception, “the manager documents that the residents care needs exceed what the facility can provide”. I would suggest that it is changed from “manager” to the “treating physician”. The treating physician should provide documentation that the resident’s care needs exceed what the program can provide. There is a conflict of interest, residents with behavioral health care needs are sometimes labeled “undesirable” and are disproportionately affected by discharges. The manager is an employee and they would have a disincentive to accept the resident back. A treating physician should be the person making the decision or at a minimum weighs in on the decision if the person can return.

Howard Sollins – This is broader than the way it works in nursing homes, because it doesn’t say anything about bed holds. If somebody goes out, and let’s assume the facility or the program has a bed hold policy. If someone elects not to hold the bed, that is not a discharge. That’s an election. Even in a nursing home context that’s the way it works. There is also in the nursing home context, by federal statute (which doesn’t apply here), for Medicaid Waiver beneficiaries the right to re-admission for first available semi-private room. There is not statutory basis for this in Assisted Living. I’m wondering what would be the basis under the law for someone who is no longer a resident, because they haven’t held the bed. I’m not sure they have a right to return. The way the statutes work, I’m not sure if you can legally impose that obligation. In terms of an earlier comment about a clinical judgment, not every decision about a resident return is clinical. Suppose there is a behavioral issue. Workplace violence is a big concern not just resident to resident altercations but resident to staff. Hopefully there is never a staff to resident altercation. Sometimes people with behavior issues act out relative to people on staff. I would have a concern if someone’s treating physician said that the facility could handle the resident. There has to be a way to make a reasonable judgment about the resident’s needs and the ability to provide care, what resources are available, what it means for the resident being accepted back, what it means for the other residents in the facility.



Monica Brunson (Health Care Consultants) – I agree with what the previous two speakers said. I believe the wording should include an interdisciplinary team and not just the manager. As there are decisions that are not just clinical or social, there needs to be input from the Assisted Living as to whether they feel the person can be managed. In some cases the physicians need education as to what an Assisted Living is and what they can and cannot do. Wording should change to include a team decision with the manager or representative being required to be at the discharge planning meeting from the nursing or rehab center.

Horizon Concepts – I agree with the previous speakers. Not all Assisted Livings have a dedicated health care team. The wording could be changed to include, manager, case manager, delegating nurse, and/or the designee of the facility. The facility manager and case manager should be a part of making that decision. Not all physicians are educated in COMAR 10.07.02. Should not accept any one outside the scope of what the facility can provide.

Ms. Mae (Beyond Care) – As a vendor and as a representative of Assisted Living's throughout the state, Assisted Livings are diverse and range from small to large outlined in uniform disclosure statement. They offer a variety of services. The manager and owner should have sole discretion of who remains in the facility. Based on whether they feel their program is able to provide the services that meet the resident's needs. If for any reason they find that the facility is not the appropriate setting. The facility should not be mandated to keep the resident. Or that they go through a series of screenings or processes to determine if they stay. There should be procedures to assist individuals being discharged to place them in appropriate settings. Managers should have the right to say that their program is not the right fit for the resident.

David Jones- Agree with previous commenter's that talked about the need for team coordination for transition of care from acute care settings back to the Assisted Living setting. I think it might be up to the facility to designate the composition of their team. How to work it from the point of Assisted Living, Long-term care, and acute care.

Debby – I agree with Mae and David. It should be up to the independent Assisted Living and it should be a team decision. The team could consist of the manager, owner, delegating nurse or case manager. We are ultimately responsible and it could be detrimental to the resident that returns as well as the other residents in the facility. A lot of facilities don't have in-house physicians and they may not be aware of what Assisted Livings can and cannot handle. Unfortunately physicians need a lot of education as Assisted Livings can treat different levels of care and they may not be aware of this. Having them make the decision forces Assisted Livings to accept residents that they are not able to care for safely. Facilities should be able to decide who they accept.



Kim Burton (Mental Health Association) –There needs to be a balance of protection of residents with behavioral health issues (mental health and substance abuse issues). The behavioral health issue may pose an issue with other residents, staff, and the resident in distress themselves. In looking through the regulations, we need to look for a place in the regulations where everyone’s interests are protected. The individuals with behavioral health issues are disproportionately cast out by regulations that are not included to protect them. This discussion highlights the need to address behavioral health issues, provide resources and support to providers. Managers and owners need to know what they can do for those residents that have behavioral health issues. They need to know support and resources are available. The HCBS rules will present other resident rights that may cause a two tier system. We hope OHCC is inclusive of those rules and makes sure that regardless of payer source, resident’s rights do not bifurcate the system. I am concerned that all residents won’t have the same rights. .23 Says have reasonable access to telephone. Remove the word “reasonable”. Would like added an acknowledgement of additional technologies.

Pat Younger – Address the previous comment of reasonable access to a telephone. No one wants to restrict residents using the telephone. However, there are behavioral health residents that will call 911 incessantly. There does need to be a degree of reasonableness. We have to rely on the judgment of managers.

.32 Abuse, Neglect, and Financial Exploitation.

Kristin Neville (Board of Health Occupations) – We suggest adding roman numeral IV. Appropriate Health Occupations Board to C(1) b. We would like the appropriate Health Occupations Board to be notified of any misconduct of individuals or facilities licensed by them. The health occupation boards appreciate being notified and can investigate and potentially take action against the persons or facilities licensed and can prevent people “hopping” from facility to facility. If possible, similar language should be added under E as well.

.33 Restraints.

David Jones – In C(4) Presence of Adverse Consequence. We would like to see the prevention or the attempt to prevent risks before the pharmacist is involved.

.34 Protection of a Resident's Personal Funds.

Eileen Bennet – There should be no commingling of resident funds. Assisted Living managers should not commingle various residents’ funds or commingle them with the facilities funds. We want to make sure those protections are spread throughout the regulations.



.35 Misuse of Resident's Funds.

Eileen Bennet – Request clarification of sharing information after the fact with the Department of Aging. It doesn't list the Ombudsman program. The Ombudsman program should be included wherever they are housed.

.40 Approval of Burial Arrangements for Unclaimed Deceased Residents.

Kristen Neville – The Board of Morticians and Funeral directors would like added, in the appropriate section, language similar to what is found in the Long-term care regulations should be added to the Assisted Living regulation. If a resident of a facility passes away, their remains are picked up and removed in accordance with COMAR 10.29. Only a permitted mortuary transport service may pick up and remove remains. We want to prevent non-permitted people or programs picking up and removing remains.

.36 General Physical Plant Requirements.

Monica Brunson – Language should be added to D. Cleaning supplies kept by residents should be "locked and secured".

.37 Water Supply.

No comment.

.38 Sewage Disposal.

No comment.

.39 Security.

Eileen Bennet – There have been situations where people have eloped out of back doors without alarms. There should be stipulations and training around types of security measures such as surveillance cameras. Staff should have an awareness of who is entering the facility and ways to manage who is in the facility at all times.

Ms. Mae – Question about a past survey where the surveyor made a provider remove the lock from the door. The facility should be able to determine the mechanism to avoid elopement of residents.

.40 Assist Rails.

No comment.

.41 Emergency Preparedness.



Eileen Bennet – D, the emergency plan should be posted for everyone in the facility to see.

David Jones – Would like to include protection for the refrigerator used for drug storage in this section of the regulations.

.42 Smoking.

No comment.

Other Notes

- Following the comment session, an open discussion was held for participants to discuss the regulations on the agenda for October 1, 2015.