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<th>Rationale</th>
<th>Name</th>
<th>Organization</th>
<th>OHCQ Response</th>
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<tbody>
<tr>
<td>10.07.14.02</td>
<td>Recommend adding definition of “resident representative”. Suggested wording: “Representative” means the person designated in writing by the resident who was competent at the time of designation, to serve as a representative regarding services and supports and resident rights.</td>
<td>The term “resident’s representative” is used in the regulations. It is important to resident’s autonomy and exercise of self-direction to establish that a representative in this context is designated by the resident. This could help to avoid situations in which a family member or other individual makes or attempts to make decisions on behalf of the resident without their authorization/permission.</td>
<td>Jane Wessely</td>
<td>Private Citizen</td>
<td>Agree to add phrase, “who was competent at the time of designation.”</td>
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<td>The person-centered care planning process is defined as: The process is directed by the individual, with assistance as needed or desired from a representative of the individual's choosing. It is intended to identify the strengths, capacities, preferences, needs, and desired measurable outcomes of the individual.</td>
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<td>Phyllis McShane</td>
<td>Maryland Dietetics in Health Care Communities</td>
<td>Agree: Add Definition</td>
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<td>It can be difficult to determine if a death occurs from natural causes. If the information required for an incident is recorded, a surveyor may be able to identify any deaths that should be subject to additional scrutiny as well as which staff have knowledge of the circumstances surrounding the death.</td>
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Question – Why is definition of case management being added? It would be helpful to add definition to nursing home regulations: The definition is necessary as reference point for additional material being added. It is based on the definition used in Title 10 DMHNL, Subtitle 07 Hospitals, Chapter 02 Comprehensive Care Facilities and Extended Care Facilities.

Question – why is only private agency listed? Wouldn’t State Criminal Justice Information System check be acceptable? Recommend adding language: … by a private agency or through the Criminal Justice Information System.

Some private CHRC companies do not provide updates on criminal convictions. State CJIS CHRCs do. This should be an option.

And: We appreciate all of the stakeholders input and responses to our outreach efforts thus far and believe that this proposed rule reflects our desire to promote person-centered care and improve the quality of care and services, while further protecting resident’s safety, choice and well-being.

And: Addressing communication through a robust interdisciplinary team, comprehensive person-centered care planning process and through training requirements AND Revised rules would also promote more individualized care and help make nursing homes feel more like home. For example, facilities would be required to provide “suitable and nourishing alternative meals and snacks for residents who want to eat at non-traditional times or outside of scheduled meal times.”

Residents should also be able to choose their roommates. “Nursing facilities not only provide medical care, but may also serve as a resident’s home,” the proposed rules say. “Our proposed provision would provide for a rooming arrangement that could include a same-sex couple, siblings, other relatives, long term friends or any other combination” as long as nursing home administrators “can reasonably accommodate the arrangement.”

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10.07.14.02 13 Case management requires clarification, clarifying the role of the case manager and delegating nurse. Stevanne Ellis Office of the State Long Term Care Ombudsman Addressed. The terms, "case manager/delegating nurse," "delegating nurse/case manager" have been removed. These terms are replaced by the term "delegating nurse."

10.07.14.02 35 Incident – should be rewritten to “an assault on a resident” instead of “an assault on a resident resulting in injury.” Clarification is needed to help understand the regulations. Incidents should include an assault on a resident whether an injury results or not. This would allow for investigation by OHCQ, and allow for advocacy by the Ombudsman Program. Stevanne Ellis Office of the State Long Term Care Ombudsman Agree

10.07.14.02 32 Health condition – include behavioral health and add a definition for behavioral health. No Change. Karen Besaw Office of the State Long Term Care Ombudsman

10.07.14.02 31 Health Care Practitioner – the definition should be provided not just a reference to the law, and language should in the regulation should specify who can be a health care practitioner. No Change. Stevanne Ellis Office of the State Long Term Care Ombudsman

10.07.14.02 A definition is needed for emergency. No Change. Stevanne Ellis Office of the State Long Term Care Ombudsman

10.07.14.02 27 Facilitating access – What does this mean? No Change. Stevanne Ellis Office of the State Long Term Care Ombudsman

10.07.14.02 Definition requires clarification The meaning of facilitation access needs to be included in the definition. The definition currently only states what facilitation access does not mean. Agreement was added. Lynn McCamie Baltimore County Ombudsman Program Agree. What it means was added.

10.07.14.02 Include a definition for “non-routine hospitalization” so providers understand it includes ER trips also (not just when residents get admitted to a floor). Karen Besaw Private Citizen No Change.

10.07.14.02 Or define “hospitalization” to mean non-routine hospitalizations including ER trips, not just being admitted to a floor. Karen Besaw Private Citizen

10.07.14.02 Change to include the words “and documentation” so it reads: Karen Besaw Private Citizen Agree. Add “and documentation”

10.07.14.02 (52) “Nursing assessment” means an assessment completed by a registered nurse that: Karen Besaw Private Citizen Agree.

10.07.14.02 (c) Includes but is not limited to: Karen Besaw Private Citizen

10.07.14.02 (6) Extensive initial and ongoing collection and documentation of resident data, Karen Besaw Private Citizen

10.07.14.02 This needs to be rewritten. See below. I object to this definition. It’s more than just looking at the resident and overseeing their needs. It involves checking the record to make sure documentation is appropriate, accurate, and current. And it’s not just the resident’s service plan. Half the resident assessment tools are filled out by docs who do a lousy job, and the DN’s don’t bother re-writing them to make them accurate. How can you track what’s happening to a resident when you can’t even tell what their actual diagnoses are because half of them are missing from the record? Nursing oversight includes making sure the record is accurate! Karen Besaw Private Citizen No Change.

10.07.14.02 What happened to the Pilot RAT? Is it being done away with? You need to include it in the above definition if it’s still going to be around. Karen Besaw Private Citizen Follow-up required once forms are finalized.

10.07.14.02 I don’t see the above on our website?? And aren’t you going to reference the new Pilot Service Plan? The only thing we publish on our website the Pilot RAT, and that says July 2013. Karen Besaw Private Citizen No Change.

10.07.14.02 Maybe you could include something that will prevent the following, because this was financial abuse of a resident. The provider went to a nursing home and told a resident (with no other living family) to sign a resident agreement without her looking at it. The resident was told there was nowhere else for her to go, so she felt she had no choice but to sign it. The social worker at the nursing home then had the provider named as “representative payee” of the resident with Medicare. So the provider then started getting all the resident’s Medicare checks deposited straight into the provider’s bank account. It left the woman penniless and unable to buy or pay for anything for herself. The provider got all the woman’s money and did things like wouldn’t apply any of it toward the woman’s medications. So CVS sent a letter to the resident telling her that if she didn’t pay her huge overdue pharmacy bill, they wouldn’t give her meds anymore. The provider also charged the woman for soap, shampoo, etc. because it was in the resident agreement that she could do that, but the resident had no way to pay for them with her checks going into the provider’s bank account. The provider would drive the resident to Target and made the woman pay for those things with a credit card, which of course the resident couldn’t pay for either, because all her money was going straight to the provider, so then it ruined her credit. So – is there any way we can write something into the regs to prevent that from happening?? Karen Besaw Private Citizen No Change.

10.07.14.02 Add: “Attorneys may not attend an IDR.” Because they can’t, but why not just spell it out. Karen Besaw Private Citizen Agree. Add: “Attorney’s may not attend an IDR.” See .10 Investigation by Department. (c)(3).
10.07.14.02 Change this to:
Take out the words “such as a fall” so it reads:
(a) An injury to a resident which may require treatment by a health care practitioner, or an event which could subsequently require treatment;
Add (b) A fall;
Add (c) Neglect of a resident.

10.07.14.02 Delete the definition or change it to be correct.

10.07.14.02 “or from the resident’s room” is incorrect.

10.07.14.02 Hopefully, you really mean “respite” care???

10.07.14.02 Involuntary seclusion is an intervention used with psychiatric patients and it’s the exact opposite – it’s when you force someone to stay in their room and don’t allow them to come out!

10.07.14.02 Change language to read:
There is no such thing as residential care – there is only respite care!

10.07.14.02 There is no such thing as residential care – there is only respite care!

10.07.14.02 Also, make it clear that there is no such thing as a “trial” stay. You’re either a full-time resident or you’re respite, but there is no such thing as a “trial” of being a resident. And if you keep the words “short-term residential care” that’s exactly what they’re going to think!

10.07.14.02 Change “agent” to “resident representative” undermines the definition. The regulations would be better off with no definition of “financial exploitation” than the proposed definition.

10.07.14.02 NSERT a saw (44) “Licensed Registered Dietitian” means a person who is authorized to practice dietetics under Health Occupations Article, Title 5, Annotated Code of Maryland.

10.07.14.02 Add (i) Neglect of a resident.

10.07.14.02 Change language to read: “Synthesis of biological, mental, behavioral, cognitive, spiritual and social aspects of the resident’s condition.”

10.07.14.02 The addition of “mental”, “behavioral” and “cognitive” to this definition is in keeping with current terminology and alignment with the domains of assessment that should be applied to accurately determine resident issues (e.g., mental illness, substance use disorder, dementia) and the care needs that should be reflected in the plan of care. We would also accept “psychiatric” in lieu of “mental”

10.07.14.02 Add (h) A fall;
Add (i) Neglect of a resident.

10.07.14.02 The addition of “cognitive and behavioral health” is more consistent with current terminology and alignment with the domains of assessment that should be applied to accurately determine resident need and inform the service plan.

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10.07.14.02 Change language to read: “Significant change of condition” means a shift in a resident’s health, functional, cognitive, behavioral or psychosocial conditions that either causes and improvement or deterioration in a resident’s condition.

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10.07.14.02 Change the definition of “Health condition” to read:
“Health condition means the status of a resident’s physical, cognitive and behavioral well-being.”

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“Health condition means the status of a resident’s physical, cognitive and behavioral well-being.”

10.07.14.02 Pg 13: [64f] (69) “Resident” means an individual 18 years old or older who requires assisted living services. Add: “A Resident may not be staff.”

10.07.14.02 Providers will tell you that a resident fell and was judged by the nurse not to need treatment, so they don’t have to fill out an incident report. But ALL falls should be tracked by having to fill out an incident report, not just the ones where the residents needed treatment.

10.07.14.02 Neglect is an incident, just as abuse is an incident.

10.07.14.02 A lavatory is another word that means bathroom. It can also mean a toilet. It’s not just a “bathroom.” And why is it defined here anyway? The word is not referenced anywhere else in COMAR so why is it here?

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10.07.14.02 Add (h) A fall;
Add (i) Neglect of a resident.

10.07.14.02 Agree. Add “neglect of resident” Question about adding “A fall”?

10.07.14.02 Agree.

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10.07.14.02 Agree.

10.07.14.02 Agree.

10.07.14.02 Agree. Add P10.07.14.02

10.07.14.02 No Change.

10.07.14.02 No Change.
"Staff" means supervisors, assistants, aides, or other employees, including independent contractors retained by an assisted living program, to provide the care and services required by this chapter. Change to read: "... independent contractors and volunteers...". But then you need to define what a volunteer is. Include in the definition cooks and housekeepers. Additionally, add to the definition of "staff": "A staff may not be a resident." See previous example for why.

Do we need a definition in 10.07.14.02. Primary delegating nurse

Karen Besaw

Private Citizen

No Change

Private Citizen

If they’re with staff while they’re with the residents, then they don’t need... etc.

And what about the age requirement? Should we allow high school kids (all under 18yo) to help with the cooking and things like that, and are they staff? Or do we just require them to be at least 18yo, have a statewide criminal background check already completed, proof of required annual training as well as cognitive impairment/mental health training: proof of first aid and CPR?

Karen Besaw

Private Citizen

No Change

Karen Besaw

Private Citizen

No Change

Karen Besaw

Private Citizen

No Change

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Ager. The term delegating nurse/case manager has been replaced with 'delegating nurse'.

Karen Besaw

Private Citizen

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Karen Besaw

Private Citizen

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No Change

Karen Besaw

Private Citizen

No Change
10.07.14.02 Definitions. Clarify the definition of “background check.”

- does this mean a specific check by a national company or is the Maryland judiciary case search adequate? (the Maryland judiciary case search would only pick up problems in Maryland.)

- Clarify “service plan” definition

- the definition does not require the delegating nurse be involved. The expertise of the delegating nurse is useful in developing the service plan, especially for medical issues.

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<th>Marianne Uphold</th>
<th>Private Citizen</th>
<th>No Change</th>
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10.07.14.02 After the definition of “Bank”, insert: “Behavioral Health” means the condition of an individual’s thoughts, moods and/or actions which may be negatively impacted by a brain-based disorder such as mental illness, dementia, delirium, addiction or brain injury.

- “Behavioral Health” is the current term used to be inclusive of mental illness, addiction, brain injury, etc. and needs to be used throughout the regulations. This particular definition is intentionally broader than the one used by the Behavioral Health Administration because of the high prevalences of dementia and delirium among older adults – both of which include behavioral and psychiatric symptoms and may require attention by behavioral health professionals.

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10.07.14.02 LifeSpan will address the changes to definitions in the substantive section of the proposal.

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10.07.14.02 B Add: “Standard precautions.” Standard precautions are a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. These measures are to be used when providing care to all individuals, whether or not they appear infectious or symptomatic. Standard precautions includes: 1. Hand Hygiene. 2. Personal Protective Equipment. 3. Safe injection practices. 4. Respiratory hygiene and cough etiquette.

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10.07.14.02 Amendment the definition of chemical restraint to read: “Chemical restraint” means the administration of drugs with the intent of significantly curtailing the normal mobility, physical activity or behavior of a resident in order to protect the resident from injuring the resident or others.

- Agitated, distressed and disruptive behaviors are some of the reasons chemical restraints are used. We feel this needs to be reflected in the definition.

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10.07.14.02 B.13 “Contact precautions” – The use of a private room and appropriate personal protective equipment, such as gowns, gloves, and/or masks to prevent the transmission of certain organisms between an infected individual and others.

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<th>Sister Irene Dunn</th>
<th>Victory Housing, Inc.</th>
<th>Agree</th>
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10.07.14.02 B.18 “Contact precautions” – The use of a private room and appropriate personal protective equipment, such as gowns, gloves, and/or masks to prevent the transmission of certain organisms between an infected individual and others.

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10.07.14.02 B.21c The expansion of delegating nurse/case manager duties include appropriate duties to facility licensed nursing personnel (including LPNs).

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10.07.14.02 B.31 Please include who can be a health care practitioner:

- A list of appropriately qualified professionals would make the definition much clearer and less likely for a provider to misinterpret the requirement.

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10.07.14.02 B.35 Please remove “resulting in injury”.

- It should state “an assault on a resident” instead. This will allow the incident to be reported regardless if injury is a result.

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10.07.14.02 B.8 Change wording to a specific location, Alzheimer’s and Dementia Special Care Unit (.26, page 114) versus including Alzheimer’s /Dementia Special Care (.27, page 117).

- Additionally, clarification is requested regarding the intention of segregating Alzheimer’s/dementia special care and requiring increased services versus other clinical diagnoses/needs.

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<th>Lynn McCarne</th>
<th>Ombudsman_Baltimore County</th>
<th>Agree</th>
</tr>
</thead>
</table>

10.07.14.02 B.8 Change wording to a specific location, Alzheimer’s and Dementia Special Care Unit (.26, page 114) versus including Alzheimer’s/Dementia Special Care (.27, page 117).

- Additionally, clarification is requested regarding the intention of segregating Alzheimer’s/dementia special care and requiring increased services versus other clinical diagnoses/needs.

<table>
<thead>
<tr>
<th>Susan Hirsch</th>
<th>HCR ManorCare</th>
<th>No Change</th>
</tr>
</thead>
</table>

5 of 51
To ensure people with disabilities may live in the most integrated settings with natural support, the proposed regulations should be amended to explicitly exclude unpaid caregivers from the definition of assisted living programs so that the Office of Health Care Quality (OHCQ) will not, by regulatory action, displace people who are living in unlicensed homes with natural supports.

The Developmental Disabilities Administration (DDA) encourages individuals to live with and receive natural supports and to live in the most integrated community setting appropriate to their needs, so informal living arrangements with non-family members should not be disrupted unless the individual wants to leave or is subject to abuse, neglect or exploitation. Family caregivers are excluded from regulation as assisted living facilities but non-family caregivers are not. OHCQ’s interpretation of its assisted living regulations does not permit people with disabilities to choose to live with a non-family member unless the caregiver becomes licensed as an assisted living facility. Licensee is too onerous a process for most informal caregivers. OHCQ took enforcement action against at least one unpaid caregiver who provides natural support to a single person with severe developmental disabilities though there is no allegation of abuse, neglect, or exploitation; the person’s mother requested that the caregiver support her son if she could no longer do so; the individual has no other living family; professionals have affirmed he is doing well and the care is appropriate; OHCQ agrees that remaining in the home is the best option; and the person would need to disrupt his life and relationships and obtain state residential services at substantial cost to the state if the informal arrangement is not permitted to continue. OHCQ charged the caregiver with operating an unlicensed assisted living facility and may now be subject to fines or imprisonment. We understand that if the caregiver petitions for legal guardianship or adoption, OHCQ will allow the arrangement to continue; however, these actions impact the civil rights of the person with a disability. Furthermore, it is onerous to request a caregiver who is already planning to leave the home to hire a licensed caregiver. Janice Peterson  The Village at Rockville  No Change

10.07.14.02 B(9)

Many of the chapter’s subsections are incomplete. The citations are incomplete. The citation should reference the subtitles, not just one section of the subtitle, e.g., Title 19, Subtitles 4 and 4A.

Agreed.

Alice Hedt  MD Department of Aging

10.07.14.02 B(27)

Regulation 02B(27)(a) only reads in its entirety as follows: “‘Facilitating access’ means:” (The text after the word “means” has been deleted, thereby deleting the definition. This appears to be a typographical error.)

The citation should reference the subtitles, not just one section of the subtitle, e.g., Title 19, Subtitles 4 and 4A.

Agreed.

Alice Hedt  MD Department of Aging

10.07.14.02 B(31)

In the draft on which MDGA commented on 5/30/14, the defined term “delegating nurse/case manager” was used. In this draft, that defined term has been changed to “delegating nurse.” However, there are still dozens of places in the proposed regulations where the term “delegating nurse/case manager” is still used. This inconsistency needs to be corrected.

(As background, note that MDGA’s last comment on the then proposed definition of “delegating nurse/case manager,” read as follows: Neither the proposed definition nor proposed Regulation .17 makes clear whether two different people working together can perform the nursing and case management functions. In other words, could a delegating nurse or subcontract or delegate the case management functions to a social worker? If this is not to be allowed, the regulations should make clear that these functions cannot be subcontracted or delegated. The tone of the definition and Regulation .17 suggests that the functions cannot be subdivided, but it is not 100% clear.”)

Addressed. The terms, “case manager/delegating nurse,” “delegating nurse/case manager” have been removed. These terms are replaced by the term “delegating nurse.”

Alice Hedt  MD Department of Aging

10.07.14.02 B(33)

The citations are incomplete. The citation should reference the subtitles, not just one section of the subtitle, e.g., Title 19, Subtitles 4 and 4A.

Agreed. Change made.

Alice Hedt  MD Department of Aging

10.07.14.02 B(52)

An important change in the proposed regulations is the addition of the new “nursing assessment” requirements. Proposed Regulations .02B(56), .18A(2) and .22B require a resident’s service plan to be based not just on the Resident Assessment Tool (RAT), but also on the new nursing assessment. (There are 20 new references to “nursing assessment” in the draft regulations.) The nursing assessment form will be a critical form. Proposed Regulation .17E provides: E. Nursing assessments shall be completed using assessment forms approved by the Department or shall include substantially equivalent content. Please provide us with a copy of the current draft of the form. (Will the nursing assessment form be incorporated via Regulations .03?)

Further, the interaction between the nursing assessment and the Resident Assessment Tool is unclear to us. The RAT form provided to the Department on June 25, 2013 states: If this form is completed by the Delegating Nurse (DN), there is no need to complete an additional nursing assessment. If this form is completed by someone other than the DN, the DN must still document their [sic] assessment of the resident. In contrast, the proposed definition of “Resident Assessment Tool” at Regulation .02B(71) provides that the Resident Assessment Tool “does not include or replace a nursing assessment.” So, the above quoted language on the RAT form itself basically indicates it can replace the nursing assessment, while Regulation .02B(71) says it does not.

Follow-up required once forms are finalized.

Alice Hedt  MD Department of Aging

10.07.14.02 B(53)

The proposed definition of “delegating nurse/case manager” is unclear as to whether two different people working together can perform the nursing and case management functions. In other words, could a delegating nurse, subcontract or delegate the case management functions to a social worker? If this is not to be allowed, the regulations should make clear that these functions cannot be subcontracted or delegated. The tone of the definition and Regulation .17 suggests that the functions cannot be subdivided, but it is not 100% clear.

Addressed. The terms, “case manager/delegating nurse,” “delegating nurse/case manager” have been removed. These terms are replaced by the term “delegating nurse.”

Alice Hedt  MD Department of Aging

10.07.14.02 B(58)

The Department is concerned some of these changes may lead readers to believe that a representative has more authority than the actual scope of the representative’s authority and believes that the “agent/representative” changes need careful scrutiny. For example, neither a guardian of person, a surrogate decision maker, nor a representative payee has the powers or responsibilities of an agent. The regulations need to be able to recognize these important distinctions. See the definition of financial exploitation for an example of why it is important. An agent has a fiduciary duty to his or her principal, a resident representative, such as a surrogate decision maker, may not have such a duty. Should a nurse who qualifies as a health care surrogate decision maker be able to use her demented uncle’s money as a gift to buy herself a new boat?

Alice Hedt  MD Department of Aging

No Change
The new definition of financial exploitation that replaces the word “agent” with “resident’s representative” could be construed to allow the niece in the above example to consent to the expenditure to buy herself a new boat and avoid the expenditure being viewed as financial exploitation. We do not believe OHCQ intends that. Because of other statutory and common law constraints that apply to an agent, an agent would not be able to consent to such an expenditure absent the express of special powers, which is why it is important to retain the use of the word “agent” in the financial exploitation definition. (If OHCQ is determined to get rid of the definition of “agent,” then, in the definition of financial exploitation, please consider retaining the undefined term “agent” instead of replacing it with the seemingly broader phrase “resident representative.”)

Under the existing regulations, there is overlap between the definition of “agent” in Regulation 21B(1), which requires that a resident agreement contain certain financial provisions. The existing regulation speaks to the obligations of the resident and the resident’s agent to handle the resident’s finances. Changing “agent” to “representative” muddles the meaning of the regulations because some resident representatives do not have authority to handle a resident’s finances, e.g., a surrogate decision maker or guardian of person.

How is a provider to create a resident agreement that sets forth financial provisions containing the obligations of all the seven or eight different kind of representatives a resident may have for all of the matters set forth in 21B(1)? The word “agent” may be problematic, but MDDoA respectfully submits that the phrase “resident representative” may be more problematic.

Under the existing regulations, there is overlap between the definition of “agent” in Regulation 02B(6), which focuses on the funds used to pay for the resident’s care, and the definition of “representative” in Regulation 02B(63), which cross references the much broader and more elaborate Regulation 34. The proposed regulation would maintain the existing definition of “representative” but eliminate the definition of “agent” and change a number, but not all of the references to “agent” in the regulations to “representative.”

By including the phrase “but not limited to” in the definition of personal care services, OHCQ may be making the definition too vague to mean anything. Given “activities of daily living” is broadly defined as “normal daily activities” washing dishes, balancing a resident’s check book, or mowing the grass at the facility could be a personal care service under this definition.

The title “Assisted Living Resident Assessment Tool” used in the text of this regulation does not match the title of the same form used in the text of Regulation .03, namely, “Assisted Living Resident Assessment and Level of Care Scoring Tool.” In addition, there is no subject for the sentence at Regulation .02B(71)(b).

We would like to see language added to the provisions on restraints that makes clear that drugs (and/or chemicals) may not be used to secure the convenience of the staff or to discipline residents. We defer to your judgment on whether it would be more appropriate to address this in proposed Regulation .33 than in the definition of restraint.

The proposed new definition reads in part “a written plan incorporated by reference in Regulation .03.” Should this instead reflect something like “a written plan on the form incorporated by reference in Regulation .03”? In addition, the phrase “in conjunction with the resident or resident’s representative” undermines a resident’s rights because the disjunctive “or” would permit a provider to bypass a resident, even a competent resident, and create a service plan with a resident representative alone. A better way to express this concept would be to say, “in conjunction with the resident and, if applicable, resident’s representative.” The phrase “if applicable” also helps keep in mind that not all representatives have the authority to make service plan decisions.

This comment is in support of Regulation 10.07.14.G(3), which permits internet-based training to be used as a mode of instruction for long-term care staff. These are referenced in 29 Relocation and Discharge, however the regulations provide no guidance as to what constitutes an emergency, and therefore allow for broad interpretation to the potential detriment of residents.

Karen Brosaw
Private Citizen
No Change

Put the above COMAR somewhere in the regs. ALF providers don’t want to pay for a CDS license so they skip it. They should be REQUIRED to provide proof of having one at the time they apply for licensure (the rationale is that they can’t provide all the services residents need if they don’t have a CDS license, because eventually some residents will need CDSs prescribed). They should also be REQUIRED to produce a current CDS license for the surveyor whenever a survey takes place, and also when it’s time to renew their AL license. In summary, ALFs should be required to have a CDS license at all times, regardless of whether their current residents take any CDSs or not.

Karen Brosaw
Private Citizen
No Change

Add to this list the following: COMAR 10.19.03.03(A) states “A person shall register with the Department and obtain and maintain a registration certificate before the person: (1) Manufactures, distributes, or dispenses controlled dangerous substances.” (Per Div. of Drug Control, an ALF is considered to “dispense”.)

Karen Brosaw
Private Citizen
No Change

Add the Nurse Practice Act (NPA) into this.

Karen Brosaw
Private Citizen
No Change

Delete subsection E.

Karen Brosaw
Private Citizen
No Change

Add residents who are in the hospital have to be included in the count.

Karen Brosaw
Private Citizen
No Change

There is no such thing as “short-term residential care.” If it’s short-term then it’s respite. They have someone move in when a resident’s in the hospital for a while. They tell you “Oh they’re in the hospital, so I’m really not over my count.”

Karen Brosaw
Private Citizen
No Change

When a person operates an unlicensed home, regulations allow that the unlicensed individual, within 30 days of receiving a violation notice, apply for licensure; application “or” remove resident(s) from the premises. In other words they are allowed to keep residents in the home while the application process proceeds forward. It is strongly recommended that the residents who are found in the unlicensed home be relocated to a licensed facility while the application process moves forward.

Karen Brosaw
Private Citizen
No Change

Add residents who are in the hospital to be included in the count.

Karen Brosaw
Private Citizen
No Change

The unlicensed provider, generally has had no assisted living training, no knowledge of medication administration, there is no delegated nurse to provide medical oversight, during this application period. They most likely are not even qualified to pass meds (no med tech certification or nursing license). In addition they’ve had no criminal background check, or T.B. testing. The environment may not meet AL requirements. The unlicensed person most likely still needs to pass inspections required by their local jurisdiction (e.g. Fire, zoning, well/septic, etc.). It makes no sense that once discovered, the unlicensed provider can keep the vulnerable residents in the home, when the unlicensed provider is not qualified and the home has not passed required inspections. I believe the unlicensed provider, after being issued the violation notice, should have the option of applying for an assisted living license, if he or she chooses, only after all the residents have been first removed from the unlicensed home and relocated to an appropriate licensed facility. This allows the unlicensed provider to receive the required training and meet all required qualifications, first before caring for residents. It also discourages those individuals from knowingly and purposely bringing in residents before being licensed.

Karen Brosaw
Private Citizen
No Change

Family members should not be included in the stats for resident count

Marc Somms
Beyond Care
No Change

Many new providers are starting their facility in their own home and have family members that in no way will affect the service to the residents they will be licensed to provide

Marc Somms
Beyond Care
No Change

Combine section D and E to read, “The Secretary shall issue a license for a specified number of beds, which shall include those beds being used for short-term residential care as well as those beds intended to be occupied by family members of the owner or operator being cared for by the program.”

Danna Kaufman
LifeSpan
No Change

DELETE SUBSECTION E.

Karen Brosaw
Private Citizen
No Change

Regulation 04 concerns obtaining a license and states that licenses are based on the number of licensed beds. It is unclear why OHCQ is seeking information on census at the time of licensure. In addition, the term “family member” under this regulation is unclear as to whom it refers.

Karen Brosaw
Private Citizen
No Change
<table>
<thead>
<tr>
<th>Date</th>
<th>Support</th>
<th>Baltimore County Ombudsman Program</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.07.14</td>
<td>An ALF should not provide services beyond its licensed capacity.</td>
<td>Lynn McCamie</td>
<td></td>
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<td>Lynn McCamie</td>
<td></td>
</tr>
<tr>
<td>10.07.14</td>
<td>This regulation is an important aspect of the regulation and needs to stay. Not only does it address significant conditions that affect a resident as their need for support increases, but more importantly it describes the skills and capability needed by the staff providing the care and lays an excellent premise for recognizing if your facility is the appropriate setting.</td>
<td>Lynn McCamie</td>
<td></td>
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<td></td>
<td>There should be somewhat of some uniformity for having some means of measuring the right fit. Also establishing a fair compensation for the level of care needed. It is needed to distinguish your Medicaid Waiver compensation.</td>
<td>Lynn McCamie</td>
<td></td>
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<td></td>
<td>Mar Simms</td>
<td>Beyond Care</td>
<td>Agree</td>
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<td></td>
<td>Agree</td>
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<td></td>
<td>I understand that over 90% of homes are level 3 but they don't all admit level 3 Residents. Most homes did this because back when we help with the regulations it was felt that the OHCQ took too long to get the waiver completed. I touch the DN course and 80 Manager course the students always talk about the levels. If we do away with the levels of care the ALM will not know the Residents, and in Homes where the delegating nurse goes in every 45 days, she will know the residents needs and condition if a doctor would call for information. We are going backwards not forward. I am finding major problems with ALM who are not doing the assessments, when I am not consulting in these homes. I think some of the owners want to do away with the levels so they won't have to pay for a ALM who is on top of the needs of the every changing Residents health needs. What does the surveyors feel about the levels being taken out? I trust me there are many problems going on in our larger homes then you all are aware! I am sorry I have not been able to attend the forums because I am either teaching those days or consulting.</td>
<td>James Rowe</td>
<td>Agree</td>
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<td></td>
<td>I agree with Lynn McCamie</td>
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<td>James Rowe</td>
<td>Agree</td>
</tr>
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<td></td>
<td>I agree with Lynn McCamie</td>
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<td></td>
<td>LifeSpan diligently worked with OHCQ to revise the assessment and scoring tool based on the removal of level of care. As members will discuss, removing the level of care (given that the majority of providers are licensed for level 3) provides for a better service plan more focused on quality.</td>
<td>Danna Kaufman</td>
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<td></td>
<td>The Usefulness of Levels 1, 2 and 3 as a Good Structure for Consumers and the AL Industry for Setting Fees. One of the challenges for assisted living both from the standpoint of consumers and the industry is setting appropriate pricing structures. One approach would be for the regulations to have nothing to do with pricing, leaving it to each provider to develop its own pricing structures and apply the prices as it sees fit – sort of a Wild West approach.</td>
<td>MD Department of Aging</td>
<td>Agree</td>
</tr>
<tr>
<td>10.07.15</td>
<td>Continue to remove level of care from the regulation.</td>
<td>Danna Kaufman</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LifeSpan</td>
<td>Levels of Care was retained due to statute Health-General §19-1805(a), which requires licensing according to level of care.</td>
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<tr>
<td>10.07.15</td>
<td>Please leave the “Levels of Care” wording intact as written in the current regulations. To provide a consistent definition of each level of care among Assisted Living Providers in the state of Maryland. The consistent definition would help the consumer compare programs. The definition remains part of the waiver program requirement and should be defined uniformly.</td>
<td>Anne Patterson</td>
<td></td>
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<tr>
<td>10.07.15</td>
<td>LifeSpan strongly supports the removal of the levels of care.</td>
<td>Danna Kaufman</td>
<td></td>
</tr>
<tr>
<td>10.07.15</td>
<td>My biggest concern was levels of care, the need for them from many providers needs, plus the fact that it take the Assisted living manger assessment out , so the managers will not know the residents medical needs. The fact that I find nothing about inspection of or. I also feel there is nothing to say that the surveyor's should follow the same type of inspection . I find when working with many providers , each surveyor tells staff to use this form then another states no use these forms. I felt none of this is being addressed. We need to look at the providers who want to follow the regulations as little as possible , by not having true mangers trained and cutting staff down.</td>
<td>Jim Rowe</td>
<td>Agree</td>
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<td>Levels of Care retained due to statute Health-General §19-1805(a), which requires licensing according to level of care.</td>
<td></td>
</tr>
</tbody>
</table>
10.07.14.05 I would like to see the levels of care remain part of the regulations.  
As a provider all of Victory Housing Homes are level 2. They have been set up specifically as level 2’s and we need to monitor carefully who we admit into our Homes. The levels of care help us to explain who is appropriate to be admitted. We do affordable housing and the higher the level of care you provide, the higher the cost is going to be.  
Sister Irene Dunn  Victory Housing, Inc.  Agree.
Recommend adding after "revoked":,"or license applicant denied,"...

A limitation is fair and in the public interest because an applicant receives tremendous assistance and support by OHCQ staff during the application review process, applicants can and are encouraged to fix deficiencies during the application process, if denied is to be recommended to the Secretary, the applicant receives full administrative due process rights, and is granted a hearing to make their case for license approval. And finally if the license is denied, the applicant is entitled to appeal the license denial to the state courts, seek redress, and during the appeal can seek a settlement with the Attorney General to modify their application if the state will grant the license.

Robert Moore   Private Citizen   No Change

Recommend adding after "revoked":,"or license applicant denied,"...

The denial process is fair and comprehensive, with many opportunities for the applicant to amend their application, repair any deficiencies, tell the truth where misrepresentations were originally filed under penalty of perjury with the State. Therefore in the highly unusual case of a denial, (senior staff says the Casey Application in 2012 was the first in 40 years), an applicant should be on notice that there is a 10 year period before an application can be routinely resubmitted (10 years is taken from the other 10 year period in the regs). This time period is in the public interest, and is not unfair, because the denied applicant can apply sooner if they meet the reapplication standard already in the regulations.

Robert Moore   Private Citizen   No Change

Recommend adding after "revoked":,"or license applicant denied,"...

A set period of time needs to be articulated in the new regulation before a denied applicant can reapply. As it stands, after all of the cooperation by the department, investigation, resubmission opportunities, administrative hearing, AG settlement opportunity, trial court hearing, and court of appeal rights, have occurred, an applicant can resubmit the next day, and rightfully demand all of the Department's time and resources to review the 'new' application. There needs to be a known published regulatory standard, so the denied applicant has notice of a resubmission timeline. Thank you.

Robert Moore   Private Citizen   No Change

Recommend adding after "revoked":,"or license applicant denied,"...

Do to the critical need for ALF facilities in Maryland, the department works very hard to cooperate with license applicants to meet standards, so that they can eventually, with the appropriate training and development, meet the regulatory requirements for an ALF license. In the highly unusual situation where OHCQ and the Secretary affirmatively deny an application—approximately only once in the past 40 years, there should be a limitation to when that individual can reapply.

Robert Moore   Private Citizen   No Change

1. New Section E. – requires that a license is void and shall be returned to the Department by certified mail if the program ceases to provide services to residents for a period of 120 consecutive days. Lifespan would add a qualifier that states "except in emergency situations where the Department has justified the program. 2. New Section F(3) – requires that if a renewal application has not been filed at least 45 days before license expired, the program shall cease operations and relocate residents. This section should be deleted.

Danna Kaufman   LifeSpan   Agree

Pl ease state:

The date of change of ownership shall be requested by the new owner. The new owner must be in possession of the facility at the time of survey. The survey will include review of all of the new owners credentials. The new owner will be responsible for fixing all deficiencies prior to licensure.

The change of ownership drama continues to evolve. Many times a new owner has already taken over and the former owner is long gone and unwilling to fix anything. The application should be submitted at least 45 days in advance and the applicant will be in compliance as long as the application has been submitted.

Kim Fiore   Private Citizen   No Change

(7) if a licensee intends to relocate its program, the licensee shall apply for a new license the license will have the new facility available for survey by the Department at the time of application to assure continuity...

Kim Fiore   Private Citizen   No Change

Recommendation. Add language to the regulations requiring facilities with less than 100 beds notify the State 60 days prior to closing and facilities with more than 100 beds notify the state 90 days prior to closing.

Draft language for legislative suggestion [removed] (new in italics)

Delegate Will Smith   Agree

Add language to the regulations requiring facilities with less than 100 beds notify the State 60 days prior to closing and facilities with more than 100 beds notify the state 90 days prior to closing.

Delegate Will Smith's office, with the support of several Montgomery County officials. Delegate Will Smith   Agree
10.07.14.07 A3.b-c
Make (b) 5 – 16 beds. In order to take advantage of the Group Home Subsidy program which allows us to care for some residents who would otherwise not be able to afford assisted living, the Home cannot have more than 16 residents. When you are taking in residents to give them care and a good home, and you are only receiving $1375/month or $1600/month, every penny counts. That $300 every 2 years can really make a difference when looking at 15 beds or 16 beds. When we paid for one bed over the 15, it was not so bad, but this makes a huge difference. We are already paying the county $900 to $950 every year for the county license. Is there any way it could be made 1 – 16 beds for those who accept county subsidies? Sister Irene Dunn Victory Housing, Inc. No Change

10.07.14.07 C 2.a
Give some grace period for providers who are working on renewal, but are unable to get everything needed. I know there have been times when it has been difficult to get the Fire Marshal to do the inspection in a timely manner even though it had been requested well before the time it was needed. If you have everything except one paper, would that give an extension until it arrived? Sister Irene Dunn Victory Housing, Inc. No Change

10.07.14.07 E
add “A license is void and shall be returned to the Department by certified mail if the program ceases to provide services to residents for a period of 120 consecutive days, except in emergency situations.” Danna Kauffman LifeSpan Agree: Already added

10.07.14.07 F (3)
delete number (3) in its entirety regarding the program ceasing operations if a sufficient renewal application has not been filed. Danna Kauffman LifeSpan Agree

10.07.14.07. All Assisted Living Managers must complete the 80 hour training and pass the examination set forth in Regulation 16. All Assisted Living managers shall complete 20 hours of approved continuing education every 2 years. We entrust the lives of others with Assisted Living Managers. They are licensed, pay fees, and are subject to inspection. Why are they not all required to be properly trained and complete continuing education to attain and maintain proficiency? To not require training invites institutionalized abuse for failure to impose standards. Adrienne Cromwell Workforce Development and Continuing Education No Change

10.07.14.09
As mentioned above, there is work that needs to be done to achieve good coordination between the UDS and the continuing care statutes. We believe now would be the perfect time to work on those issues. In addition, there is one small typographical error in this regulation. The second deletion of the word “program” was not followed with the replacement word “license.” Alice Hodi MD Department of Aging Agree

10.07.14.09 Please note that this should be .88.

10.07.14.09 2. Remove the requirement for filing an amended Uniform Disclosure Statement within 30 days. Given the workload of OHCQ and the providers, it is not necessary to submit any changes within 30 days. This should be checked during the survey process. We are unaware of any comments that are ever made by OHCQ regarding amended disclosure statements submitted to OHCQ. Danna Kauffman LifeSpan No Change

10.07.14.09 1. This is again a document that would need to be changed to reflect if the levels of care are removed – which LifeSpan endorses. Given the workload of OHCQ and the providers, it is not necessary to submit any changes within 30 days. This should be checked during the survey process. We are unaware of any comments that are ever made by OHCQ regarding amended disclosure statements submitted to OHCQ. Danna Kauffman LifeSpan Agree

10.07.14.09 A 
Delete that a provider must file an amended statement to OHCQ within 30 days of the change of service. Instead, the statement should simply be reviewed during a survey to reduce administrative burdens on both the provider and OHCQ. Danna Kauffman LifeSpan No Change.

10.07.14.10 Add that an assisted living cannot deny access to OHCQ, APS or the ombudsman program. This should also be added to .11 Compliance monitoring and .31 Resident’s Rights. Timely access is critical for each agency to perform their mandate. Ombudsman Program access is not just a resident right, but a requirement of the Older American’s Act. Stefanie Ellis Office of the State Long Term Care Ombudsman No Change.

10.07.14.10 Add that an ALF cannot deny access to the Department and any agency designated by the Department. This will reinforce the role to investigate resident driven complaints. Lynn McCamie Baltimore-county Ombudsman Program No Change.

10.07.14.10 Add fire drills and emergency and disaster drills. They need to be on site because we have to be able to inspect them. Karen Brown Private Citizen No Change.

10.07.14.10 1. On page 35, remove “staff” from the records that must be maintained on-site. 2. IDR page 36, include the provision that the venue for IDR must be mutually agreed by both OHCQ and the provider. 1. Many providers have more than one site and combined HR departments. Providers would still be required to provide the records within 24 hours. 2. OHCQ also needs to develop procedures for EHR. Surveyors are often requesting paper copies, which either do not exist or creates a burden on providers. 3. IDR – Providers have reported feeling at a disadvantage when OHCQ required that the IDR be completed via phone when the provider requested in-person. Danna Kauffman LifeSpan Agree: Remove “staff”. No other action taken.

10.07.14.10 allow staff records to be kept off-site to accommodate those providers operating multiple locations with one central human resources department. Danna Kauffman LifeSpan Agree

10.07.14.10 add a section to address that records can be electronic. Danna Kauffman LifeSpan Agree

10.07.14.10 Section E (informal dispute resolution), revised to state: (2) At the discretion of OHCQ, as mutually agreed upon by OHCQ and the provider, the IDR may be held in-person, by telephone, or in writing. Danna Kauffman LifeSpan No Change.

10.07.14.10 Add that an ALF cannot deny access to the Department and any agency designated by the Department. This will reinforce the role to investigate resident driven complaints. Lynn McCamie Ombudsman_Baltimore County Agree.

10.07.14.11 Add that an assisted living cannot deny access to OHCQ, APS or the ombudsman program. This should also be added to .11 Compliance monitoring and .31 Resident’s Rights. Timely access is critical for each agency to perform their mandate. Ombudsman Program access is not just a resident right, but a requirement of the Older American’s Act. Stefanie Ellis Office of the State Long Term Care Ombudsman No Change.
(1) This section needs more requirements. At least require them to do a root cause analysis when serious events occur – abuse, neglect, falls, deaths. Make it clear that they need to show that each resident is reviewed individually, and the documentation must show each individual resident. (1) All they do is the 4 things listed and nothing else. They do not look at root causes when serious things like resident deaths, cases of abuse, neglect, etc., occur, or even frequent falls. They should at least be required to investigate for root causes to find where the system broke down.

2) None of this business of a facility handing you a report where they’ve gone over a bunch of residents in the aggregate and not individually. They need to review and document on each individual resident.

Karen Bronaw Private Citizen No Change

On a number of occasions, the Ombudsman Program has had assisted living providers refuse access. Human Services Article § 10-905 guarantees the Ombudsman access. Please include the following revisions to COMAR 10.07.14.12B (Proposed Regulation 11B) to clarify that the Ombudsman Program cannot serve as an inspection agent of OHCQ and to confirm its access to assisted living facilities and residents. B. Consistent with an interagency agreement, the Department may delegate certain aspects of its monitoring, inspection, or waiver responsibilities to a local area agency on aging or a local health department. The Department may not delegate any of its monitoring or inspection responsibilities to the Long Term Care Ombudsman Program. However, the assisted living program shall be open at all times for announced and unannounced visits by representatives of the Program in order to comply with Human Services Article 10-905, which provides that Ombudsman shall have access to assisted living residents.

Alice Hedd MD Department of Aging No Change

NOT at least every 6 month is appropriate, perhaps added in the event of added complexity when it has received written recommendations, requests, or grievances from the family council. The program shall respond in writing to the family council and attempt to accommodate those recommendations and grievances that affect resident care and life in the facility. The program shall allow them to do so without interference. The program shall provide the group the right to privacy for meetings and, if possible, the space to meet privately. Staff members of the program may attend the meeting only if requested to do so by the family council. When families wish to organize a family council, the assisted living program shall make reasonable attempts to support and cooperate with the family council. When families wish to organize a family council, the program shall attempt to accommodate those recommendations and grievances that affect resident care and life in the facility. The program shall respond in writing to the family council when it has received written recommendations, requests, or grievances from the family council.

Karen Bronaw Private Citizen No Change

We are suggesting this change because it is our understanding that the delegation agreements are with the local aging agencies, not the Maryland Department of Aging. We recommend that the quality assurance meeting between the delegating nurse and the assisted living manager be at least every three months instead of every six months. The needs of residents in assisted living are often very complex, and need more frequent oversight, individualized planning, and review.

Alice Hedd MD Department of Aging No Change

It should be at least every three months instead of every six months. The increasing complex medical needs of most assisted living residents.

Alice Hedd MD Department of Aging No Change

Alice Hedd MD Department of Aging No Change

Beyond Care No Change

Office of the State Long Term Care Ombudsman No Change

Baltimore County Ombudsman Program No Change

Ombudsman_Baltimore County No Change

Thank you for your comment. In response OHCQ has re-written this section.
10.07.14.12 C(1) A program that has a good resident council and works well with the council is generally able to better provide individualized care based on resident preferences. In addition, the program is able to learn about concerns and problems that residents experience so that these can be resolved. Towards that end, we recommend adding the following reinforcments to the proposed regulation as follows: (1) If assisted living program residents have a resident council, the assisted living program shall make reasonable attempts to support and cooperate with the resident council. When residents wish to organize a resident council, the program shall allow them to do so without interference. The program shall provide the group the right to privacy for meetings and, if possible, the space to meet privately. Staff members of the program may attend the meeting only if requested to do so by the council. The program shall consider the council’s recommendations and grievances and attempt to accommodate those recommendations and grievances that affect resident care and life in the facility. The program shall respond in writing to the resident council when it has received written recommendations, requests, or grievances from the council.

Alice Helt MD Department of Aging Agree

10.07.14.13 Recommend adding language: … social and recreational services, including those which facilitate integration into the community.

It is important to support residents to participate in activities in the greater community as often recreational activities if offered at all are limited to the facility or in adult medical day care centers.

Jane Wessely Private Citizen Agree


Consistency with previous regulation changes

Jane Wessely Private Citizen Agree

10.07.14.13 Definition requires clarification

The definition does not clearly state the roles of the case manager and the delegating nurse. Are the two roles the same?

Lynne McCamie Baltimore county Ombudsman Program

Agree. Delegating Nurse definition has been updated. Case manager has been removed.

Karen Brosaw Private Citizen No Change

10.07.14.13 (2) If the assessing health care practitioner, in their clinical judgment, does not believe that a resident requires awake overnight staff, the health care practitioner shall document the reasons in the area provided in the Resident Assessment Tool. You need to add something where it says that if someone other than the delegating nurse fills this area out with something like that, then the delegating nurse still must show that she’s aware of it and agrees with it. She has to note something here along with her name and date. You can’t just leave it up to another practitioner to fill this in.

If an MD fills this out, it doesn’t matter if they say they don’t think a resident needs awake overnight staff... the delegating nurse MUST show that they are aware and agree with this. So the delegating nurse must document something in this area to show that. That’s in accordance with the Nurse Practice Act. The other practitioner isn’t responsible for the resident, the delegating nurse is.

Karen Brosaw Private Citizen Addressed. The terms “case manager/delegating nurse” “delegating nurse/case manager” have been removed. These terms are replaced by the term “delegating nurse”.


(1) [An assisted living] A program shall provide on-site nursing when a delegating nurse or [physician] health care practitioner, based upon the needs of a resident, issues a nursing or clinical order for that service. (2) If [an assisted living] manager determines that a nursing or clinical order should not or cannot be implemented, the manager, delegating nurse or case manager, and resident’s [physician] health care practitioner shall discuss any alternatives that could safely address the resident’s needs.

Karen Brosaw Private Citizen

(1) Spelling: practitioner

(2) Wrong term: delegating nurse or case manager

Karen Brosaw Private Citizen

10.07.14.13 “new section” between existing (5) “Administer necessary Medication…” and (6) “Monitor and provide…”

A new section is needed: “monitor and provide” to identify, improve or maintain resident nutritional and hydration status.

Recent lack of identification of failing nutrition and hydration status has resulted in unplanned morbidity, unplanned hospitalizations, and in limited cases morbidity with lawsuits. (http://www.pbs.org/wgbh/pages/frontline/social-issues/life-and-death-in-assistedliving/catherine-horses-assisted-living-is-a-ticking-time-bomb/).

Phyllis McShane Maryland Dietetics in Health Care Communities

No Change

10.07.14.13 Change language to read: Planning of medical and behavioral health services; and

The Maryland Coalition on Mental Health and Aging has, for years, heard from network stakeholders that psychiatric services are seriously lacking given the rate of individuals with behavioral health disorders and / or taking psychotropic medications in assisted living programs. Regulatory language needs to specify expectations that psychiatric services are on par with medical services in meeting the needs of residents.

Kim Burton Mental Health Association of Maryland

Agree

10.07.14.13 The AL manager and delegating nurse should meet at least every three months.

The acuity of health care conditions and the high utilization of medications in the current AL population requires greater oversight than just a 6 month review.

Kim Burton Mental Health Association of Maryland

No Change

10.07.14.13 e. A staff member who completes an approved 80 hour manager training course shall be required to complete the annual trainings set forth in (2) (7) of this regulation every other year.

The staff should be required to complete annual training every year, or at least every other year.

Kim Fiore Private Citizen

No Change

10.07.14.13 Add “and behavioral health” so that the section reads “Planning of medical and behavioral health services; and

Behavioral health needs are not well planned for hence there is a greater likelihood for problems when behavioral health needs arise. The provider and delegating nurse / case manager must consider behavioral health needs on par with somatic health needs.

Kim Burton Mental Health Association of Maryland

Agree

10.07.14.13 f.(2) Add “and behavioral health” so that the section reads “Planning of medical and behavioral health services; and

Behavioral health needs are not well planned for hence there is a greater likelihood for problems when behavioral health needs arise. The provider and delegating nurse / case manager must consider behavioral health needs on par with somatic health needs.

Kim Burton Mental Health Coalition on Mental Health and Aging / Mental Health Association of Maryland

Agree
10.07.14.13 (H.4 or l) Definition requires clarification

The definition does not clearly state the roles of the case manager and the delegating nurse. Are the two roles the same?

Lynn McCusker, Ombudsman_Baltimore County

10.07.14.13 C delete full name of the staff and substitute “identifying name of staff.”

Danna Kaufman, LifeSpan

10.07.14.13 E delete Section (E) in its entirety.

As written, it implies that “all” staff must possess the ability to comply with the listed function which would be beyond the scope of practice for many staff.

Danna Kaufman, LifeSpan

10.07.14.13 E 2. Explain on page 41 the addition of “the licensee shall comply with applicable requirements of COMAR 10-27.09” as it relates to electronic monitoring. This regulation relates to the standards that registered nurses must follow for assessing, developing a plan of care and implementation. What is the intent of this provision now?

Danna Kaufman, LifeSpan

10.07.14.13 E 1. Delete Section E.

This section refers to “having staff with the ability to ……..”. As written, the language is unclear as to what staff must possess the stated abilities or if all staff must meet them. For example, “recognize and accurately describe and define a resident’s health condition and identify likely causes and risks associated with the resident’s condition.” Arguably, certain staff should not be responsible for identifying likely causes of a resident’s condition. Section E already states that the staffing plan must meet the 24 hour scheduled and unscheduled needs of the residents.

Danna Kaufman, LifeSpan

10.07.14.13 F The proposed changes in paragraph (2) delete the references to a physician or nurse performing the assessment and substitute the phrase “health care practitioner.” “Health care practitioners” is defined in Regulations 02 as “an individual who provides health care services and is licensed under Health Occupations Article, Annotated Code of Maryland.” There are several problems with this definition. First, under this definition, a health care practitioner includes acupuncturists, audiologists, speech-language pathologists, chiropractors, dietitian-nutritionists, electrologists, etc. OHCQ surely does not mean to allow all the individuals licensed under the Health Occupations Article to conduct an assisted living assessment. Proposed Regulation .18B and the introductory language of the Resident Assessment Tool only permit a select few health care professionals. Second, and more importantly, throughout the regulations numerous proposed revisions change terms like “physician” or “nurse practitioner” to a “health care practitioner.” As explained above “health care practitioner” is a very broad category and inappropriate in some if not all instances. Please consider whether each of the new uses of “health care practitioners” is appropriate. Also, keep in mind that just as a resident may have multiple individuals that qualify as a “representative,” a resident may have multiple health care practitioners: a primary care physician, a cardiologist, a podiatrist, an ophthalmologist, etc., so using the singular phrase “health care practitioner” will be ambiguous in many situations.

Alice Hedl, MD Department of Aging

10.07.14.13 H new Section (H), it should say delegating nurse/case manager rather than delegating nurse or case manager.

Danna Kaufman, LifeSpan

10.07.14.13 H.2 Correct the phrase “health care fractioned” to “health care practitioner”

Given that H(1) in that same section references “health care practitioners” this must be a typo.

Kristen Neville, DBMH - Health Occupations Boards

10.07.14 All persons giving direct care and support should be trained prior to giving services and anyone with the job description that involves service to the resident need to be trained in advance NOT AS YOU GO.

Marc Simmons, Beyond Care

10.07.14 On line training should have never have been approved. Never been used it accepted and it appears persons formally from OHCQ after having started this How was that allowed, yet everyone is expecting QUALITY CARE as the department is named for.

Marc Simmons, Beyond Care

10.07.14 The classes included in the I-5 bed manager affect all providers, the information is needed for all.

Marc Simmons, Beyond Care

10.07.14 This regulation should address the need for criminal history updates. Obtaining a one-time criminal history report does not sufficiently protect residents from staff who commit serious crime after the point of employment. CTS provides updates to the criminal history requestor and this service should be available from private background check companies.

June Wesley, Private Citizen
<table>
<thead>
<tr>
<th>Date</th>
<th>Recommendation</th>
<th>Supportive Comments</th>
<th>Opposing Comments</th>
<th>Author</th>
<th>Organization</th>
<th>Status</th>
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<tr>
<td>10.07.14</td>
<td>Recommend the manager and DN meet at least every 3 months rather than every 6 months.</td>
<td>Service plan appropriateness, change in resident status, pharmacy review results, etc. should be reviewed more frequently than every 6 months due to high acuity of many residents. Allowing up to 6 months, will probably result in adoption of 6 month meetings as the facility’s standard practice. Service plans should be reviewed at a frequency indicated by change in resident status or need.</td>
<td>Jane Wessely, Private Citizen</td>
<td>No Change</td>
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<td>10.07.14</td>
<td>E. A staff member who completes an approved 80-hour manager training course shall be exempt from the required annual trainings set forth in §D(6) of this regulation for a period of 4 years. Maybe 2 years.</td>
<td>6 years is just too long.</td>
<td>Karen Bresaw, Private Citizen</td>
<td>Agree, 2 years</td>
<td></td>
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<td>10.07.14</td>
<td>H. When the training method does not involve direct interaction between faculty and participant, the program shall make available to the participant during the training a trained individual to answer questions and respond to issues raised by the training.</td>
<td>Consider letting staff take internet courses and do away with (H). If you keep it, then add wording to make it mandatory that whoever the facility provides to answer questions can show proof that they’ve had their current annual training first. Everybody is coming out with internet-based courses now. Even the Alzheimer’s Assoc. is doing everything on the internet now, and we have to accept them, so you might as well do away with this. Some of our “approved vendors” are now offering all the required annual courses via internet ONLY, and we’re not doing anything about them.</td>
<td>Karen Bresaw, Private Citizen</td>
<td>No Change</td>
<td></td>
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<tr>
<td>10.07.14</td>
<td>H. When the training method does not involve direct interaction between faculty and participant, the program shall make available to the participant during the training a trained individual to answer questions and respond to issues raised by the training.</td>
<td>There aren’t many providers who have someone qualified to answer questions during training. And if you’re taking an internet course, you’re not going to have anyone available to ask.</td>
<td>Karen Bresaw, Private Citizen</td>
<td>No Change</td>
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<td>10.07.14</td>
<td>I. Training in Cognitive Impairment and Mental Illness. Take out the wording “mental illness” and just require training in cognitive impairment. Otherwise, where are they going to get the mental illness part of the training from?</td>
<td>Personally, I think it’s extremely important they have training in mental illness. Tons of residents have “The Big 3”: schizophrenia, bipolar d/o, and depression – and they NEED training in mental illness because staff never has a clue as to what to do with these people, and they’re not treated correctly by staff. The problem is there’s nowhere to get training in mental illness. We only have 2 vendors I know of who offer training in mental illness. One of them is the Griffins, and we don’t know if that training is ever current because they were approved a long time ago and how do we know their course is even up to date now? And we’ve been told we have to take the training from the Alzheimer’s Assoc, but their course has ZERO on mental illness! And we have to take the Copper Ridge CDs but those CDs were produced a very long time ago and probably are no longer current, not to mention they have no mental illness component either! As far as I know, there are only 2 programs in the entire state that offer mental illness training in addition to cognitive impairment, and that’s the Griffins (internet only) and the partnership between the Alzheimer’s Towson Chapter &amp; Mental Health Assoc. of Maryland class which is classroom only and therefore not good for those in far-away counties.</td>
<td>Karen Bresaw, Private Citizen</td>
<td>No Change</td>
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<td>10.07.14</td>
<td>C. Other Staff (2) - Direct Care Staff shall not have housekeeping, laundry, etc… recommendation is to add wording that allows this practice if the provider is working toward a universal worker approach or is moving toward a “culture change” model to allow for a greater number of staff to help a resident. Also within a decentralized dining approach, everyone helps with everything sometimes.</td>
<td>Providers offer a variety of approaches to activities and meals and direct care staff are often part of the process.</td>
<td>Anne Patterson, Leading Age Maryland</td>
<td>No Change</td>
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<td>10.07.14</td>
<td>Please note that this should be: 12. First, this is an example where the reference should be to the program and/or designer not the manager. Second, the focus of the quality assurance plan must be changed. This plan should be broader in scope and should not be focused on individual care but the policies, trends and past practices that are focused in improving the care in the entire community.</td>
<td>Orientation programs may vary from provider to provider and by incorporating the on-the-job training wording, providers would have greater flexibility to offer a transitional timeframe for each new staff person with actual hands-on training and participation.</td>
<td>Osama Kaufman, LifeSpan</td>
<td>Agree. QA from Adult Medical Day Care used.</td>
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<td>10.07.14</td>
<td>Offer a broader timeframe to complete the initial training. The proposed regulation states “prior to assuming responsibility for resident care” we suggest adding unless participating in on-the-job training.</td>
<td>Orientation programs may vary from provider to provider and by incorporating the on-the-job training wording, providers would have greater flexibility to offer a transitional timeframe for each new staff person with actual hands-on training and participation.</td>
<td>Anne Patterson, Leading Age Maryland</td>
<td>No Change</td>
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<td>10.07.14</td>
<td>Maintain the current regulation: “Basic CPR training shall be provided on an initial and ongoing basis to a sufficient number of staff by a certified CPR instructor to ensure that a trained staff member is available to perform CPR in a timely manner, 24 hours a day.” Another option is to provide a time frame for completion of certification and specific definitions of instructors are not included in this section.</td>
<td>A time frame for completion of certification and specific definitions of instructors are not included in this section.</td>
<td>Susan Hirsch, HCR ManorCare</td>
<td>No Change</td>
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<td>10.07.14</td>
<td>Change the wording “designated unit manager” to “coordinator”.</td>
<td>Section .26 Alzheimer’s and Dementia Special Care Unit refers to the dedicated person as the “coordinator” – use the same term for clarification purposes.</td>
<td>Anne Patterson, Leading Age Maryland</td>
<td>Agree</td>
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10.07.14.14 Change: Have a two-step tuberculous skin test (TST) or a single tuberculous blood test (interferon gamma release assay, IGRA) performed at the time of hire, in accordance with the CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Facilities, 2005.

10.07.14.14 Change the requirement in (3) (a) from 2 hours to 5 hours and in (3) (b) from 1 hour to 3 hours

Given the prevalence of dementia and behavioral health disorders among the AL population, the high turnover of AL staff, the inadequate provision of behavioral health services in most ALs and the unique challenges of dementia and behavioral health disorders, the hours of training must be increased.

Kam Burton  Mental Health Association of Maryland  No Change

10.07.14.14 Change the requirement of 5 hours of initial training to 12 hours for cognitive impairment and behavioral health. (remove term “mental” and use “behavioral”)

Given the prevalence of dementia and behavioral health disorders among the AL population, the high turnover of AL staff, the inadequate provision of behavioral health services in most ALs and the unique challenges of dementia and behavioral health disorders, the hours of training must be increased.

Kam Burton  Mental Health Association of Maryland  No Change

10.07.14.14 If the regulation is passed to require the Assisted Living employees to have all training prior to being on the floor. Can I then suggest that the department of aging set up a website that has the training on a pre recorded video that allows the employee to view from our facilities. A link to the training should be available from the Department of Aging web page. There should be a test at the end of each video that the employee must pass to continue to the next training. Also a certificate should be able to be printed at the end. Thank you.

Nisha Sweeney  Baltimore Assisted Living  No Change

10.07.14.14 Requiring the additional 20 hours of of initial training for staff on the care of residents with Alzheimer's prior to providing direct resident care is unreasonable and most likely will be ineffective. Staff are bombarded with information in the first days of orientation. Some of that time is already focused on Alzheimer's care. 20 hours is excessive and costly.

Patricia Anderson  Brooke Grove Foundation, Inc  No Change

10.07.14.14 I. (1) Change the requirement of 5 hours of initial training to 12 hours for cognitive impairment and behavioral health. (remove term “mental” and use “behavioral”)

1. Timing and Scope of the Training for All Staff: LifeSpan does not question the need for training and would be supportive of examining the training requirements to determine how and what changes could be implemented. However, the proposed regulations affect not only the amount of training but the timing of the training. Under the proposal, the manager now has to have training in specified areas rather than “verifiable knowledge.” This is the result of combining the manager section with all staff. For the manager who may not be directly responsible for patient care, the “verifiable knowledge” should be maintained. Lifespan recommends that this be qualified if the manager or assistant manager does not have primary responsibility for direct patient care, verifiable knowledge is appropriate; Page 47 of 168, Regulation C(6) requires all staff to be trained in several areas (fire and life safety, infection control, emergency plans, basic food safety, environmental safety) PPRIB in assuming responsibility for resident care, which also now includes five hours of training for direct care staff in cognitive impairment (2 hours for nondirect care staff). First, current regulations for cognitive impairment training allows this specific training to be done within the first 90 days, which it is and was supported by Lifespan. This timeframe should continue and could be applied to other trainings. It is not reasonable to have all training done prior to assuming responsibility for all staff. It is helpful for staff to be familiar with residents and their care as part of their training and enhances the formal training. Many providers do not have the ability of having extended pre-employment training programs. Most are trying to fill an immediate position in order to provide care to residents. There also needs to be a Recognition of the presence on the care team.

Danna Kaufman  LifeSpan  No Change
10.07.14.14 B The all program should make reasonable attempts to support and cooperate with the family council. The Alf should support family council development and not interfere. The program should provide the family council with privacy for meetings, and a space to meet privately whenever possible. Staff members can attend the meeting only if requested by the family council. The program shall consider the family council’s recommendations and grievances, and attempt to accommodate these recommendations and grievances that affect resident care and life in the facility. The program shall respond in writing to the family council when it has received written recommendations, requests, and/or grievances from the family council.

10.07.14.14 B The all program should make reasonable attempts to support and cooperate with the family council. The Alf should support family council development and not interfere. The program should provide the family council with privacy for meetings, and a space to meet privately whenever possible. Staff members can attend the meeting only if requested by the family council. The program shall consider the family council’s recommendations and grievances, and attempt to accommodate these recommendations and grievances that affect resident care and life in the facility. The program shall respond in writing to the family council when it has received written recommendations, requests, and/or grievances from the family council.

10.07.14.14 B Recommend that regulations 10.07.14.14 B is clarified to state that an assisted living provider create a staffing plan to ensure that a staff who is CPR certified and a certified medication technician is available on each shift. It is necessary to have a med-certified staff present on each shift to meet the requirements of the regulations outlined above. A non-certified staff does not have the skill or training to provide the monitoring and support of a resident who may require medications. Specifically, medications that are administered as on an as needed basis must be administered by a certified medication technician. The lack of a requirement in writing for a facility to staff a facility 24 hours a day, 7 days a week with a certified medication technician puts the residents at risk of harm. Staff must be available in the case that a resident experiences respiratory distress and requires CPR, why does the same not apply to medication? For example, a resident has an order for nitroglycerin. The awake overnight shift at a facility is not staffed by a certified medication technician. If the resident requires this medication, the non-certified staff will be unable to meet this need. In addition, the idea of having a certified staff on-call is not reasonable for this type of setting. In this scenario, the medication needs to be administered immediately and cannot wait for the arrival of a trained staff. As a second example consider this scenario: an assisted living facility has a resident with no PRN medications. One evening, a resident is transported to the emergency room due to illness and returns at 4am with an order to administer an antibiotic 5 times a day with the next dose due at 8am. Awake overnight staff are not medic-certified and the next shift is not scheduled to arrive until 8am. This staff person is no longer able to meet the needs of the resident. The resident is placed at risk of harm due to the inability of the staff to provide all treatments and orders prescribed for this resident.

10.07.14.14 B Delete Section (B). Delete Section (B). Delete Section (B).

10.07.14.14 B & C Overnight staff should be required to be awake. At the very least, this should be the exception, not the rule. 10.07.14.14 B and C – it should be stated that staff are required to be awake overnight unless a doctor designates that a resident does not require staff to be awake overnight. It should not be stated that a resident requires awake overnight staff. Residents are paying for services for a 24 hour period yet the regulation states that for a significant period of time, staff is permitted to be asleep unless designated by the resident assessment tool to be awake.

10.07.14.14 C Resident Council – (1) If assisted living program residents have a resident council, the assisted living program shall make reasonable attempts to support and cooperate with the resident council. When residents wish to organize a resident council, the program shall allow them to do so without interference. The program shall provide the group the right to privacy for meetings and, if possible, the space to meet privately. Staff members of the program may attend the meeting only if requested to do so by the council. The program shall consider the council’s recommendations and grievances and attempt to accommodate these recommendations and grievances that affect resident care and life in the facility. The program shall respond in writing to the resident council when it has received written recommendations, requests, or grievances from the council.


10.07.14.14 D Section (D) regarding vaccines, including flu, should be aligned with the requirements recently implemented in the adult day care regulations. There is no reason for differing requirements.

10.07.14.14 D.2 Change to – Be immune to measles, mumps, rubella, and varicella (chickenpox) as evidenced by documentation of vaccine administration or proof of laboratory evidence of immunity.

10.07.14.14 D.2 Change to – Be immune to measles, mumps, rubella, and varicella (chickenpox) as evidenced by documentation of vaccine administration or proof of laboratory evidence of immunity. This could become extremely expensive if we needed to start testing everyone who did not have available the proper paperwork.

10.07.14.14 D.3 Accept or decline the influenza vaccine each fall and sign a declination form if the vaccine is refused. If the influenza vaccine is obtained outside of the facility, provide the facility with documentation of the immunization.

10.07.14.14 D.6 and D.7 Recommend removing “prior to assuming responsibilities”.

10.07.14.14 D(10) delete reference to additional training for Alzheimer’s/dementia special care unit in Regulation 27.

Stevanne Ellis Office of the State Long Term Care Ombudsman Agree
Influenza is a highly contagious disease, but one that can be significantly impeded through vaccination. Unfortunately, the disease is often more deadly for the elderly population. Thus, it is very important that if at all possible, direct care staff is vaccinated. Thus, the vaccine should not only be offered to all staff—it should be offered for free. In other words, the licensee should bear the minimal cost of providing the vaccine to staff. While we appreciate that some assisted living facilities have tight budgets, the cost of ill staff far exceeds the costs of vaccinating staff.

Given the ever increasing diversity of our State, the training requirements should include training on cultural diversity and cultural sensitivity.

Delete references that trainings must be completed prior to assuming responsibility for resident care.

Delete reference to "responding to choking and cardiopulmonary arrests, including hands-on exercise."

Due to the high numbers of residents who have Alzheimer's disease or some other type of dementia or mental illness that impacts their functioning and communication adequate training is essential to the provision of care. Discharges and resident/staff behavioral problems could be minimized through interactive training strategies that help staff understand that behaviors are often times due to illness and disease.

It is estimated that up to 80% of residents have Alzheimer’s disease or some other type of dementia. Other residents have mental illness that impacts their functioning and communication in fact, discharges and resident/resident and resident/staff behavioral problems could be minimized through interactive training strategies that help staff understand that behaviors are often times due to illness and disease. Discharges and resident/staff behavioral problems could be minimized through interactive training strategies that help staff understand that behaviors are often times due to illness and disease, and that appropriate interventions can be used rather than inappropriate medications. Therefore, we recommend increasing the amount of initial minimum training set forth in 141(3)(a) from 2 hours to 3 hours and under 141(3)(b) from 1 hour to 3 hours.

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A more standardized version of the medicated technician course conducted by medication technician course programs approved by the Board of Nursing. There have been numerous complaints concerning disregarding the guidelines for teaching the approved 20 hours medication technician course. Over the past year representatives from the health care community who employ medications technicians have been meeting at the Board of Nursing to work on new guidelines and curriculum for the Medication Technician Course. Some of the proposed changes include having programs submit their course to the Board of Nursing for approval which is similar to how the Certified Nursing Assistant course is taught. The approved program will have the delegating nurses to teach the course. This will ensure consistency in how the course is taught.

I would like to comment on having a med tech on duty at all times in an assisted living home. I feel it is absolutely necessary as any one of the residents could have an adverse reaction to a medication they are taking. Most residents also have PRN medications that are not available to take if the med tech is not available. A med tech puts a staff person in place that can have a knowledgeable conversation with the delegating nurse about any symptoms he/she might be seeing from the resident. Please see the regulations below that back this concern. Thank you.

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This comment is in support of Regulation 10.07.14.G (3), which permits internet-based training to be used as a mode of instruction for long-term care staff. Over the past 17 years, Harrington Software Associates, Inc. has studied the use of computer-based training with a long-term care audience through six federally-funded research grants (totaling 3.75 million dollars). These research grants (funded by the National Institute on Aging and the National Institute of Nursing Research) demonstrated the effectiveness of computer-based training at improving the knowledge, attitudes, and practices of long-term care administrators and staff in a variety of topics, including injury prevention, food safety, fire safety, emergency preparedness, medication management, mental illness, restorative care, ergonomics, and infection control. Several of these studies specifically compared computer-based training to instructor-led training and found computer-based training was just as effective as traditional instructor-led instruction, even when the instructor was a highly skilled and experienced nurse educator. The results of these research studies have been published in The Journal of Continuing Education in Nursing, Journal for Nurses in Staff Development, Educational Gerontology, Nurse Education Today, and Journal for Nurses in Professional Development (reference list attached). Computer-based training (whether CD-ROM or internet-based) is now a widely accepted method of training throughout the country for long-term care administrators and staff. If administrators/staff have specific questions about the training content, these questions can be answered via an immediate response “Live Chat” feature, email, or text message. (Attachment includes bibliography of sources on "Research Studies on the Effectiveness of Computer-Based Training for Long-Term Care Administrators").

Recommend deleting language: (c) Outcome of the resident’s care that results in an adverse reaction of the resident. What seems more relative and appropriate is experience in the field as well as taking the 80 hour Manager's training Course thru the Beacon Institute. I have no degree and I feel it is absolutely necessary as any one of the residents could have an adverse reaction to a medication they are taking. Most residents also have PRN medications that are not available to take if the med tech is not available. A med tech puts a staff person in place that can have a knowledgeable conversation with the delegating nurse about any symptoms he/she might be seeing from the resident. Please see the regulations below that back this concern. Thank you.
When the manager terminates the program’s contract with or employment of a delegating nurse, Not the just when the program terminates the DN. They should be required to notify OHCQ when they have a DN quit and why. Lots of DNs quit because they can’t get the manager to do what they say. And the DNs never let us know, they just quit, and the managers never tell us either. Then we go out on a survey and find they haven’t had a delegating nurse for the last six months.

We should require the managers to let us know when their DN quits and why so at least we know when it happens. And it gives us a good Aspen tag to use to site them when we find them without a DN (not just when THEY terminate one).

<table>
<thead>
<tr>
<th>Date</th>
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<td>Karen Braxaw</td>
<td>Private Citizen</td>
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<td>10.07.15</td>
<td>delete reference to Maryland Higher Education Commission</td>
<td>Danae Kaufman</td>
<td>LifeSpan</td>
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<td>Continue to allow the Department to approve both the 80 hour manager training course and the 10 hour continuing education requirement. It is unclear how the Maryland Higher Education Commission will respond as the approver. Current providers of the training may not be able to comply with possible new requirements. Existing training options may cease to exist (with the exception of the 20 hour continuing education which is still proposed to be approved by the department). This is not a college based course.</td>
<td>Anne Paterson</td>
<td>Leading Age Maryland</td>
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<td>Establish an alternate, realistic time requirement, such as notification within 24 hours. Notifying the delegating nurse/case manager, i.e. significant resident changes, is important. However, the 2-hour requirement may result in non-compliance issues, i.e. weekends, holidays, overnight.</td>
<td>Susan Hirsch</td>
<td>HCR ManorCare</td>
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<td>Replace term &quot;psychosocial&quot; with more current terminology, &quot;behavioral health.&quot; We recommend that the regulations be amended for the term &quot;psychosocial&quot; and, where appropriate, change it to &quot;behavioral health.&quot; The usage of terminology should be consistent and reflect current language that is more commonly used among state agencies and providers. &quot;Behavioral health&quot; is inclusive of a spectrum of issues and is a realm of health on par with medical / somatic issues which has assessment and treatment potential.</td>
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<td>10.07.15</td>
<td>Please state: (b) remove - (c) Complete 20 hours of continuing education every 2 years from an institute approved by the Maryland Higher Education Commission, in addition to the required annual trainings described in Regulation .14D(7) of this chapter. All Assisted Living Managers and alternate Assisted Living Managers should take 20 hours of training every 2 years from a higher education source.</td>
<td>Kim Fiore</td>
<td>Private Citizen</td>
</tr>
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<td>Please state: B. A manager or alternate manager who completes an approved 80 hour manager training course shall be exempt for a period of no more than 2 years from the =&gt; 20 (1) Continuing education requirements set forth in this section: and (2) required annual trainings. Each Assisted Living Manager and Alternate Assisted Living Manager should have no more than a 2 year reprieve from taking continuing education classes and required annual trainings.</td>
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<tr>
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<td>15 Qualifications ALM How is the evidence for the educational credentials quantified in the record. Is it diplomas or their own resume written by their own hand? What proof is required? How do you prove ALM has verifiable knowledge as stated in (H)</td>
<td>Marianne Uphold</td>
<td>Private Citizen</td>
</tr>
<tr>
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<td>Please change from “3 beds or more” to “1 bed or more” All managers (1 bed or more) should be required to undergo the 80 hour manager training course because all residents are entitled to have caregivers that have been properly trained through all of the topics, especially 12 yrs. of Dementia and Mental Illness as well as Management and Operation.</td>
<td>Mary Dent</td>
<td>ABC TRAINING CENTER</td>
</tr>
<tr>
<td>10.07.15</td>
<td>Pertaining to section 15 (Manager and Alternate Manager): we suggest adding a regulation to the effect that if a manager or alternate manager handles a resident's finances in some designated capacity (e.g., representative payee, VA fiduciary), the manager or alternate must act in the resident's best interest and the actions must be transparent.</td>
<td>Wendy Harris</td>
<td>AA County Dept. of Aging and Disabilities</td>
</tr>
<tr>
<td>10.07.15</td>
<td>Should not be exempt from continuing education. If they are the staff on duty for the day their education of how to provide care/services must be as up to date as possible for the population admitted.</td>
<td>Lynn McCarne</td>
<td>Ombudsman_Baltimore County</td>
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An RN may only have a two year degree however that individual has skills and experience equal or better than someone with a 4 year degree in a non-health care related field.

The requirement to limit the position of Assistant Living Manager and of Alternative Assistant Living Manager to an individual having a 4 year, college level degree is discriminatory. 2. It prevents those who lack the college degree, but have the experience training and knowledge from applying for these positions. 3. It precludes RN’s who may not have a 4 yr college degree from applying for this position.

Consider changing the requirement of notifying the delegating nurse within two hours of the manager to “within 24 hours” for when the manager (should be aware immediately as well as to then notify the delegating nurse.

The Office of the State Long Term Care Ombudsman has re-written this section.

No Change.

Education requirements were addressed with the retention of the Levels of Care requirements.

Level of Care was retained due to statute, Health-General §19–1805(a), which requires licensing according to level of care.

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10.07.14.15A (a) and (c) Change “Maryland Higher Education Commission” to “The Department - OHCQ” (c)
Regulation consistency

10.07.14.15A(3) &
Change from an institute approved by MHEC to “Approved training vendor by the Department – OHCQ”
Suggestion: Have all currently approved training vendors resubmit their curriculum for approval back to OHCQ to ensure that all the required topics are covered and taught as per COMAR 10.07.14.17 as well as having enrollment records available for inspection.

10.07.14.16 Recommend adding fall prevention to training requirements.

Karen Besaw
Private Citizen
No Change.

10.07.14.16 Recommend deleting reference to level of care assessments

Karen Besaw
Private Citizen
No Change.


Mary Dent
ABC TRAINING CENTER
No Change.

Consistent with national cultural change movement to promote person-centered care.

Jane Wessely
Private Citizen
No Change.

As written it is confusing.

Jane Wessely
Private Citizen
No Change.

Recommended changes include: (1) Incident report processes; and (c) Root cause analysis
Any changes should be added to the QA section also.

Karen Besaw
Private Citizen
No Change.

We recommended that managers be certified in Mental Health First Aid – Older Adult Module which is an evidence based 8 hour training that could replace some of the content requirements in this section thus reducing the hour assignment. We can negotiate this as there is no reason to repeat education.

Kim Burton
Mental Health Association of Maryland
No Change

We recommend adding language: Development of [individualized] person-centered service plans.

Jane Wessely
Private Citizen
No Change.

B.

B. Finan Center (DHMH / BHA)
No Change.

A program that fails to employ an assisted manager who meets the requirements of this regulation may be subject to: Insert the word “living” after “assisted”

Karen Besaw
Private Citizen
No Change.

It’s a assisted living manager, not assisted manager.

Karen Besaw
Private Citizen
No Change.

I take exception to “non-immune staff” because it’s well known that just because you get the vaccine, you’re NOT “immune.” Lots of people who get the vaccine still get the flu

Karen Besaw
Private Citizen
No Change.

Predictors are not doing investigations which include a root cause analysis to find out if there’s any way the event could have been prevented (or to prevent it in the future), even when terrible things happen to residents like abuse, neglect, or death. This should be a mandatory part of their QA.

Karen Besaw
Private Citizen
No Change.

The MHFA certification course is nationally embraced as a comprehensive curriculum that addresses several behavioral health issues common to AL residents.

Kim Burton
Mental Health Association of Maryland
No Change

The observation is based on an analysis of death rate information compiled by the National Vital Statistics System between 2000 and 2013. The report specifically noted that while roughly 30 seniors in every 100,000 died following a fall in 2000, that figure jumped to nearly 57 per 100,000 by 2013. Investigators also implicated falling as the cause of death in more than half (55 percent) of the roughly 90,000 unintentional injury fatalities involving seniors in 2012 and 2013. Falls requiring care beyond basic first aid are one of the leading incidents reported on Medicaid participants residing in their homes and ALFs.

Jane Wessely
Private Citizen
No Change.

Delete the word “non-immune”.

Karen Besaw
Private Citizen
No Change.

We take exception to “non-immune staff” because it’s well known that just because you get the vaccine, you’re NOT “immune.” Lots of people who get the vaccine still get the flu.

Karen Besaw
Private Citizen
No Change.

As written the flu.

Karen Besaw
Private Citizen
No Change.

See previous comment on 10.07.14.02.B(76).

Jane Wessely
Private Citizen
No Change.

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Kim Burton
Mental Health Association of Maryland
No Change

As written the flu.

Karen Besaw
Private Citizen
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Karen Besaw
Private Citizen
No Change.
The Recommendation to require ALM Refresher every four years is too long. After completing the 80 hour program, students are often unable to start their business or work as the field immediately, and there can be considerable lag time. At least at the two-year interval, they can maintain proficiency, but with four-year interval, they would need to be retrained. Additionally, the two-year interval provides the opportunity for timely updates. Establishing a four-year interval without receiving updates is untenable and potentially hazardous for the patient. Changing the interval still does not address repercussions for noncompliance. A rule without enforcement should not be a rule and says to the ALM, the patient’s family, and the patient that this is not really important, and continuing education is not a priority, until something serious happens.

Adrienne Crowell  
Prince George's Community College  
Agree. Change to 2 years.

10.07.14.16 A.5 n  
Change to: Infection prevention and control to include: Standard and contact precautions Bloodborne pathogens standard Hand hygiene Safe injection practices Use of personal protective equipment Cleaning and disinfection of equipment and the environment

After completing the 80 hour course, all non-CNA/GNA personnel initially and then annually. Every rule must be enforceable. If you truly want quality programs, then mandated training must have a consequence for non-compliance. Currently, there is no penalty for noncompliance, so refresher program opportunities dry up creating additional problems.

Adrienne Crowell  
Workforce Development and Continuing Education  
No Change.

10.07.14.16D  
Please add: Assisted Living Managers who fail to complete 20 hours of continuing education within the 2 year period must repeat the 80 hour training course with examination within 6 months after the two-year refresher period.

It is unreasonable to expect small facilities who contract the DN for the 45 day review as required to incur the added expense of paying a DN for 7 days to shadow a staff person.

Marc Simms  
Beyond Care  
No Change.

10.07.14.17  
For staff to have all necessary training as outlined in regulations with persons who are not CNA/GNAs demonstrate to the DN that they have skills to perform their duties relating to personal care. Should there be a need to orient or give training address it then.

It's redundant.

Karen Besaw  
Private Citizen  
No Change.

10.07.14.17  
Meet with the manager every 3 months rather than every six months for QA

To ensure quality of care is being provided as the residents age in place.

Lynne McCamie  
Baltimore county Ombudsman Program  
No Change.

10.07.14.17  
Ensuring accurate and consistent documentation throughout the record should be part of their oversight.

Delegating nurses’ documentation is almost across-the-board horrible. Stuff is missing, it’s inaccurate, they never re-write the sketchy stuff the docs write, etc.

Karen Besaw  
Private Citizen  
No Change.

10.07.14.17  
(4)(b) A resident’s return from a, Delete the “a”

It’s redundant.

Karen Besaw  
Private Citizen  
Agree.

10.07.14.17  
(4)(b) A significant hospitalization resulting in increased monitoring needs or a change in treatment or medication; I don’t like this wording. It’s not clear that this should be done after an ED or urgent care visit. You could add the words “...hospitalizations or ED trip resulting in...”

If a DN does a competency at all, they only do it once -- when the staff gets hired. And if it’s a med tech, the only thing they assess them on is giving medication, not how to do ADLs with elderly residents.

They need to do a competency for ADLs on all their non-CNA/GNA staff annually (med techs especially). Non-CNA/GNA staff need reminding of what they’re supposed to do, especially med techs because the DN never assesses them for how to do ADLs with people.

I’ve seen med techs grab a 90-yo by the wrists and yank them up from the kitchen table because the DN never checked them out for how to do ADLs.

My opinion is that an annual competency should be good.

Karen Besaw  
Private Citizen  
No Change.

10.07.14.17  
F (4)(b)(i) A significant hospitalization resulting in increased monitoring needs or a change in treatment or medication; I don’t like this wording. It’s not clear that this should be done after an ED or urgent care visit. You could add the words “...hospitalizations or ED trip resulting in...”

Again, they’ll interpret this as just for hospitalizations meaning when a person gets admitted to a floor and not for an ER trip or trip to an urgent care.

You need to include ED/urgent care trips in the definition of “hospitalization” which I mentioned earlier.

Karen Besaw  
Private Citizen  
No Change.

10.07.14.17  
(10) Develop, implement, and evaluate resident service plans in collaboration with the manager; Add wording to say that they must document each time they review the service plan with their name and date.

How else do you document that you did something? Surveyors need to be able to see that the DN has reviewed the service plan. The normal way you do that is by signing your name and date to the document.

And if it’s an electronic document, then they need to sign a paper copy. Otherwise, anybody can go in and type whatever they want and type someone’s name to it.

Karen Besaw  
Private Citizen  
No Change.

10.07.14.17  
Change wording to say “for all residents, whether they self-administer medications or not”

DNs should be advising the docs when residents may need certain med changes, but they don’t. The DNs often know about problems residents are having before the docs do, but they don’t do anything about them. I’ve seen this many times. The DN just isn’t paying attention.

Karen Besaw  
Private Citizen  
No Change.

10.07.14.17  
Change wording to read: “…assuring that results…”

Reads more grammatically correct.

Karen Besaw  
Private Citizen  
No Change.
10.07.14.17 G. In programs where nursing tasks are not delegated to unlicensed staff:
(1) The delegating nurse/case manager shall be exempt from the provisions of (F)(3) and (5) - (8) of this regulation; and
(2) The delegating nurse/case manager shall be on-site at least every 90 days to observe and assess each resident unless the delegating nurse/case manager determines the resident needs more frequent review. Absolutely not -- it should be kept the way it is. Those are RN/DN jobs, period.

Karen Braxw Private Citizen No Change.

Mike HOTH 25 of 51

10.07.14.17 There are some large facilities that let LPNs do everything (they don’t employ med techs), and for the most part LPNs are as a whole are horrible. I’ve read their notes and they can’t even document correctly, let alone think comprehensively about a resident. You can leave out the part about med techs only if a facility doesn’t employ them. But LPNs are NOT allowed to assess the resident and take into consideration care plans and whether something should be changed or not. That’s what you call doing a comprehensive analysis of the resident and that’s outside the scope of practice of an LPN per the NPA!

I’ve surveyed facilities with LPNs, and even though a lot of RN/DNs are bad, the LPNs are so much worse because they’re not trained to think at all. You still need a DN to (comprehensively) assess each resident every 45 days. We need to remember the words of Barbara Newman from MBON who came out here and said there might be an LPN here and there who’s smart enough to be capable of doing what an RN does, but when you look at them across the state as a whole, they’re terrible.

Karen Braxw Private Citizen No Change.

10.07.14.17 F. Duties. The delegating nurse/case manager shall:
(1) The delegating nurse/case manager shall be exempt from the provisions of §F(3) and (5) - (8) of this regulation; and

Alice Hildi MD Department of Aging Agree

10.07.14.17 (2) The delegating nurse/case manager shall be on-site at least every 90 days to observe and assess each resident unless the delegating nurse/case manager determines the resident needs more frequent review.

Mary Independent nurses service small providers whose needs may be easily addressed by phone/fax or other electronic devices. Utilizing Nurse staff agencies for temporary situation could be ideal choice for private contractors Prevents providers from using med techs to under bid or break contracts

Karen Braxw Private Citizen No Change.

10.07.14.17 The assessment cannot always be performed at the time of an admission or readmission. To be consistent with language used on page 83 of the Resident Assessment Tool section. 18 (1) (a) and (c) Reassessment.

Anne Patterson Leading Age Maryland No Change.

10.07.14.17.1. As a delegating Nurse in a facility - How do you manage a resident who comes into a facility to be in an assisted living facility as a respite care almost every other week, and spends 2-3 days in the facility. The initial nursing assessment must be completed before the resident enters the facility.

Kim Fiore Private Citizen No Change.

10.07.14.17 I. As a delegating Nurse in a facility - How do you manage a resident who comes into a facility to be in an assisted living facility as a respite care almost every other week, and spends 2-3 days in the facility. Question - is the admission assessment needs to be completed each time? - and when is the 45 day assessment due? Thank you for responding.

Simi Meadows Educator Thank you for your question. This can be answered in 18 D. Short-Term Residential Care Requirements.

10.07.14.17 Add more duties to the DN’s list so it includes ensuring oversight of a resident’s documentation to ensure that it’s correct and consistent throughout the record. Almost no DN reconciles discrepancies in the residents’ paperwork, rescribes a resident’s assessment because the doc filled it out completely incorrectly, looks to make sure the resident MARs are filled out correctly by the med techs, or makes sure reasons are next to each medication on the MARs, etc. This is all part of nursing oversight, but no DNs are doing it because it doesn’t fit on them that it’s part of their duties of oversight and COMAR doesn’t explicitly say you have to.

Karen Braxw Private Citizen No Change.

10.07.14.17 Please add: Each Delegating Nurse must also case manage residents. 30 residents to be responsible for may be more than enough.

Kim Fiore Private Citizen No Change.

10.07.14.17 Please state:
F. Duties. The delegating nurse/case manager shall:
(2) perform an initial nursing assessment prior to the time of the residents admission.

Karen Braxw Private Citizen No Change.

10.07.14.17 C. May contracting nurse choose not to have an alternate? If so how are other surveyors to acknowledge this choice. Can delegating nurse use a nursing agency to fulfill this requirement Independent Delegating nurse contractor should have choice

Karen Bryant Washington Licensed assisted living nurse services No Change.

10.07.14.17 F.2 perform an initial assessment at the time of the resident’s admission. Rationale: Again, each assisted living facility has access to various support staff to manage certain aspects of the business and should have the freedom to utilize an admission staff to sign the admission agreement in place of the ALM.

Patricia Anderson Brooke Grove Foundation, Inc No Change.

10.07.14.17 F.22 Meet with the manager every 3 months rather than every six months for QA To ensure quality of care in being provide as the residents age in place.

Lynn McGuire Ombudsman_Baltimore County No Change.
10.07.14.17 & 10.07.14.18 Regulation .17 and Regulation .18 now require BOTH a nursing assessment and the resident assessment tool be completed within 48 hours of a significant change of condition, which is a tighter timeframe than current regulation and potentially requires more paperwork than what is currently needed now. Rather than streamlining, the process has now become more cumbersome. As a reminder, the revised RAT incorporates a nursing assessment into the tool, which was done to alleviate the nurse from having to complete two separate documents.

\[\text{Danna Kauffman, LifeSpan} \quad \text{Agree. Added provision for delegating nurse.}\]

10.07.14.17 F Clarification of delegating nurse and case management role and duties. The delegating nurse should meet with the assisted living manager at a minimum every three months.

The needs of assisted living residents are often very complex. More frequent collaboration between the manager and delegating nurse will help ensure quality of care and person centered, individualized care.

\[\text{Stevie Ann Ellis, Office of the State Long Term Care Ombudsman} \quad \text{Addressed. Change to delegating nurse. No Change from 6 months to 3 months.}\]

10.07.14.17 F(12) This newly proposed provision states that the need for oversight staff will be determined from the nursing assessment, but new Regulation .13F provides that the need for oversight staff will be determined from the Resident Assessment Tool.

\[\text{Alice Hedt, MD Department of Aging} \quad \text{Follow-up required once forms are finalized.}\]

10.07.14.17 F(2) and F(8) Section F(2) and F(8): LifeSpan is opposed to the mandatory requirement that the DN/CM perform an initial nursing assessment at the time of the resident’s admission as well as requiring the DN/CM to document each direct care staff person’s competency in providing activities of daily living prior to the staff person assuming responsibility for resident care. Current requirements allow a 7-day time period to conduct this evaluation if the staff person was working with a CNA or GNA.

Both will have a significant impact on operations and the former will drastically hinder the provider’s ability to admit with short-term notice or based on a resident’s schedule. In addition, residents moving in to assisted living are frequently anxious and stressed. Requiring a nurse to perform a physical assessment is often a very intrusive request on a very difficult day, particularly for residents with dementia.

\[\text{Danna Kauffman, LifeSpan} \quad \text{No Change.}\]

10.07.14.17 F(22) In accordance with the recommendation above on Proposed Regulation .12A(2)(a), we recommend that the quality assurance meeting between the delegating nurse and the care manager occur at least every three months, instead of six months, because of the complex medical needs of most assisted living residents.

\[\text{Alice Hedt, MD Department of Aging} \quad \text{No Change.}\]

10.07.14.17 F(23) This new provision does not specify when the required notification must be given. Would it be acceptable to wait three months to provide the notice?

\[\text{Alice Hedt, MD Department of Aging} \quad \text{Thank you for comment. In response OHCQ has re-written this section}\]

10.07.14.17 F(4) Maintain current competency timeframe requirement: to be completed within 7 days.

Requiring the delegating nurse/case manager to complete the direct care staff’s competency prior to assuming responsibility for resident care may create HR issues. This may limit facilities to hiring CNAs and GNAs, which is a financial factor re. pay rate and decrease opportunities for other applicants’ employment.

\[\text{Susan Hirsch, HCR ManorCare} \quad \text{No Change.}\]

10.07.14.17 G This section appears to say that if all the aides at a particular facility are CNAs, then the delegating nurse only needs to appear at the facility once every 90 days. We do not think this is adequate at a Level III facility with 10 or more residents. Given the level of responsibility of the delegating nurse/case manager, they should visit the facility at least once every 45 days even if all the staff is licensed in one way or another.

\[\text{Alice Hedt, MD Department of Aging} \quad \text{No Change.}\]

10.07.14.17 G(1) This provision exempts the delegating nurse from the requirement in .13F(5) to “appropriately delegate nursing tasks to certified medication technicians, certified nursing assistants…” We doubt this is literally what is intended by OHCQ, but given the structure of the exemption, it creates what appears to be a disconnect.

\[\text{Alice Hedt, MD Department of Aging} \quad \text{No Change.}\]

10.07.14.17 G(2) As discussed above in the general comment on new Regulation .17, a great deal of additional responsibility is to be placed on the delegating nurse. .17G(2) reduces the requirement for an onsite visit by the delegating nurse from a minimum of once every 45 days to 90 days when all staff is licensed. We are concerned whether a delegating nurse can realistically satisfy all of the requirements of the regulations, especially the newly proposed requirements, if he or she only visits once every 90 days.

While the language of .17G(2) allows for more frequent visits, we are worried that this will create a source of friction between the delegating nurse and the provider. It seems that many delegating nurses will see a need to visit more than once every 90 days, but that will cost the provider additional money so the provider will press the delegating nurse to only visit every 90th day. That is all the regulations will require. It would be better to state this new standard in the converse, i.e., “if all staff are licensed, the delegating nurse may lengthen the period of the nurse’s periodic onsite review from 45 days up to a period as long as 90 days, if the delegating nurse determines more frequent reviews are not necessary.” This formulation may put more pressure on the nurse’s malpractice premiums.

\[\text{Alice Hedt, MD Department of Aging} \quad \text{No Change.}\]

10.07.14.17 G(3) Talking about completion of the Resident Assessment Tool (RAT) and nursing assessment.

A(1): “…in collaboration with the DN/CM…” Require the form to be signed by the DN/CM before the resident gets admitted, but it can’t be done earlier than 30 days before:

ALFs are constantly admitting residents and the DN has no clue that they’re there because the managers don’t tell them until after the admission occurs.

Just saying “in collaboration with the DN” isn’t going to work. The DNs are the ones who should be required to complete the RAT, because the managers can’t tell if a resident is beyond what they can care for. And they don’t care, either; they’ll just admit as many as they can for the money and tell the DN later.

Keep the requirement to be “…within 30 days before admission” and not any earlier. If the RAT is done too early, the resident’s condition might change and they might not be suitable for the ALF anymore.

\[\text{Karen Besaw, Private Citizen} \quad \text{No Change.}\]

10.07.14.18 C(1) - change wording to be “at least every 6 months” Because it’s more accurate.

\[\text{Karen Besaw, Private Citizen} \quad \text{Agree}\]
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<tr>
<th>Date</th>
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<tr>
<td>10.07.14.18</td>
<td>C.(2) A new RAT shall be completed. Require the DNs to document in the record, by signing their name and date, exactly what they did after someone returned from the hospital (whether from an admit to a floor or an ED/urgent care trip) and why. Too many DNs are getting away with never signing their names and dates when they do things.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
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<td>10.07.14.18</td>
<td>Change the word Residential to Respite.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
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<td>10.07.14.18</td>
<td>Change wording to make it more accurate. Like “….subsequent short-term (respite) admissions” to “….subsequent respite admissions.” See previous. Otherwise they’ll think they can do “trial” admissions.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
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<td>10.07.14.18</td>
<td>Some ALFs are co-located with an AMDC. In those places, it’s common for a resident to be admitted for respite on a frequent basis. Like you’ll have a resident admitted for the first weekend that month, followed by the second weekend that month. In that case, the DN should only have to document that the resident’s condition hasn’t significantly changed from the last time. However, they must be required to document if their needs have changed since the last time, and what those changes are.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
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<td>10.07.14.18</td>
<td>Delete the requirement for an alternate delegating nurse/case manager to be “under contract” and on call at all times. Recommend inclusion of delegation of duties to appropriate facility licensed staff re. on call status. The requirement of an alternate delegating nurse/case manager being on call may increase expenses, i.e. payment for on call status, and consequently increase room rates and limit placement options. This requirement, also, limits the responsibilities of the facility, licensed staff.</td>
<td>Susan Hirsch</td>
<td>HCR ManorCare</td>
<td>No Change</td>
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<td>10.07.14.18</td>
<td>Lists professional Are those the professions that should be listed in the definition of health practitioner rather than just citing the law (the law is too broad).</td>
<td>Lynn McCauley</td>
<td>Baltimore county Ombudsman Program</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.18</td>
<td>Delete the requirement for an alternate delegating nurse/case manager to be “under contract” and on call at all times. Recommend inclusion of delegation of duties to appropriate facility licensed staff re. on call status. The requirement of an alternate delegating nurse/case manager being on call may increase expenses, i.e. payment for on call status, and consequently increase room rates and limit placement options. This requirement, also, limits the responsibilities of the facility, licensed staff.</td>
<td>Lynn McCauley</td>
<td>Baltimore county Ombudsman Program</td>
<td>No Change</td>
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<td>10.07.14.18 A.1</td>
<td>Is the resident assessment tool taking the place of the healthcare practitioner form? Rarely do small facilities admit patients 30 days in advance. Occasionally when patients are being transferred/discharged from hospitals or acute stays the HCPF is not always complete. Hospitals try discharging residents at last minute without completing forms or don’t know enough about patients. They also wont complete both the resident assessment form and the HCPF. Many often state can’t give discharge summary</td>
<td>Ken Bryant Washington</td>
<td>Timeframe assisted living nurse services</td>
<td>Follow-up required once forms are finalized</td>
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<tr>
<td>10.07.14.18 A.1</td>
<td>Allow the RAT to be completed thirty (30) days prior or within 48 hours following admission to match the timeframes in 18.3a. It is often very hard to get a full RAT done prior to move in day especially if a resident is coming from out of state.</td>
<td>Osama Pontefio</td>
<td>Country Meadows</td>
<td>No Change</td>
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<td>10.07.14.18 A(1)</td>
<td>Completion of the Resident Assessment Tool (RAT) and nursing assessment should be changed to reflect the Simplified RAT if completed by a RN will meet the requirements for the RAT and the DN’s assessment. In Transmittal AL-13-0001, the simplified Resident Assessment Tool was given as an alternative to the 3-part RAT to reduce paperwork load for providers.</td>
<td>Cyndi Rodgers</td>
<td>Winters Growth Inc.</td>
<td>Follow-up required once forms are finalized</td>
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<td>10.07.14.18 A(3) AND E</td>
<td>For emergency placement by the local department of social services, .18A(3) requires completing the Resident Assessment Tool within no more than 48 hours, while .18E provides for a 14 day exemption from the Resident Assessment Tool requirements “if the resident is in temporary emergency shelter and services status.” It would be helpful to consolidate or clarify the interrelationship of these two provisions. If there is a difference between these two types of emergencies, providers may not know the difference. If there is no difference, the provisions need to be revised or consolidated to make them consistent.</td>
<td>Alice Hilt</td>
<td>MD Department of Aging</td>
<td>No Change</td>
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<td>10.07.14.18 D</td>
<td>Section D of Regulation 18 should be removed which relates to short-term residential care requirements. This should be a separate numbered regulation given that the provisions include more than assessments, which is the topic of Regulation 18. In addition, there is a bracket at the end of Section F but there is no closing bracket so it is unclear if any provisions are being changed. We would also request discussion about the parameters outlined in this section for short term care. For example, requiring the full assisted living contract to be completed is of concern, as most of the components do not apply in a short term relationship.</td>
<td>Cyndi Rogers</td>
<td>Winters Growth Inc.</td>
<td>No Change</td>
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<td>10.07.14.18 E</td>
<td>Section E of Regulation 18 should be combined with the other provisions related to emergency services for clarity.</td>
<td>Cyndi Rogers</td>
<td>Winters Growth Inc.</td>
<td>No Change</td>
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<td>10.07.14.19</td>
<td>OK, I’m confused now. This section is a repeat from the one I made the recommendation to delete para E on earlier. Around pg 44??? So what I said was -- Para E. Maybe we should let people get these courses over the internet and drop the requirement for it to be in-person? The whole world seems to be offering online courses now. Should we allow it? Even our approved vendors, who didn’t bother asking us whether they were allowed to do that or not, are now offering internet-only courses. And ALFs aren’t going to provide someone to answer staff’s questions as they’re going through training, they’ll just say they did. If you keep this in, then make sure you say that there has to be proof that the person answering the questions has current training themselves.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
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<td>10.07.14.19</td>
<td>A program shall not admit, without the Department’s approval of a resident-specific waiver request, an individual who at the time of initial admission... Delete the word “initial”. Change the wording so that it’s clear that you can’t take care of someone with stage 3 or 4 ulcers AT ANY TIME without getting a waiver from us.</td>
<td>Karen Besaw</td>
<td>No Change</td>
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<td>10.07.14.19</td>
<td>The Red Cross has an instructor (who’s one of our ALMs – and I’ve been told is quite a bad one at that) who teaches RNs in the DNVCM course how to cheat OHCQ, and one of the things she tells them is that the regs say you can’t admit someone initially with those things, but it doesn’t say that you can’t RE-ADMIT them with those things (like when you get them back from a hospital with a stage 3 or 4)!</td>
<td>Karen Besaw</td>
<td>No Change</td>
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<td>10.07.14.19</td>
<td>Require that the hospice plan of care be documented and that it actually addresses things that need to be addressed, or else the facility has to come up with one.</td>
<td>Karen Besaw</td>
<td>No Change</td>
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<td>10.07.14.19</td>
<td>I went round and round with a large facility on this once. The hospice didn’t do a plan of care. I told the facility I wouldn’t approve the waiver unless they had one. So they contacted the hospice and the hospice said they’d have one in a couple days. The hospice came up with a plan of care, but when I read it, it was awful; it was completely canned text and wasn’t even accurate. So I told the facility the hospice was going to have to document a care plan that was correct, or the facility would have to come up with their own plan of care. They kept arguing with me that they didn’t have to have one because the regs say they don’t need one if the resident is on hospice. I couldn’t explain to them that it had to be a plan of care that actually had substance and was correct. Then the resident actually died before we could get any further, so it became a moot point. So if someone’s on hospice, then the hospice needs to have a plan of care to address whatever is going to be done or not done for them. I wish the regs were more clear on that.</td>
<td>Karen Besaw</td>
<td>No Change</td>
<td></td>
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<td>10.07.14.19</td>
<td>Delete “to a sufficient number of staff”. Just make it so that CPR is required for everybody.</td>
<td>Karen Besaw</td>
<td>No Change</td>
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<td>10.07.14.19</td>
<td>Everybody should have CPR, period. How about these facilities where there’s only a couple staff. And someone has an emergency and the one person who knows CPR is tied up? Make all staff working in an ALF be CPR certified, period.</td>
<td>Karen Besaw</td>
<td>No Change</td>
<td></td>
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<td>10.07.14.19</td>
<td>Para G – Training in cog imp and mental illness. For one thing, almost no one teaches anything about mental illness (as I mentioned earlier). Has anyone looked at where people are supposed to get the specific training we list on pgs 69-70 (iia), (ib), (ii), (iii), (iv), (v). (vi), (ii), (iii), (iv) [and a bunch of others]? Somebody needs to take a look at this.</td>
<td>Karen Besaw</td>
<td>No Change</td>
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<td>10.07.14.19</td>
<td>I’ve gone to lots of dementia training (including the state-sanctioned course given jointly by the Towson Alz. Chapter and the Mental Health Assoc. of Maryland), and nobody is teaching these things. So where are they supposed to learn them from? And by the way, the regular Alzheimer’s Assoc. (the head of all the chapters in Chicago) doesn’t teach a thing about mental illness at all in their classes! They don’t even teach cognitive impairment. I believe it’s all specific to Alzheimer’s dementia! And probably Copper Ridge doesn’t either, but we tell people on our website to take classes from them. If we require them to get that training, who’s going to provide it? Has this been worked out with the Maryland Higher Education Commission already? And what happens when they cancel the class because not enough people signed up? Just wondering…</td>
<td>Karen Besaw</td>
<td>No Change</td>
<td></td>
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<td>10.07.14.19</td>
<td>J(1) – 20 days. I think it should be 30. We’re always overloaded. I just don’t think 20 days is right. We may need more time than that.</td>
<td>Karen Besaw</td>
<td>No Change</td>
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<tr>
<td>10.07.14.19</td>
<td>(2)(b) – 5 days. Should be 10 days. We’re always overloaded. I just don’t think 5 days is right. We may need more time than that.</td>
<td>Karen Besaw</td>
<td>No Change</td>
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The MDoA staff found the changes in this regulation confusing. Sections A and B were particularly confounding. A reader of Regulations .19A and B could conclude that Regulation .19B is a complete list of the admission prohibitions and that Regulation .19A is a complete list of the services prohibitions. However, that interpretation is challenged by Regulations .19C and D, which at least suggest that the admission criteria in Regulation .19B are also service prohibitions. That interpretation is also challenged because, if one cannot provide services to someone under Regulation .19A, it would seem that that person should not be admitted under Regulation .19B. The wording is confusing. As presently drafted, Sections A, B, C, and D read as though they are coming from different directions: Section A about services and Section B about admission standards. We found it quite difficult to figure out how they would work in tandem until we realized they were probably just two lists: one of “waiveable” conditions and one of “non-waiveable” conditions. We believe that the basic intent is that, subject to the possibility of a waiver for .19B categories, a provider may neither admit nor provide services to a person in the nine categories listed in Regulations .19A and B. If that is the intent, it needs to be made more apparent to the reader. There are a number of ways that this could be done. One approach would be to begin both Sections A and B with the phrase “Except as provided in Section .19A and B, an assisted living program may not admit or provide services…” Opening both Sections with the same phrase will help readers understand that the provisions work in tandem; that one contains conditions for which a resident specific waiver can be obtained and the other addresses conditions for which a waiver cannot be obtained. Another solution would be to consolidate Sections A and B into a new Section A that begins with the phrase “Except as provided in Section .19A and B, an assisted living program may not admit or provide services…”

There is a problem with ALs getting rid of residents deemed “dangerous” when it is probable that 1) sensitive de-escalating approaches have not been implemented or 2) the resident has not had appropriate behavioral health treatment or 3) the AL wants the resident out and uses the term dangerous without warrant or 4) staff do not know how to work with the individual.

Resident Specific Waiver. We are concerned that this definition allows for subjective determinations by assisted living provider of when an individual is “dangerous” and what “appropriate treatment modalities” are.

We are also concerned that section A(2) is vague and leaves a determination of “high risk” solely to an assisted living manager. The determination that a resident is “at high risk for health or safety complications which cannot be adequately managed” is a medical determination and as such should require a physician certification that a resident meets this criterion.

Entry level for direct care staff in health care should be a certified nursing assistant whether it be in skilled nursing, hospitals, assisted living, congregate housing or home care. Certification can also ensure a standardized level of training. When direct care staff are fired due to incompetence they can be rehired again by another facility, but if they were certified action could be taken against their certification to ensure they are not rehired.

There are a number of ways that this could be done. One approach would be to begin both Sections A and B with the phrase “Except as provided in Section .19A and B, an assisted living program may not admit or provide services…” Opening both Sections with the same phrase will help readers understand that the provisions work in tandem; that one contains conditions for which a resident specific waiver can be obtained and the other addresses conditions for which a waiver cannot be obtained. Another solution would be to consolidate Sections A and B into a new Section A that begins with the phrase “Except as provided in Section .19A and B, an assisted living program may not admit or provide services…”
10.07.14 B.8.e About Basic First Aide and CPR. These are 2 separate issues, and should be addressed separately. Basic First Aide should not be required of licensed nurses (LPNs and RNs), since it is taught in every nursing school, and very basic for nurses. It is fine to require it of non-nurses, but nurses should be exempt from First Aide every year. Also, online courses of First Aide are very good and should be allowed. For CPR training—it shouldn’t say ‘Annual’ since CPR cards are good for 2 years. It should just say ‘current CPR certification’.

I am an American Heart Association former CPR and First Aide Trainer, and an RN. The above recommendations would make more sense in the regulations! Thank you!

January Peterson
The Village at Rockville
No Change.

10.07.14.20 Delegating Nurse
C. The delegating nurse shall be on site to observe each resident every 45 days. Facilities are not doing the 45 day assessments. The facilities claim that since the nurse may be an employee the 45 day reviews are not necessary, or that since the staff are LPNs the delegating nurse is not delegating the act of giving medications. They forget that the LPN cannot do a complete assessment on his or her own and there is no way to show that the delegating nurse is involved in the care of the Resident if there is not note or document written.

Marianne Uphold
Private Citizen
No Change.

10.07.14.20 No one but the team from the Assisted Living facility should determine a resident’s be admitted or returned to the facility. Taking into consideration input and recommendations should be considered, but not mandated.

The owner and or manager should know what is going to be in the best interest of the resident, the staff, and other residents. What’s working and what is not.

Marc Simms
Beyond Care
No Change.

10.07.14.20 Medicaid Waiver participants will in the future have the protections of landlord tenant law as required by CMS. This will create a great disparity in the rights of residents who are not Waiver participants. A model resident agreement is being developed to address necessary protections. While it may be necessary for the current regulation revision process to move forward without addressing this issue, it is critical that DHMH and OHCQ address this critical issue with regard to COMAR 10.07.14 in the near future.

The regulations do not sufficiently provide for discharge protections for residents. There is a lack of sufficient safeguards to ensure resident rights and safety as provided for in appropriate discharge planning.

Jane Wessely
Private Citizen
No Change.

10.07.14.20 Recommend deleting language: … the availability of locks, [if any,] for the resident’s rooms.

Residents should have the right to privacy in their room. Providers for residents in the Medicaid Community Options Waiver will be required to provide locks for individuals’ rooms, unless there is a health and safety issue for a specific individual. Having some residents in the same facility without the right to privacy allowed for residents in the Medicaid Waivers, will be very inequitable and difficult to manage for the providers.

Jane Wessely
Private Citizen
Agree

10.07.14.20 Recommend deleting language: “The staff's right, if any, to enter a resident’s room.”

Consider alternative language such as: Circumstances under which staff may enter a resident’s rooms without their permission.

Residents should have a right to privacy in their room.

Jane Wessely
Private Citizen
Agree

10.07.14.20 Add that resident should have a choice of roommates whenever possible.

The resident should have the right to make as many independent life choices as possible.

Jane Wessely
Private Citizen
No Change.

10.07.14.20 Change wording to read: “…short-term respite care…”

I'm not going to keep citing this. Please change it everywhere it needs to be in this document.

Karen Buzaw
Private Citizen
No Change.

10.07.14.20 All should be required to submit their admission’s contract for approval before it can be used.

OHCQ review of the admission’s contract will hopefully ensure that it complies with all relevant laws and regulations, and that it will be understandable and fair to the resident.

Stevanne Ellis
Office of the State Long Term Care Ombudsman
No Change.

10.07.14.20 Change the second (b) at the bottom of the page to (c).

As written, there are two “(b)”s under item (9).

Kristen Neville
DHMH - Health Occupations Boards
Agree.

10.07.14.20 Insert a requirement that deceased individuals be removed from a facility in accordance with COMAR 10.29.21.

COMAR 10.29.21 refers to the required permitting of a Mortuary Transport Service by the Board of Morticians and Funeral Directors. To clarify my previous comments on this subject, the Board inspects all vehicles that are used in the removal and transport of human remains and that are owned by a licensed funeral establishment or by a permitted mortuary transportation company. Those vehicles that pass inspection are issued a sticker to prominently display on the vehicle. Human remains should only be removed and transported in a vehicle that displays the Board-issued sticker. Please include language in this chapter that is consistent with language in the Long-Term Care regulations, requiring that human remains be removed from a long-term care facility in accordance with COMAR 10.29.21.

Kristen Neville
DHMH - Health Occupations Boards
No change.
10/07/14 A
Except as otherwise provided under E of this regulation, for a person admitted for other than short-term residential care, the resident or the resident’s agent and the assisted living manager shall, before or at the time of a admission, consent to a resident agreement that:

- Change this to read the assisted living manager or designee.

10/07/14 D
Delete the text at the top of page 70 (items (8) and (9)) which is the same as text at the bottom of page 69.

10/07/14 D D.6 d ALM Owners need clarification and example of type provision can be used to emergently discharge resident whose needs cannot be met by facility even if licensed at highest ALF levels. Nurses need to be given opportunity to review medical documentation depending on hospital location nurses should be given opportunity to review medical documentation of residents Oftentimes delegating nurses are not informed that residents are / have been discharged from hospitals until after the fact. often hospitals just call ALF and say pt being discharged without giving and previous medical update even if update requested

10/07/14 D(1) The requirement for “a listing of those services the program does not provide,” while a carryover from the current regulations, seems likely to cause confusion. There are thousands of services that could be listed that an AL facility does not provide, e.g., pedicures, Tai Chi classes, cocktails before dinner. Would it make more sense for it to read something like “a listing of personal care and health care services the program does not provide”? Alice Hedt MD Department of Aging Agree

10/07/14 D(3) The reference here and throughout to “domestic partner” may be obsolete in light of recent legislative enactments.


10/07/14 B
Add wording to make it “known allergies to medications, foods, and environmental factors.” It’s already talked about this one before — where the manager had the social worker at the nursing home declare her the Medicare Representative Payee of the resident, then took all the woman’s money and never paid her pharmacy bill. Then I’ve gone to a few places where the manager (who was the RN/DN) refused to pay for several residents’ pharmacy reviews, and the resident agreement said nothing about who would pay for them if the resident didn’t have the money. The ALM/DN told me the family refused to pay for them, and so she refused also?

10/07/14 B In .21 B(1) the word “agent” is changed to “representative.” Please see MDaA’s comment on this proposed change in Comment A above. In .21 B(2) the proposed changes include adding notice to “the Department of Aging and Adult Protective Services.” Consumers will get quicker assistance, and hence better assistance, if this is reworded to say, “the local area agency on aging and the local adult protective services office.” Alice Hedt MD Department of Aging No Change.
<table>
<thead>
<tr>
<th>Date</th>
<th>Note</th>
<th>Approved By</th>
<th>Document Ref.</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.07.14</td>
<td>D.3 D.3 (k) should ensure the resident’s choice regarding services and providers to the extent possible. This concept of resident involvement is important and should be reflected in the form.</td>
<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.3(k)</td>
<td>Agree and re-wrote to add resident's preference.</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Recommend adding language: D.1(4d) so that the concept of resident involvement espoused in the definition of “Service plan,” 10.07.14.02 (76), is actually implemented during the service plan development.</td>
<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
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<td>10.07.14</td>
<td>Recommend adding language: D.1(4d) so that the concept of resident involvement espoused in the definition of “Service plan,” 10.07.14.02 (76), is actually implemented during the service plan development.</td>
<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
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<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
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<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
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<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
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<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
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<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
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<td>Lynne McCamie, Baltimore county Ombudsman Program</td>
<td>.22 D.1(4d)</td>
<td>No Change.</td>
</tr>
</tbody>
</table>
10.07.14.22 A  We recommend that the following language be added in section .22 (A) so that the concept of resident involvement espoused in the definition of “Service plan”, 10.07.14.02 (7), is actually implemented during the service plan development.

The manager, or designee, shall ensure that all services are provided in a manner that respects and enhances the dignity, privacy, resident choice, resident capabilities, individuality, and independence without compromising health or reasonable safety of other residents.

Lynn McCanne
ombudsman_Baltimore County
Agree.

10.07.14.22 C  Suggest Service Plan with new Service Plan form

Section C of Proposed Regulation .22 makes the Service Plan form optional as long as equivalent content is achieved. This does not seem synchronized with the new definition of Service Plan and the new Service Plan form that is incorporated by reference in Regulation .03. They do not seem to make the form optional.

Lynn McCanne
ombudsman_Baltimore County
Follow-up required once forms are finalized.

10.07.14.23  Recommend adding language to (1) ... of a resident’s medical records and medical information;

Residents have the right to privacy concerning their protected health information. Medicaid staff have observed as well as received complaints regarding non-private discussions of resident’s medical conditions, treatments, etc. by ALF staff. This includes posting of residents’ medications and other PHI in areas accessible to anyone in the facility.

Jane Wesely
Private Citizen
Agree.

10.07.14.23  Make it “Current signed medical orders.”

Because just about nobody has current orders for the meds those residents are on. They only have initial med orders. So if you don’t require it, they won’t do it.

Karen Besaw
Private Citizen
Agree. Addressed in regulation. Section for .25 LifeSpan

10.07.14.23  Define “hospitalization” as being admitted to a floor AS WELL AS going to the ED/urgent care when they come back with meds changed or specific instructions for care.

Because they’re only doing re-assessments if they get admitted to a hospital floor. They don’t consider trips to the ED/urgent care as a hospitalization.

Karen Besaw
Private Citizen
No Change.

10.07.14.23  Make it clear that a separate note is to be written when the resident has a medical appointment; to include what the date was, what the outcome was, did anything change as far as the service plan goes, etc.

Because they don’t write separate notes for this. They mention it in the weekly care note, but you can’t tell what date the aptt was on or what the outcome was because they don’t record that. This is also important for QA review time because if it’s not documented anywhere, you could miss many things about the resident.

Karen Besaw
Private Citizen
No Change.

10.07.14.23  If a facility writes “progress notes” do they still have to write “care notes?”

We ran into this with larger facilities often. The care notes are generally awful. But the DR or others may be recording progress notes as well. Do we take either, or do they HAVE to have care notes?

This should be clarified.

Karen Besaw
Private Citizen
No Change.

10.07.14.23  Maintain a record for 5 years. I thought for Medicaid Waiver it was 6 — ?

Karen Besaw
Private Citizen
No Change.

10.07.14.23  Require ALFs to have an MAR for each resident which lists, at a minimum, all medications, reasons for all medications, diagnoses, and allergies.

Almost no provider makes sure that MARs have reasons for all meds. And a lot of them leave the allergy section blank.

And it’s good to have the diagnoses appear there because then we can check them with the medications, the diagnoses listed on the RAT, the service plan, etc.

Karen Besaw
Private Citizen
No Change.

10.07.14.23  (1) Require that ALL their caregivers have access to the resident records and must be trained by the manager so they’re able to show everything to the surveyors as soon as they request it.

(2) Include that they must keep all initial paperwork in the current record.

We go out and nobody there knows where the records are and they can’t get hold of the manager.

Karen Besaw
Private Citizen
No Change.

Karen Besaw
Private Citizen
No Change.

10.07.14.23  Amend this section to reflect use of electronic records.

Danna Kauffman
LifeSpan
Agree.

10.07.14.23  Page 102, delete weekly care notes and make it monthly care notes similar to other industries. In addition, the list that triggers a more frequent care note is too expansive and should not include “non-routine leaves of absence” for what is that? or when seen in home by any health care provider. The provider performing the service is already required to leave a note. This is high priority for LifeSpan.

Danna Kauffman
LifeSpan
Agree. Change from weekly to monthly.

10.07.14.23  Assisted Living Facilities that have None’s 24 hours a day, 7 days a week and a Nurse Practitioner 3 days a week, and an RN Monday through Friday 8 hours a day, is a 45 day assessment going to continue to be necessary? Additionally, all orders are reviewed and transcribed by nurses, do weekly notes have to be completed?

Frances Wiland
Pickersgill Retirement
No Change.

10.07.14.23  “new section” between existing (7) “Medical Orders for...” and (8) “Pharmacy reviews, etc.”

(6) Monthly Weight Monitoring

“Appendix A: How to Identify a Significant Change of Condition” page 28 states “At a minimum, weights should be taken monthly.” Since monthly weights are required to evaluate for significant change, they should be included in the regulations text directly.

Phyllis McShane
Maryland Department of Health Care Communities
Agree.
<table>
<thead>
<tr>
<th>Date</th>
<th>Comment</th>
<th>Author</th>
<th>Organization</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.07.14</td>
<td>The list of documents to be included in a resident’s record should include an advance directive if the resident has one.</td>
<td>Alice Hodi</td>
<td>MD Department of Aging</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Eliminate weekly care notes</td>
<td>Danna Pintero</td>
<td>Country Meadows</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Recommend deleting language: three meals [in a common dining area].</td>
<td>Jane Wessely</td>
<td>Private Citizen</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Recommendations and wording during the evening hours each 24-hour period.</td>
<td>Private Citizen</td>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Recommend adding language: snacks or food supplements during the evening hours each 24-hour period.</td>
<td>Private Citizen</td>
<td></td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Recommend adding language: as determined in the resident assessment and according to resident preferences, including...</td>
<td>Private Citizen</td>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Recommend adding language: ...and leisure activities which reflect resident choice and preferences and which promote the...</td>
<td>Private Citizen</td>
<td></td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>C. Nursing services: “...delegating nurse or case manager...” Change wording to “delegating nurse.” Just make sure you define delegating nurse as the delegating nurse/case manager in the definition section. Then stop repeating the whole long thing and just say “delegating nurse.”</td>
<td>Karen Brown</td>
<td>Private Citizen</td>
<td>Addressed: The terms, “case manager/delegating nurse,” “delegating nurse/case manager” have been removed. These terms are replaced by the term “delegating nurse”.</td>
</tr>
<tr>
<td>10.07.14</td>
<td>RESTORE Subsection (2) (a) (b) and (c) in their entirety and in (2e) REPLACE “licensed dietitian or nutritionist” with “LICENSED REGISTERED DIETITIAN”, DELETE the proposed language under new subsections “(2)” and “(3)” in their entirety.</td>
<td>Gill LeVeen</td>
<td>Maryland Academy of Nutrition and Diets</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Delete that menus have to include portion sizes, which is an impossible standard given that the requirement must be tailored to each resident on the menu.</td>
<td>Danna Kauffman</td>
<td>LifeSpan</td>
<td>Agree</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Delete Section (B) on special care needs as redundant.</td>
<td>Danna Kauffman</td>
<td>LifeSpan</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Add a new section after section (e): “Residents have access to snack...” as “A Copy of the State Diet Manual, free of charge as a download, shall be available for resident and family review.”</td>
<td>Phyllis McShane</td>
<td>Maryland Dietetics in Health Care Communities</td>
<td>Agree</td>
</tr>
<tr>
<td>10.07.14</td>
<td>(1) The manager shall ensure that: Recommendation - Add a new section after section (e): “Residents have access to snack...” as “A Copy of the State Diet Manual, free of charge as a download, shall be available for resident and family review.”</td>
<td>Phyllis McShane</td>
<td>Maryland Dietetics in Health Care Communities</td>
<td>Agree</td>
</tr>
<tr>
<td>10.07.14</td>
<td>(b) Meals and snacks section – instead to read as: Meals and snacks are well-balanced, varied, palatable, properly prepared and of sufficient quality and quantity to meet the daily nutritional needs of each resident based on the USDA Dietary Reference Intake (DRI) with special...</td>
<td>Phyllis McShane</td>
<td>Maryland Dietetics in Health Care Communities</td>
<td>Thank you for the comment. In response ORCQ has re-written this section.</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Retain (DO NOT REMOVE) the section entitled “(2) Menus”, but change language to: (a) Menus shall be written at least 1 week in advance... (b) Menus shall be maintained on file, as served for 90 days in compliance with COMAR 10.15.13. (c) As part of the licensure approval and renewal process, an applicant shall submit a 4-week menu cycle with documentation by a licensed registered dietitian that the menus are nutritionally adequate. The licensed registered dietitian shall review menus on quarterly visits to the facility.</td>
<td>Phyllis McShane</td>
<td>Maryland Dietetics in Health Care Communities</td>
<td>Agree with (a) and (b)</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Change language from “special diets” to “therapeutic diets” Recommendation – (c) Change wording of this section to: “Document special diets in the resident’s record. The licensed registered dietitian shall review therapeutic diets on quarterly visits to the facility.”</td>
<td>Phyllis McShane</td>
<td>Maryland Dietetics in Health Care Communities</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14</td>
<td>Change the language to: (a) “Dietary consultation and services”. Quarterly visits by a licensed registered dietitian shall (at least include) review of menus, kitchen sanitation, therapeutic diets, residents with stage 3 or 4 débilities breakdown, residents receiving enteral (tube) feedings and monthly weight records for all residents.</td>
<td>Phyllis McShane</td>
<td>Maryland Dietetics in Health Care Communities</td>
<td>No Change</td>
</tr>
</tbody>
</table>
10.07.14.24 Change sentence to read: “Other specialty health, including behavioral health and social work services such as residents with mental illness and/or cognitive impairment.”

We feel it is important to underscore behavioral health services. If, for example, an individual needs substance abuse services, this would be necessary to facilitate but doesn’t fit under the terminology throughout this section unless we can include “behavioral health” in this section.

Kim Burton Mental Health Association of Maryland Agree

10.07.14.24 Based upon the above MD DHCC recommends the addition of quarterly visits by a licensed registered dietitian to facilities of 30 or more residents. Facilities of smaller size would need to consult a registered dietitian prior to submitting requests for waivers for residents on dialysis, tube feedings, intravenous nutrition feedings or with stage 3 (or higher) decubitus and any one with unplanned weight loss of > 10% in a three month period. MD DHCC further suggests that OHCQ consider setting up a small task force that would allow ALF providers to meet with MD DHCC to develop a easy to use screening mechanism for facilities of less than 30 residents for ongoing weight change monitoring and intervention.

Physio. McShane MD DHCC No Change

10.07.14.24 The citizens of Anne Arundel county currently residing in Assisted Living Facilities deserve to be provided with a nutritionally adequate meal as required by COMAR 10.07.14.24 Services. This regulation states that as part of the licensure approval and renewal process, all licenses of Assisted Living Programs in Maryland must submit a 4 week cycle menu with documentation by a licensed dietitian or nutritionist. Removing this requirement will be detrimental to the County and the State. This is why I oppose the proposed revision of the regulation that will remove this current requirement.

Steven Schuh Department of Aging and Disabilities No Change

10.07.14.24 We believe that our aging population deserves the maximum level of protection afforded by the law. The proposed revisions should be rejected, retaining the protective provisions of COMAR 10.07.14.24 Services which are currently in effect.

At the direction of Count of Executive Steve R. Schuh, we are writing to express our opposition to changes in the Assisted Living Program regulations proposed in COMAR 10.07.14.24 Services. We are extremely concerned that these changes eliminated nutritional standards in Maryland’s assisted living facilities. In Anne Arundel County alone, there are currently 106 licensed assisted living facilities, home to perhaps our most vulnerable populations. To the detriment of these residents and their families, the proposed revisions replace concise, enforceable language with vague standards, subject to interpretation by the operators of these facilities and the regulators alike. As regulators, it is imperative that we have the tools to ensure that operators are serving nutritious, balanced meals and that the appropriate dietary records are developed and maintained. As proposed, the language eliminates some of these provisions and renders other virtually unenforceable.

Pamela Jordan Department of Aging and Disabilities Thank you for comment. In response OHCQ has re-written this section.

10.07.14.24 A MDDoA supports the views expressed by the Maryland Academy of Nutrition and Dietetics in their written comments, dated June 23, 2015. Our Department concurs with the suggested language, which clarifies and strengthens issues related to meal service, menus, and overall nutritional care in these settings.

Alice Hedt MD Department of Aging No Change

10.07.14.24 A(1) This sentence has no subject.

Alice Hedt MD Department of Aging Agree: Change to Program or License

10.07.14.24 A(2) MDDoA does not believe that the requirement for keeping menus on hand should be reduced from two months to one month. Likewise, we do not believe that the requirement that there be “documentation by a licensed dietitian or nutritionist that the menus are nutritionally adequate” should be eliminated. Without this requirement, how will we know residents are receiving nutritionally adequate meals? The training providers receive is not equivalent to that of a licensed dietitian/nutritionist. Removing this requirement will serve only those providers who fail to observe nutritional requirements. Many of these providers are repeat offenders and require continuous monitoring and investigation due to complaints. While obtaining approval from a licensed dietitian or nutritionist costs money, we have seen so many problems with food that we believe this regulation remains necessary.

Alice Hedt MD Department of Aging No Change
<table>
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<tr>
<td>10.07.14.24 A(4)</td>
<td>Special Diets INSERT a new (ii) ARRANGE for at least Quarterly Visits by a Licensed Registered Dietitian, AND</td>
<td>Gill Livleen</td>
<td>Maryland Academy of Nutrition and Dietetics</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.24 F</td>
<td>INSERT after &quot;services&quot; in (8) &quot;PROVENED BY A LICENSED REGISTERED DIETITIAN ON AT LEAST A QUARTERLY BASIS&quot;:</td>
<td>Gill Livleen</td>
<td>Maryland Academy of Nutrition and Dietetics</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>&quot;Can be complex&quot; should that be the case let it be the decision of the owner with input from the DO or possibly their HCP to have more frequent consultations. It should remain a minimum of 6 months with discretion per resident if need presents itself to be sooner not mandated.</td>
<td>Mar Simon</td>
<td>Beyond Care</td>
<td>Agree. Will remain 6 months.</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>Change &quot;delegating nurse or case manager&quot; again.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>I did this earlier, but I'll put it here again. You need to require that each resident has an MAR, which shall contain at least the meds the resident is on, reasons for the meds, diagnosis, and allergies.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>Change wording to: Two staff shall count and sign the name...</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>It should be left up to them how to do it. It should be according to how the Div. of Drug Control says.</td>
<td>Karen Besaw</td>
<td>Private Citizen</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>Residents should have the choice to have privacy when taking medications, and they should be in a secure locked place when a resident self-administers.</td>
<td>Stevannie Ellis</td>
<td>Office of the State Long Term Care Ombudsman</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>Change &quot;their health care provider&quot; to &quot;DN/CMC&quot; for documenting the resident’s competency and ability to safely administer medications to their spouse or domestic partner.</td>
<td>Danna Kauffman</td>
<td>LifeSpan</td>
<td>Agree</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>Delete prohibition against allowing for interim medications. In addition, given the cost of medication, we request discussion on providers being allowed to maintain stock medications for &quot;PRN&quot; use, such as Tylenol. In comprehensive care facilities, there are acceptable over the counter medications that can be purchased in bulk - Memo Dated October 13, 2010. Can this list extend to assisted living providers?</td>
<td>Danna Kauffman</td>
<td>LifeSpan</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>We recommend changing the review requirement from every 6 months to every 3 months for any resident receiving 9 or more medications.</td>
<td>Kim Burton</td>
<td>Mental Health Association of Maryland</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>(b) Narcotics and controlled drugs be destroyed as directed by regulation.</td>
<td>Gayle Walter</td>
<td></td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25</td>
<td>The Consultant Pharmacist must be able to independently review all patient charts even if the patient is not using the Provider Pharmacy. This does not imply that the Consultant Pharmacist must be an independent practitioner. He or she may be an employee of the provider pharmacy. The important fact is that the Consultant Pharmacist is able to do a comprehensive review of all charts for all patients. In addition and in a supporting statement, the Consultant Pharmacist must have full access to the EHR for all patient records, with special reference to Transitions of Care and PDMP.</td>
<td>David Jones</td>
<td>Board of Pharmacy</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25 F</td>
<td>Suggest 3 day rather than 14 day time frame.</td>
<td>David Jones</td>
<td>Board of Pharmacy</td>
<td>No Change</td>
</tr>
<tr>
<td>10.07.14.25 F</td>
<td>Medication Review upon admission: (1) states (the assisted living manager shall consult with 14 days of a resident's admission with the individuals set forth in GC) of this regulation; (2) of this regulation.</td>
<td>Patricia Anderson</td>
<td>Brooke Grove Foundation, Inc</td>
<td>No Change</td>
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</tbody>
</table>
| Date       | Comment Type          | Comment | Author | Organization | Change
|------------|-----------------------|---------|--------|--------------|--------
| 10.07.14.25 G | Pharmacy Review | Support a review every 3 months, not 6, and regardless of number of medications. | David Jones | Board of Pharmacy | No Change
| 10.07.14.25 G.1 | Pharmacy Review | Instead of having a pharmacy review every 6 months, why not have resident's PDM do a medication reconciliation with each visit. This is what the hospitals are doing. | Robin Peace | | No Change
| 10.07.14.25 I | For the triple check, suggest that “Refer to MAR” on the label is appropriate especially when directions may change. | David Jones | Board of Pharmacy | No Change
| 10.07.14.25 Lh | Labelling: Deleted “refill limits,” any such information should be on the POS. | Dina Campanella Cooper | Pickersgill Retirement | No Change
| 10.07.14.25 J | 1. No pill boxes for self medications - | | | | No Change
| 10.07.14.25 J | This new provision would prohibit a facility from having interim medications, which are defined in Regulation 02B. Is this supposed to prohibit just prescription medications or, for example, having aspirin or Neosporin on hand? Please consider clarifying the wording. | Alice Hoth | MD Department of Aging | Remove statement that facilities may not have interim medications.
| 10.07.14.25 J | A program may not have interim medications. | Constance Smith | Mercy Ridge, Inc. | Remove statement that facilities may not have interim medications.
| 10.07.14.25 J | The proposed regulation under medications, {021} .25 MI I states no interim medications box. We find it necessary as even STAT deliveries are at a minimum of 4 hours. Having an interim box can alleviate this IR visit. | Pam Harris | Mercy Ridge | Remove statement that facilities may not have interim medications.
| 10.07.14.25 O | Question the title “controlled dangerous substance” since much of the data does not relate specifically to CDS. | David Jones | Board of Pharmacy | Agree. Changed to “Required Documents”
| 10.07.14.25 P | Delete the word “mucostics” C-II and II contain non-opioid drugs. | David Jones | Board of Pharmacy | No Change
| 10.07.14.25 S | Insert language permitting the storage of medication in a refrigerator that is not also used for the storage of food, drink, etc. | Kristen Neville | DIMHS - Health Occupations Boards | No Change
| 10.07.14.26 | 26 Service Plan | (i) more specifically define a “change in condition.” 28 Services D. Personal Care Services (4) Toileting – specific about supplies needed in the Resident bathroom to provide for this need. Toilet paper, soap, towel | Marianne Uphold | Private Citizen | No Change
| 10.07.14.26 | Propose new B: | The person-centered service planning process should be driven by the resident to the degree possible. | Jane Wessely | Private Citizen | No Change
| 10.07.14.26 | Recommend adding a D.41. The service plan must clearly document reasons for any exceptions to resident-specific regulations regarding resident rights, such as the right to door locks, based on an individualized assessment of the resident’s health and safety. | Jane Wessely | Private Citizen | No Change
| 10.07.14.26 | Include other dementias to the language | Language not clear and consistent throughout sections E.F.G. | Lynne McCamie | Baltimore County Ombudsman Program | No Change
| 10.07.14.26 | Change the title, it’s a terrible misnomer. | This section doesn’t just talk about the service plan, it has to do with the RAT and nursing assessment also. | Karen Bosaw | Private Citizen | No Change
| 10.07.14.26 | Are (2) – 30 hours? “A course…” just one? It can’t be a series of courses taken at different places? Has anybody checked this out? Are these places you can get that many hours? Because I don’t know of any…just wondering. | Karen Bosaw | Private Citizen | Agree. Sec. 26 A (2)
| 10.07.14.26 | I think the person who heads an Alzheimer’s unit should be a different person than the facility’s ALM, and I’m not sure this wording communicates that. | Karen Bosaw | Private Citizen | No Change
| 10.07.14.26 | I saw that the pharmacist was pushing their service to visit the homes more frequently. This service should be done on as needed basis. | Dawn Backmore | Caribbean Breeze Assisted Living | No Change
10.07.14.26 Are there going to be any requirements for where they get this 20 hours of training? Are 100% online courses ok? Because I don’t know where else they’d get this many hours... Sounds like a good idea but... Karen Besaw Private Citizen No Change.

10.07.14.26 You need to include wording that at the time of initial licensure they have to show to us whatever we state we want to see! So you need to include statement (12) “Any other information that the Department may require” not just for relicensure time (cf’s on p 117), but for INITIAL licensure! I’m going through this right now with one of the Sunrise facilities. They don’t have a clue what they’re doing with the special unit they just built. The ALM knows nothing, and they have nobody except the recreational therapists who understand anything about dementia or how to run a dementia unit. So I plan on requiring them to submit to me admission and discharge protocols, and a few other things – like protocols for how they’re going to handle that hot stove that all the residents have access to in the middle of the night when no staff is around? Karen Besaw Private Citizen No Change.

10.07.14.26 Change wording to read “…full assessment of the...” to “…full and accurate assessment of the...” Also, spell out what a “full assessment” means. Are we still using the Pilot RAT and Pilot Service Plan? Or just the old 3-part RAT/nursing assessment/service plan - ??? It should specify exactly what constitutes a “full assessment” because providers interpret this differently. Karen Besaw Private Citizen No Change.

10.07.14.26 Add wording to say “…shall be conducted and documented by the DN’s name and date of assessment every...” It’s not enough to conduct an assessment. They need to document that they did it through their signature and date. Otherwise we can’t tell what they did or when. Karen Besaw Private Citizen No change.

10.07.14.26 You need to specifically require that ALFs should address each diagnosis that a resident has. And a diagnosis includes anything they’re getting with meds for. Unless you specifically require certain things, it’s going to be like it was before the Pilot Service Plan, where those service plans ALFs came up with on their own were an absolute MESS, and addressed nothing. Karen Besaw Private Citizen No change.

10.07.14.26 Add wording to say that if the resident comes in with, or shortly thereafter develops dangerous or sexually inappropriate behavior just after admission, that you MUST document a service plan immediately, you don’t get 14 days! I just did a place where it was documented by the physician at a nursing home that a male resident displayed inappropriate sexual behavior toward females. So they admit the guy but the DN doesn’t document anything about that on her assessment, and she doesn’t do a service plan. Then the guy beats up his roommate on the first day there. The roommate was sent to the hospital and died a week later from his injuries. Then the guy makes inappropriate advances to two females there. Finally, he gets a knife and tries to kill one of the male staff. They had to call the police to disarm him and they sent him off to the hospital for a psych eval and wouldn’t take him back. So in the whole two weeks that the guy was there the DN didn’t bother documenting anything about any of that behavior on a service plan, nor did she come up with any plans to keep the other residents safe – because she felt COMAR gave her 30 days to do a service plan, so she didn’t do one. So if you give someone 14 days, you better add “or soon as the behavior warrants.” Karen Besaw Private Citizen No change.

10.07.14.26 The inclusion of this new unit and its requirements are strongly opposed by LifeSpan and cannot be administered by the programs. Most troubling are the requirements for and education levels needed of a coordinator, the number of training hours for both the coordinator and other staff (page 114) and the prohibition against using a universal worker (page 115). Donna Kaufman LifeSpan No Change.

10.07.14.26 It is recommended that the training requirements be 8 hours for both initial and annual timeframes. A specific definition of “primary responsibilities” is requested. Re-assessment of delineation of medication technician’s direct care staff’s duties is requested. The increased, initial training requirement may increase expenses re: additional training hours. The delineation of tasks may increase staffing needs re: additional staff to complete specific duties and increase expenses/day rates. The role of a “universal worker” will be decreased, thus limiting staff’s abilities for career development, i.e. caregiver growth to certified medication technician. *If current responsibilities, i.e. laundry, are re-assigned to another position, there is an increased cost factor. Based on the current staffing patterns of our memory care communities (which currently exceed the requirements), the estimated, increased expenditures follow: One laundry aide hired on two shifts Average wage per laundry aide - $10.00 per hour Benefits factor - 30% Estimated, annual cost per facility - $72,000 per year Susan Hirsch HCR ManorCare No Change.
It is recommended that the training requirements be 8 hours for both initial and annual re-certification. A specific definition of "primary responsibilities" is requested. Re-assessment of delineation of medication technician's/direct care staff's duties is requested. The increased, initial training requirement may increase expenses re. additional training hours. The delineation of tasks may increase staffing needs re. additional staff to complete specific duties and increase expenses/home rates. The role of a "universal worker" will be decreased, thus limiting staff's abilities for career development, i.e. caregiver growth to certified medication technician. If current responsibilities, i.e. laundry, are reassigned to another position, there is an increased cost factor. Based on the current staffing patterns of our memory care communities (which currently exceed the requirements), the increased expenditures follow: One laundry aide hired on two shifts Average wage per laundry aide - $10.00 per hour Benefits factor – 30% Estimated, annual cost per facility - $72,000 per year

The recommendation is to include the wording "anyone passing meds" as the LPN, RN or CMA could be passing meds. Include wording "unless there is an emergency or the individual receiving the medication requests something from the medication administration office of the State Long Term Care Ombudsman. The designee is not referenced as part of the team to view the Service Plan. The service plan is developed within 30 days of admission to the program; and

When the resident census includes with or more residents, the recommendation is to allow the Coordinator, Delegating Nurse or Case Manager to determine staffing levels based on the enhanced service plan requirements and in-house skill set.

Certified medication technicians shall not be responsible for any direct care activities while administering medication during the assigned times. Direct care staff shall not have housekeeping, laundry, food preparation, or maintenance duties as primary responsibilities.

The following recommendations are made:

- Allow ample time to become familiar with resident, hopefully engage residents and support system if they have one.
- The service plan is developed within 30 days of admission to the program; and
- The staff levels should be determined based on the need and not on numbers.

The designee is not referenced as part of the team to view the Service Plan. The service plan is developed within 30 days of admission to the program; and

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When the resident census includes with or more residents, the recommendation is to allow the Coordinator, Delegating Nurse or Case Manager to determine staffing levels based on the enhanced service plan requirements and in-house skill set.
10.07.14.26 Ch. 2  Remove 26 C (h) (2)  Best practices indicates that universal workers are the best model for dementia care.  This proposed regulation makes that impossible.
Brooke Grove Foundation, Inc.  Office of the State Long Term Care Ombudsman  No Change

10.07.14.26 D3  Recommend that the plan be reviewed more often than six months, and the resident and/or resident representative should be involved in the service plan development process.  This will help ensure more individualized and a more current plan of care. The service plan is the foundation for determining the resident’s preferences and needs.
Stevanne Ellis  Office of the State Long Term Care Ombudsman  No Change

10.07.14.26 E, F, G  Include other dementia to the language  Language not clear and consistent throughout sections E,F,G  Lynn McCann  Ombudsman_Baltimore County  Agreed

10.07.14.27  As above, LifeSpan opposed the creation of this new regulation and believes that it is duplicative given that the requirements contained in this section should be captured in the resident assessment tool and the nursing assessments and then captured in the service plan, similar to any other diagnosis. LifeSpan also is very concerned with the decision to use a ratio for direct care staff and believes further discussion must take place on this issue (page 119). OHCQ, itself, has questioned the use of ratios and, in other health care provider industries, has moved away from implementing ratios in favor of staffing to the needs of the residents. Lastly, on page 117, the reference to “probable or confirm diagnosis of Alzheimer’s disease or related disorder” must be deleted. *** It is important to note that LifeSpan strongly agrees that changes are necessary to the training requirements for Alzheimer’s, dementia and behavioral health. However, these changes should be focused on the training content, how the trainings are performed, the specific training needs of the residents, etc. LifeSpan has been meeting with representatives from the Alzheimer’s Association and the Mental Health Association on this issue.
Diana Kaufman  LifeSpan  No Change

10.07.14.27 A  Specific delineation of Special Care and Special Care Unit requirements is requested.  Additionally, clarification is requested regarding the intention of segregating Alzheimer’s/dementia special care and requiring increased services versus other clinical diagnoses/needs.  This regulation and requirements may limit facilities from moving in individuals with the preceding diagnoses, thus limiting move-in options.
Susan Hirsch  HCR ManorCare  No Change

10.07.14.27 D  Modification of these requirements is requested.  If the regulation is approved, recommend that a chart to log the requirements be included to assist with compliance.
Susan Hirsch  HCR ManorCare  No Change

10.07.14.27 F  Remove the 1 to 8 staff ratio.  Change to adequate staff to meet the needs of the resident population.
Diana Ponterio  Country Meadows  No Change

10.07.14.27 F  When the resident census includes eight or more residents with Alzheimer’s/Dementia, there shall be a minimum of one direct care staff on each shift for every eight residents.  Additionally, clarification is requested regarding the intention of segregating Alzheimer’s/dementia special care and requiring increased services versus other clinical diagnoses/needs.  Rationale: OHCQ should not define staffing ratios is assisted living. Again, appropriate staffing is determined by the organization providing the services. This determination is made by careful evaluation of the resident's needs, type of staffing provided and possibility of requiring private duty care givers in situations where appropriate. Too many details go into making this determination and cannot be successfully determined by OHCQ by making a blanket statement for all facilities.
Patricia Anderson  Brooke Grove Foundation, Inc.  No Change

10.07.14.27 F  Delete F.
Patricia Anderson  Brooke Grove Foundation, Inc.  No Change

10.07.14.27 F  Reconsideration of staffing requirements, particularly on the 11-7 shift.  Additionally, clarification is requested regarding the intention of segregating Alzheimer’s/dementia special care and requiring increased services versus other clinical diagnoses/needs.  Also, clarification is requested if the staffing ratio pertains to just the individuals with an Alzheimer’s/dementia diagnosis in a unit or all individuals in the facility.  This requirement includes potential expansion of services, i.e. staffing requirements, which may increase expenses* and consequently increase resident room rates. Additionally, if the facility cannot meet the staffing requirements, they will not be able to admit individuals with dementia, thus limiting their placement options. *Based on the current staffing patterns of our memory care communities (which currently exceed the requirements), the estimated, increased expenditures follow: 7-3 shift - No additional direct staff needed 3-11 shift - One additional direct care staff member needed per shift 11-7 shift - Two additional direct care staff members needed per shift Average wage per direct care staff member – $10.50 per hour/Additional staff hours per day - 22.5 hours Benefits factor – 30% Estimated, annual cost per facility - $112,100
Susan Hirsch  HCR ManorCare  No Change

10.07.14.28  Clarification request – does “law enforcement authority” include adult protective services?  If not, recommend adding APS.  Staff aware of abuse, neglect or exploitation are required to file a report with APS.  If not, recommended adding APS.
Jane Wessely  Private Citizen  No Change

10.07.14.28  Recommended adding language: Abuse or neglect.  Deaths resulting from neglect should be reported according to same policy as abuse.
Jane Wessely  Private Citizen  Agreed

10.07.14.28  Support the AlF notifying OHCQ when a resident dies. In addition, the ALF should notify OHCQ about injuries of unknown origin. The ALF should report elopements to OHCQ.
Stevanne Ellis  Office of the State Long Term Care Ombudsman  Agreed, the term elopement added. Unknown origin is included in “injuries incurred in program”

10.07.14.28  Make it clear that “notification to the DN” must include the date and time when the DN was notified.
Karen Brown  Private Citizen  No Change
I'm dealing with a place where the DN of the ALF fills out every single incident report. And it's a problem because she's doing it after-the-fact, so a lot of things aren't being reported clearly. Like the times she's
declaring - you don't know if that's the time the incident occurred or the time when she's filling out the incident report. I think the staff that first finds the resident should be required to fill the incident report out immediately. In all other facilities, they have the staff that finds the resident fill the form out right away.

Karen Besaw
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Karen Besaw
Private Citizen

No Change.

Karen Besaw
Private Citizen

No Change.

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No Change.

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Private Citizen

No Change.
The Ombudsman Program believes that assisted living residents should have the same minimal protections against improper or unsafe discharges or transfers as nursing home residents. The resident should have a right to appeal a discharge.

Alice Hedt  
Office of the State Long Term Care Ombudsman  
No Change

As a long term care ombudsman in Montgomery County, I question the fact that assisted living residents in continuing care communities have far greater protection against involuntary discharge than equally vulnerable residents in other Maryland assisted living communities. I strongly urge you to consider adopting language similar to that in COMAR 32.02.31.B, as follows: B. Dismissal or Discharge by the Provider. (1) An agreement may not permit dismissal or discharge of a subscriber from a facility, including by involuntary transfer, to an accommodation outside the facility, before expiration of the agreement for any reason, unless the: (a) Dismissal or discharge is for just cause; and (b) Subscriber is given advance notice of at least 60 days. (2) Just cause can exist only when there is: (a) Nonpayment; (b) Material breach of: (i) The agreement, or (ii) Written reasonable rules of the provider that contractually bind the subscriber; or (c) Health status or behavior that constitutes a substantial threat to the health of the subscriber or other subscribers. (c) Health status or behavior that constitutes a substantial threat to the health of the subscriber or other subscribers. (c) Health status or behavior that constitutes a substantial threat to the health or safety of the subscriber or other subscribers. (c) Health status or behavior that constitutes a substantial threat to the health or safety of the subscriber or other subscribers. (3) A notice of dismissal or discharge shall include at least the following: (a) A statement of the intent to dismiss or discharge; (b) A statement of each reason for dismissing or discharging, which shall be at least 60 days from the date the subscriber receives the notice; (c) The effective date of dismissal or discharge, which shall be at least 60 days from the date the subscriber receives the notice; (d) The facts that serve as the basis for the provider’s decision to dismiss or discharge; and (4) An agreement may recognize that a subscriber may have to be moved in the event of an emergency. A move or transfer of a subscriber to an accommodation outside the facility because of an emergency may not, in and of itself, constitute just cause for a dismissal or discharge.

Allison DeGravilles  
Montgomery County Department of Health & Human Services  
No Change

The citation needs to be updated to “Estates and Trusts Article, Title 17, Annotated Code of Maryland.”

Alice Hedt  
Office of the State Long Term Care Ombudsman  
Agree

\[8.14.29 B\]  
We recommend amending COMAR 10.07.14.33.B (Proposed Regulation. 29.B) as follows: B. Discharge. (1) Discharge of a resident or transfer to another facility or address without the consent of the resident or the resident’s representative may not result in a resident’s welfare and the resident’s needs cannot be met in the facility, as documented by a physician or the delegating nurse in the resident’s medical record; (b) The transfer or discharge is appropriate for the resident’s welfare; and (c) The resident has failed, after reasonable and appropriate notice, to pay for, or under Medicaid or otherwise, to have paid for a stay at the facility; or (d) The facility ceases to operate. (3) Except as provided in subsection (4) of this section B, a resident’s health has improved sufficiently so that the resident no longer needs the services provided by the facility, as documented by a physician or the delegating nurse in the resident’s medical record; (c) The health or safety of an individual in the facility is endangered, as documented by a physician or the delegating nurse in the resident’s medical record; (d) The resident has failed, after reasonable and appropriate notice, to pay for, or under Medicaid or otherwise, to have paid for a stay at the facility; or (e) The facility ceases to operate. (3) Except as provided in subsection (4) of this section B, an assisted living program shall notify a resident or if the resident has one, the resident’s representative, within at least 30 days before a non-emergency discharge with written notice that provides, in clear and simple language, at least the following information: (a) Notice of the proposed discharge or transfer of the resident; (b) Each reason for the proposed discharge or transfer to The staff of the resident to which will be provided a copy of this regulation; (c) The right of the resident to consult with a resident’s representative, within at least 30 days before a non-emergency discharge

Alice Hedt  
Office of the State Long Term Care Ombudsman  
No Change

Requiring facilities to post visitation hours would result in facilities serving Medicaid home and community-based setting requirements stipulate that individuals must be able to receive visitors at any time. It will create conflict within a facility to have two sets of standards regarding visitation hours. Facilities serving Medicare Waiver participants must comply with Medicare regulations and COMAR 10.07.14. Requiring facilities to post visitation hours would result in facilities serving Medicare participants bring deemed by Medicaid as non-compliant with federal funding requirements.

Jane Wessely  
Office of the State Long Term Care Ombudsman  
No Change
10.07.14.31 Recommended new language: Residents have the right to be supported to self-direct their services and supports to the degree possible and regulation language should encourage this philosophy as opposed to the more traditional model of being a passive recipient of services and care.

Jane Wessely Private Citizen Agree

10.07.14.31 Recommend replacement language for (b): Privacy, including the right to grant permission to to staff members prior to their entering the resident’s room, unless there is an emergency situation.

Residents should have the expectation of privacy and respect, especially in their own room.

Jane Wessely Private Citizen Agree


Jane Wessely Private Citizen Agree.

10.07.14.31 Please include who can be a health care practitioner.

List of appropriated professions would make the definition much clearer and less likely for a provider to misinterpret the requirement.

Lyman McCamie Baltimore county Ombudsman Program No Change.

10.07.14.31 On a number of occasions assisted living providers have refused Ombudsmen access to residents. This is more than just a resident rights issue. It is a privilege provided to the Ombudsmen by both the federal Older Americans Act and Maryland statute, Human Services Article §10-905. Thus, we request coordinated modifications to two different regulations, Proposed Regulations §11, Compliance Monitoring, and §31, Resident’s Rights, to make clear that Ombudsmen have the right to visit residents and that residents have the right to meet, in private, with Ombudsmen. The actual text of the requested modifications is in part VI below.

Alice Hedt MD Department of Aging No Change.

10.07.14.31 Include a right to appeal for discharge, meet privately and have access to procedures with meeting with Ombudsmen, and language about the next available ALF bed

18-currently says have access for procedures to meet with the ombudsman.

Anne Arrington Carroll County Bureau of Aging and Disabilities No Change.

10.07.14.31 In this section, include a right to appeal involuntary discharge. Include a right to have access to the ombudsman at any time with privacy and information about ombudsmen access to the resident and chosen family / friends.

These are two areas of rights that are protective and helps when residents fear or are subject to any punitive actions or discharge.

Kim Burton Mental Health Association of Maryland Thank you for comment. In response ORCQ has re-written this section.

10.07.14.31 Section E was deleted. Unless there is another section in the regulations that specify that notice of resident rights should be posted and copied as stipulated in section E, we would like to see Section E reincorporated into this section of the regulations.

Residents, their representatives, staff and visitors should have easy access to the notice of resident rights document otherwise they may not know the full rights and personal rights may be infringed upon.

Kim Burton Mental Health Association of Maryland Agree.

10.07.14.31 Include a right to appeal for discharge, meet privately and have access to procedures with meeting with Ombudsmen, and language about the next available ALF bed

18-currently says have access for procedures to meet with the ombudsman.

Lyman McCamie Baltimore county Ombudsman Program No Change.

10.07.14.31 Add a right to appeal for involuntary discharge. Add a right to have ombudsmen access and visitation including meeting privately with the ombudsmen, and procedures to provide information about ombudsmen access to the resident and family. Support returning to the program from a hospitalization after 15 days, and considering adding language about a resident has a right to return to the next available bed

To ensure that the resident’s rights are respected and protected.

Stevanne Ellis Office of the State Long Term Care Ombudsman No Change.

10.07.14.31 Section 155. 31 Resident's Rights. (b) The Adult Protective Services Program of the local department of social services as set forth in COMAR 07.02.16.

Residents have the right to be supported to self-direct their services and supports to the degree possible and regulation language should encourage this philosophy as opposed to the more traditional model of being a passive recipient of services and care.

Valerie Colmore Maryland Department of Human Resources Agree. Amanda Follow-up to look for places where APS is located. Add "the local department of social services".

10.07.14.31 Include a right to appeal for discharge, meet privately and have access to procedures with meeting with Ombudsmen, and language about the next available ALF bed

18-currently says have access for procedures to meet with the ombudsman.

Lyman McCamie Ombudsman_Baltimore County No Change.

10.07.14.31 A.4 Suggest rewriting to something like "provided that the pharmacy can comply with all essential policies and procedures for patient safety in medication supply and administration."

David Jones Board of Pharmacy Agree

10.07.14.31 A(18) ORCQ has not proposed any changes to this paragraph, but as mentioned above in Part IV, MDOA would like to add language to clarify this resident right and coordinate it with the right of the Ombudsmen and others to have access to the residents. The Ombudsmen Program has been having difficulty with some providers who will not allow, or resist allowing, an Ombudsmen Program representative to meet privately with a resident. For this reason, MDOA proposes changing the introductory clause to read as follows: "Meet privately with representatives of and have access to the procedures for making complaints to."

Alice Hedt MD Department of Aging No Change.
This is an important new addition, but it needs to be written more clearly to address the numerous variations that can occur: a hospitalization of four months; a skilled facility stay of less than 15 days; a skilled facility stay of three years. What happens if all of the facility’s assisted living beds are full when the resident wants to return? Should it refer to the "next available bed" or something similar? In addition, it should probably be made clear to what extent this right can be made contingent on the resident continuing to pay the assisted living provider fees during the period when the resident resides at a higher level of care. For example, can a provider satisfy this new requirement by making it contingent on the resident reserving the bed by continuing to pay the full daily fee for the assisted living bed while at a higher level of care? What happens if the resident’s contract with the provider has expired? Does this right trump the expired contract? Should this right be coordinated with a new mandatory contract provision?

Agree. Added back in.

Reports of Abuse- Health General 19-347 and Family Law 14-302 require abuse to be reported to APS, the proposed regulation makes it optional which would be in violation of the statutes.

Stevanne Ellis
MD Department of Aging
Agree.
10.07.14.39 Any safe device that can be use to prevent those residents with cognitive impairment elope and incur harm or death should be put in place, as long as it is approved by the Fire Inspection, if they have no problem then OHCQ should not supersede their findings and approval

Karen Besaw Private Citizen No Change:

10.07.14.39 If a facility doesn’t have to use an automated alert…if they have a receptionist. They should be required to use an automated alert period.

Karen Besaw Private Citizen No Change:

10.07.14.39 While we’re on the subject of security…

Karen Besaw Private Citizen No Change:

10.07.14.39 There is a need for additional language for preventing elopement in ALF. Suggestions include an alert system all doors that lead outside rather than just the main door. Also, there should be training for staff to prevent elopement, and resident specific care planning if elopement is a risk for the resident.

Karen Besaw Office of the State Long Term Care Ombudsman No Change:

10.07.14.39 Add language and training in the regulation

Karen Besaw Office of the State Long Term Care Ombudsman No Change:

10.07.14.41 ADD having emergency plans available to all staff 24/7 in evacuation plans section A.

Karen Besaw Private Citizen Agree:


Karen Besaw Private Citizen Agree: Section re-written to clarify what's required in the packet.

10.07.14.41 (ii) – add wording to say that service tags have to be on the extinguishers (rather than “documentation has to be maintained on-site”).

Karen Besaw Private Citizen No Change:

10.07.14.41 (f)(1)(d) – add wording to say that service tags have to be on the extinguishers (rather than “documentation has to be maintained on-site”).

Karen Besaw Private Citizen No Change:

10.07.14.41 Add wording to say that they must document when they annually instruct staff in the use of fire extinguishers with date, time, and names of staff. And tell them that staff have to sign their own names.

Karen Besaw Private Citizen No Change:

10.07.14.41 (ii) Brief medical fact sheet. Include wording to say that it must exist in paper format, not electronic.

Karen Besaw Private Citizen No Change:

10.07.14.41 Fire drills. I don’t like the way this is worded. It seems to imply that you can talk about a “scenario” and not have to actually do the drill.

Karen Besaw Private Citizen No Change:

10.07.14.41 (f)(1)(d) – add wording to say that service tags have to be on the extinguishers (rather than “documentation has to be maintained on-site”).

Karen Besaw Private Citizen No Change:

10.07.14.41 Fire drills. I don’t like the way this is worded. It seems to imply that you can talk about a “scenario” and not have to actually do the drill.

Karen Besaw Private Citizen No Change:

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Karen Besaw Private Citizen No Change:

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Karen Besaw Private Citizen No Change:

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Karen Besaw Private Citizen No Change:

10.07.14.41 Fire drills. I don’t like the way this is worded. It seems to imply that you can talk about a “scenario” and not have to actually do the drill.

Karen Besaw Private Citizen No Change:
10.07.14.41 ADD having emergency plans available to all staff 24/7 in evacuation plans section A. 

All staff on duty should be aware of the emergency plan and have access to any necessary documents to execute the emergency plan. Lynn McCame Ombudsman_Baltimore County Agree

10.07.14.42 There should be a process in place to determine smoking opportunities outside of the building in designated areas.

Residents that smoke should be provided with the opportunity to smoke in designated areas. Stevanne Ellis Office of the State Long Term Care Ombudsman No Change

10.07.14.43 There should not be any regulation that have residents have access to the kitchen at all times to have snacks or whatever they wish. The Kitchen, as a rule of thumb be OFF limits to residents “unsupervised” for their health, safety, for very life. That does not mean they do not have access to snacks which according the regulation are a minimum of 2 snacks a day.

There are four basic reasons for this Dietary, Allergy, Safety, and Hygiene. There may be foods that effect the resident in an adverse, safety issues that could result in injury or worse. Foods there are allergic to too, could cause death, and Hygiene reasons.

Karen Besaw Beyond Care No Change

10.07.14.43 Correct temperatures to current national standards of as “at 41 degrees or below or 135 degrees or above...”

Current state potentially hazardous food temperatures should be consistent with COMAR 10.15.03. Phyllis McShane Maryland Dietetics in Health Care Communities Agree

10.07.14.44 That being said to allow that option, and as well as it will providers to take time in being selective in setting the rooms before residents are admitted. The provider should have at least 50% of their rooms completely set up as required.

Allowing residents to bring furnishing allows for a continuity of environment that really make it “home”. It can also allow the owner to personalize the resident’s space based on their preference.

Marc Simmons Beyond Care No Change

10.07.14.44 Recommend deleting language: ...shall have a latching door and [may] a lock on the resident room side of the door [at the licensee’s option].


Jane Wessely Private Citizen No Change

10.07.14.44 State that no one may share a room with a resident unless they’re also a resident.

Managers will move roomers in with a resident. Karen Brosaw Private Citizen No Change

10.07.14.44 Define the meaning of “competent” resident in the definition section if it’s not already there.

A psych nurse would know what that means, but the rest of the nurse surveyors don’t, so spell it out. Karen Brosaw Private Citizen No Change

10.07.14.45 Every facility is different resident is different. There are some residents that may be in better condition that the provider, the owner, manager is capable of knowing what is accessible to the resident and what they are capable of, that is what the assessment process is for.

The facility is capable of making a judgment call on what amenities are appropriate for the population they will serve, and should not be pre-judge by anyone else regardless of their well intentions for the well being of the resident.

Karen Brosaw Beyond Care No Change

10.07.14.45 Add wording so that an ALF can’t make elderly people go downstairs in the middle of the night to use a toilet on the first floor.

I surveyed a place where they had the requisite number of toilets, but one of them was located on the first floor. I had to give them the bed increase they wanted, but hated to do it because it meant that somebody upstairs would have to walk downstairs in the middle of the night to use the toilet if the one upstairs were occupied. And that’s just not right.

Karen Brosaw Private Citizen No Change

10.07.14.47 Clarification of the approval process for space heater and the citation of the appropriate law and regulation

Clarification on access to funds in an emergency. Stevanne Ellis Office of the State Long Term Care Ombudsman No Change


You already stated you can’t have indoors smoking rooms. Karen Brosaw Private Citizen Agree

10.07.14.51 Encourage the enforcement of sanctions and sharing information about surveys, sanctions, revocations, and outcomes of the process Recommendation: OHCQ should develop a website with information that the public can access that contains information about surveys, sanctions, revocations, and outcomes of the process

Encourage enforcement of sanctions by sharing information about surveys, sanctions, revocations, and outcomes of the process. Stevanne Ellis Office of the State Long Term Care Ombudsman Agree. Information will be posted to the website again.

10.07.14.55 Support the enforcement of this regulation

Support the enforcement of this regulation. Stevanne Ellis Office of the State Long Term Care Ombudsman Agree/Thank you

10.07.14.56 Clarification on access to funds in an emergency

Clarification on access to funds in an emergency. Lynne McCame Baltimore county Ombudsman Program No Change

10.07.14.56 & 10.07.14.58 (D) Relocation – Clarification is needed on how to access funds in an emergency

Support. The Department in assisting with the relocation of residents

Support the Department in assisting with the relocation of residents. Stevanne Ellis Office of the State Long Term Care Ombudsman Thank you.

10.07.14.56 F Clarification on access to funds in an emergency

Support the Department in assisting with the relocation of residents. Lynne McCame Ombudsman_Baltimore County No Change


(A) The resident is at risk of abuse, neglect or exploitation.

Valerie Colmore Maryland Department of Human Resources Agree. Amanda Follow-up to look for places where APS is located. Add "the local department of social services"


C. The licensee shall notify the residents, or residents’ representatives, and the local department of social services Adult Protective Services Program of any final revocation.

1. The resident is at risk of homelessness;
2. The resident is at risk of abuse, neglect or exploitation.

Stevanne Ellis Office of the State Long Term Care Ombudsman Agree. Amanda Follow-up to look for places where APS is located. Add "the local department of social services"

10.07.14.62 Recommending notifying the Ombudsman Program

This would allow the Ombudsman Program to be informed about the status of the ALF to assist residents at the ALF as needed. Residents have the right to be informed about the status of the ALF where they reside, and need time to plan should an ALF close.

Stevanne Ellis Office of the State Long Term Care Ombudsman Agree
| General | In an informal paper dated January 29, 2010, MDoA previously raised with OHCQ a number of regulatory issues arising from the overlapping roles of MDoA and OHCQ in regulating assisted living in continuing care retirement communities (CCRCs). These issues include MDoA’s difficulties administering DHMH’s “sample list of assisted living program services” (Human Services Article §10-444(e)) and the conflict between the UDS and continuing care law. The issues remain unresolved. As OHCQ considers major changes in the regulation of assisted living, this would be a good time to work on these issues. Alice Hildt  | MD Department of Aging  | No Change  |
| General | MD Department of Aging recognizes that balancing the cost of complying with regulations against the protection of public health and safety is always a difficult task and that the perfect balance is elusive. The proposed regulations place more duties and responsibilities on the delegating nurse, or as proposed—the “Delegating Nurse/Case Manager”—was probably done to help maximize the probability of good and safe care, these increased duties and responsibilities will make assisted living more expensive, if for no other reason than the delegating nurses’ enlarged malpractice premiums. Larger facilities may be able to bear these added costs easily, due in part to economies of scale and strong market share. However, most Maryland assisted living facilities have five or fewer beds. Some licensees may find it hard to charge enough to pay these added costs given the limited amounts that their residents can pay. Given that assisted living payments are generally not covered by insurance or government subsidy, that may mean that some Marylanders will be “priced out” of assisted living by the added costs of complying with these changes. Increasing the cost of providing assisted living services may also adversely impact the number of assisted living providers willing to participate in the Waiver for Older Adults, unless the Medicaid reimbursement rate increases commensurately. Under some Medicaid programs like Money Follows the Person, assisted living facilities must be four units or less. We urge OHCQ to seek the input of the Medicaid program. Alice Hildt  | MD Department of Aging  | No Change  |
| General | The Culture Change movement is having a significant impact on nursing homes, but it is not limited to comprehensive care facilities. Its philosophy and precepts are also applicable to assisted living. In Maryland, the nursing home regulations have in some instances been a hurdle to be overcome before a provider could institute something like the Green House model. We want to make sure that nothing similar happens in the assisted living arena so please keep this issue in mind as you continue to develop the new regulations. Alice Hildt  | MD Department of Aging  | Thank you  |
| General | I am commenting on the 80 Assisted Living Manager training course. Due to the inconsistencies in the training provided by the currently approved 80 hour vendors, the recommendation was to have the community colleges throughout the State of Maryland offer the 80 hour Assisted Living Manager training. This way the Assisted Living Providers will no longer use the vendors, who are charging extremely high fees and in some cases are not providing accurate information in the training. Offering the 80 hour AL Manager’s training in the community colleges will be consistent in curriculum and cost throughout the State of Maryland. Current colleges offering the 80 hour AL Manager’s training course are: Anne Arundel Community College Carroll Community College Howard Community College and Prince George’s Community College. Denise Williams  | OHCQ/Assisted Living Unit  | Agree  |
| General | There was a commentator who suggested including the resident in the service plan meetings. LifeSpan would suggest the resident and/or resident’s representative. Danna Kaufman  | LifeSpan  | Agree  |
| General | There was a commentator who suggested the resident in the service plan meetings. LifeSpan would suggest the resident and/or resident’s representative. Danna Kaufman  | LifeSpan  | Agree  |
| General | Lastly, we want to point out that throughout the regulations, many references have been changed from “program” to “manager.” We do not believe that this is appropriate given that many providers have specific individuals assigned to various tasks and that it is the program as a whole that is responsible for ensuring that quality of care is being provided to all residents. We request that, when reviewing the regulations, OHCQ revert back to referencing the program rather than the manager, unless there is a specific task that can only be performed by the manager. Danna Kaufman  | LifeSpan  | Agree  |
| General | There was a commentator who suggested that medications should be only distributed in resident rooms and not common area. This should not be mandatory but at the request of a resident. Often, programs provide medications while the residents are in common areas. Danna Kaufman  | LifeSpan  | Agree  |
| General | Can we make sure that the packet referenced in the proposed regs concerning the emergency preparedness packet is available within the OHCQ website (to make sure we are all referencing the same packet)? I see forms on the website but a “packet”.

Alice Hildt  | MD Department of Aging  | No Change  |

Legal Aid Follow-up required once forms are finalized.
General 4. The regs really should be reflective of the type of AL. What I mean by that is many of us have licensed nurse around the clock and they should be able to do assessments etc and not only the Delegating Nurse. When one is in a SNF an LPN can do the admit assessment why can’t an LPN also do that in an AL.

I would appreciate any consideration to my above suggestions/concerns. Thank you.

Karen Besaw

General 5. Why is the documentation more in AL than in SNF referring to the weekly notes.

This is a huge problem for surveyors. We waste so much of our time going to a place just to find a caregiver who has no idea where the records are, or tells us they’re locked up and only the manager can get them etc.

Karen Besaw

General There were comments regarding furniture. LifeSpan strongly agrees that this is a resident rights issue and that residents should have the ability to bring in their own furnishings and not have a mirror or chair in the room just because the regulations require. Residents should have the option to have the furnishings but should be the ultimate decision makers. In addition, subjective terms such as “comfortable” should be deleted.

General Can we require providers to have their staff trained so that when we arrive wherever is there will know where the records are, will be able to get them and give them to us –???

If you have residents and you’re not licensed, you have to move them. We have places that don’t have a license and they’ve kept their residents for years.

Karen Besaw

General Define “operate” to mean that you have residents.

If you have residents and you’re not licensed, you have to move them. We have providers must keep hardcopies of certain things in the homes, and the caregivers have to sign their name and date to any paper copies kept in the record. The MARs are an afterthought to DNs and they give little attention to them. Med techs or the manager fill them out incorrectly. And you almost never see a DN who makes sure that reasons for all meds are listed next to each med.

Karen Besaw

General Add around p 64 under delegating nurse oversight. Add: Ensure the accurate filling out and complete documentation of the MAR, to include having reasons for all medications.

The MARs are an afterthought to DNs and they give little attention to them. Med techs or the manager fill them out incorrectly. And you almost never see a DN who makes sure that reasons for all meds are listed next to each med.

Karen Besaw

General For those with EHRs (electronic health records):

1) Require that they keep copies of service plan versions to prove to you that they really did review them after residents came back from ED trips, etc. If they keep overwriting one version with another, you can’t see whether they’ve ever made changes or not.

CareManager is used by a lot of providers. But once you “edit” something, the last version is overwritten. Consequently, you can’t tell whether the service plan was adjusted after someone came back from the hospital.

Karen Besaw

General For those using EHRs (electronic health records), the manager and delegating nurse should have to sign their name and date to any paper copies kept in the record.

Otherwise there’s no guarantee that they actually did it. Anybody can go in and type whatever they want if the paperwork isn’t signed and dated by the real people involved.

Karen Besaw

General For EHRs.

Providers must keep hardcopies of certain things in the homes, and the caregivers must have access to them. Like MARs and service plans.

Those things must be available to caregiving staff if they have questions about the residents. Too many providers are starting to keep everything online, but their staff has no access to a computer or printer. Not to mention if staff has to call EMS – they’d have nothing to give EMS to take to the hospital.

Karen Besaw

Karen Besaw

General Emergency and disaster tracking system – require them to have that resident information on paper, not electronic records.

We have a checklist posted on our website that’s ancient and nobody reads it, but it says that you can’t have that stuff online because if the power goes out you won’t be able to access those records.

Karen Besaw

General Under “Staffing” somewhere. Require ALFs to have a minimum of two staff who are available at all times to administer meds if meds are needed.

And require the staff who stays overnight to be a med tech (or get a med tech there within 10 minutes or something).

A lot of ALFs only employ one staff person who can administer med. And if that one staff isn’t there that day, then no one is available to give meds.

Karen Besaw

General Make it mandatory that an ALF does a complete personal inventory of everything a resident comes into their facility with.

Managers don’t bother doing this but they should be required to do it. Residents wind up with all kinds of expensive things (hearing aids, dentures, insulin pumps) missing and can’t do anything about it. They need more safeguards.

Karen Besaw
| General | Make unlicensed facilities move their residents out while they’re applying for a license. | They play this game with us where they get caught, so they put in for a license. As soon as they do that, we can’t touch them but they’re making money by being allowed to keep the residents. They should have to move them out and wait till they get the license before acquiring residents again. | Karen Besaw | Private Citizen | No Change |
| General | Allow us to give out fines for various reasons (like not responding to us). | We have a staggering number of providers who know they can just refuse to respond to us and there’s nothing we can do about it. We send them letters over and over and over and they do nothing because they know we can’t do anything to them. We should be allowed to fine them a small amount each time this happens. Example: Like $5/day for each day they don’t send us the supporting documentation we asked them for on the Plan of Correction. | Karen Besaw | Private Citizen | No Change |
| General | Limit the caseload of each delegating nurse to 30 residents total (not per facility). | Delegating nurses try to get as many residents as possible for the money. And then they’re not doing the oversight they need to on all those residents because they can’t keep track of that many people at one time. So just arbitrarily cap the number of residents they’re allowed to handle because we all know the Board of Nursing isn’t going to. | Karen Besaw | Private Citizen | No Change |
| General | Add wording so that an LPN may not assess a resident after a fall. | Large places like Sunrise employ a lot of LPNs. And when a resident falls in the middle of the night, the LPN assesses them. Then when the DN comes in in the morning she does NOT assess the resident because the LPN already did it. But LPNs should not be allowed to assess a resident after a fall. That should be the DN’s job. It wouldn’t down on them that maybe the resident’s service plan needs adjusting, maybe more interventions need to be put into place or interventions need to be changed. And that’s why the DN needs to assess them – that’s not within the scope of practice of an LPN. | Karen Besaw | Private Citizen | No Change |
| General | Add: “The record must be complete and accurate.” | This is something that all federal program regs have in them, and AL needs it badly. It comes in extremely handy when you’re trying to cite a facility which has horrible documentation. For example: resident records where half the stuff that should be there is missing; residents with diagnoses that aren’t consistent throughout the record (like their assessment tool says they only have 3 diagnoses, the service plan only lists 1, and then you look at the MAR and find they’re being treated for 12 different medical problems. Or when a resident goes to the hospital and you can’t even find out the date they went because nobody kept track, not to mention the date they came back; and they didn’t keep the discharge instructions or the transfer summary report from their discharge. The list goes on and on… | Karyn Balbina | BGF | No Change |
| General | Responding to choking and cardiopulmonary arrest with hands on exercise as a training requirement for the ALM is not necessary. | The ALM is already required to maintain current first aid and CPR. It seems redundant to have this requirement as it is part of CPR already. What institution will actually give out a card with the words “trained in choking and cardiopulmonary arrest”? | Karyn Balbina | BGF | No Change |
| General | Incorporation of all transmittals that are currently references for Assisted Living regulatory compliance: e.g. To: Nursing Home Administrators Subj: Holiday Decorations in Facilities, October 10, 2010; To: Assisted Living Providers and Stakeholders, Subj: Assisted Living Course Enforcement Date and New Vendor, June 30, 2008; To: Maryland Assisted Living Providers and Stakeholders, Subj: Revisions to COMAR 10.07.14- Maryland Medication Management and Administration/Consultant Pharmacy Review February 17,2009; ... | | | |
| General | New regulations 10.07.14 should clearly state that the presence of a Medication Technician is required in the ALF setting 24/7. This is mandated in the Nurse Practice Act 10.27.11.05H that requires the presence of the CMA or M.T in the unit on a continuing basis to monitor outcomes, effects of the medication,record and report to CMS/DN etc. This is currently supported by 10.07.14.29C that states: All medication shall be administered consistent with applicable requirements of COMAR 10.27.11 which is the Nurse Practice Act. | Susan Tandy | Howard County OOA | No Change |
| General | 2. CMT requirement- Is there any plan to review the requirement(s) to be a CMT. I know right now they only need to have high school and be able to read & write. | | Smt Meadows | Educator | No Change |
| General | Require that providers have a personnel file for each staff. | So many providers have no personnel files. It’s just a disorganized mess of papers and you can’t find anything you’re looking for. | Karen Besaw | Private Citizen | No Change |
| General | It used to say in the old regs that we only had 60 days from the date of the survey to deliver to the provider the CMP or sanction letter. This should be deleted or at least changed to at least 90 days. | 60 days from the survey date isn’t enough time when you have to write a large number of deficiencies. We’re overwhelmed as it is, we need more time to get those large ones out. | Karen Besaw | Private Citizen | No Change |
| General | Does the proposed assistant living regulations require for caregivers to be certified nursing assistants or geriatric nursing assistants? | | Felicia Anthony | | Thank you for your question. No they don’t. The only requirements are age and training. |
General

Please keep the big picture in mind. We are serving a population that is largely self pay and has limited resources. More regulation tends to equal more cost which in turn decreases accessibility. One example: 85-90% of residents in the two facilities I am familiar with have some form of dementia so the additional staffing and nursing over site requirements for residents with dementia will have huge financial implications.

Cheryl Wale
The Chalet ALF

Thank you.

General

LifeSpan supports the format of the Uniform Disclosure Statement in WORD so that facilities can update it more easily.

Danna Kauffman
LifeSpan

Thank you.

General

LifeSpan supports the posting of all plans of corrections.

Danna Kauffman
LifeSpan

Thank you.

General

LifeSpan opposes applying the CMS Final Rule for HCBS to all assisted living providers.

Danna Kauffman
LifeSpan

Thank you.

General

There were several comments on increasing frequency of pharmacy review and requiring programs to contract with pharmacist services. Again, this is examples of increased regulations than can unduly burden programs and increase costs. If a specific program has significant issues in these and any other areas, it should be addressed individually by OHCQ through its enforcement process.

Danna Kauffman
LifeSpan

Thank you.

General

Way, way too many inappropriate placements in community group home assisted living facilities. Clients with Delmarva-certified nursing home level of care living in a baby sitter environment means that many of our most vulnerable seniors are not getting the care they need and as a result are declining, suffering and dying. It's truly one of the worst forms of senior abuse we have. There is a lack of oversight of our community group home assisted living facilities. We must correct that. More effective oversight is required.

Henry Nash
Attorney

Thank you.

General

Voices for Quality Care (LTC), Inc. strongly supports all recommendations made regarding the Maryland Assisted Living Regulations revisions by the Maryland Ombudsman Program. Please consider these recommendations Voices’ recommendations also.

Kate Ricks
Voices

Thank you.

General

Hope you are well, I'm sure that you are very busy finalizing these regulations. After my one on one meeting with you and Carol Fornderson a few months ago, I have reviewed the minutes of the AL regulation open houses, and also talked to others in the state of MD about the need for more structured training for assisted living administrators. I am reaching out to you again via email as I am under the impression that you still are able and willing to accept last minute comments concerning the content of these proposed regulations. I am also keenly aware of the fact that the state of VA has a more structured process for training Assisted Living administrators, including passage of the NAB Residential Care/Assisted Living administrator exam, which has been in existence for a number of years, is a sound, reliable and valid licensing examination vetted by a national testing agency, and is used by a number of other states for credentialing their assisted living administrators. A copy of this state’s regulations were sent to your attention a few months ago. After reading the minutes of the ALF Open Forums in the state of MD, it appears that a number of individuals have concerns about the training of ALF administrators in this state; and the content of the current 80 hour certification course. In light of these comments, I would like to suggest that if the state of Maryland is not yet ready to embrace licensure for all ALF administrators, it should allow individuals seeking to practice as ALF administrators in the state to take and pass the National Association of Long Term Care Administrator Boards’ Residential Care/Assisted Living national examination vs. the current 80 hour ALF course as an alternative to taking the current state mandated 80 hour course. Many states offer a variety of different paths to certification and licensure for ALF administrators, and offering options to individuals rather than nesting them all inside the current state regulations will make it easier for new administrators to ready to embrace licensure for all ALF administrators, it should allow individuals seeking to practice as ALF administrators in the state to take and pass the National Association of Long Term Care Administrator Boards’ Residential Care/Assisted Living national examination vs. the current 80 hour ALF course as an alternative to taking the current state mandated 80 hour course. Many states offer a variety of different paths to certification and licensure for ALF administrators, and offering options to individuals rather than nesting them all inside the current state regulations will make it easier for new administrators to

Mary McSweneey
Towson University

Thank you.

General

Not knowing the specifics, and wouldn't want you to require that at least one (7) individual has a current AED certification from a national organization is onsite - here is an example of how this can be done:

A. An assisted living facility shall:
   (1) Be required to have an automated external defibrillator (AED) on site:
      (a) For smaller facilities, within 18 months of the effective date of this regulation*; or
      (b) For larger facilities, within 3 years of the effective date of this regulation*; and
   (2) Ensure that at least one individual who has a current AED certification from a national organization is onsite at all times.

Michele Phaneuf

Agree.

General

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Michele Phaneuf

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General

I have reviewed the minutes of the AL regulation open houses, and also talked to others in the state of MD about the need for more structured training for assisted living administrators. I am keenly aware of the fact that the state of VA has a more structured process for training Assisted Living administrators, including passage of the NAB residential care/assisted living administrator exam, which has been in existence for a number of years, is a sound, reliable and valid licensing examination vetted by a national testing agency, and is used by a number of other states for credentialing their assisted living administrators. A copy of this state's regulations were sent to the MD OHCQ via email a few months ago. After reading the minutes of the ALF Open Forums in the state of MD, it appears that a number of individuals have concerns about the training of ALF administrators in this state, and the contents of the current 80 hour certification course. In light of these comments, I would like to suggest that if the state of Maryland is not yet ready to embrace licensure for all ALF administrators, it should allow individuals seeking to practice as ALF administrators in the state to take and pass the National Association of Long Term Care Administrator Boards' Residential Care/Assisted Living national examination vs. the current 80 hour ALF course as an alternative to taking the current state mandated 80 hour course. Many states offer a variety of different paths to certification and licensure for ALF administrators, and offering options to individuals seeking to enter the field makes the process more flexible. NAB is also recognized for the quality of its NHA licensure exam which is mandated in all states in the US, as well as its RC/AL licensure exam offered in a number of states. The current 80 hour class varies widely in structure and in usable content. Alums of our degree programs at Towson University have commented to us about their concerns with the 80 hour class, and how it varied widely in structure and in usable content.

Mary Helen
Towson University, Towson MD
No Change.