Regulation Code	Comment	Rationale	Name	Organization	OHCQ Response
10.07.14.02	Recommendation - "new definition" for Page 10 – between (43) "Licensed Pharmacist" and (67) "Licensee" Licensed Registered Dietitian – Means an individual who is authorized to practice dietetics under the Health Occupations Article, Title 5, Annotated Code of Maryland and who meets the certifying requirements for registration as administered by the Commission on Dietetic Registration, and who maintains the continuing education requirements of registration.	The definition is necessary as reference point for additional material being added. It is based on the definition used in Title 10 DHMH, Subtitle 07 Hospitals, Chapter 02 Comprehensive Care Facilities and Extended Care Facilities.	Phyllis McShane	Maryland Dietetics in Health Care Communities	Agree. Add Definition
10.07.14.02	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.	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.	Jane Wessely	Private Citizen	Agree to add phrase, " who was competent at the time of designation.
10.07.14.02	Change "or" to "of" an individual	Appears to be a typo	Jane Wessely	Private Citizen	Agree
10.07.14.02	Question – Why is definition of case management being added? It would be helpful to add a definition of "case manager" as it is confusing due to varying references in regulations to "DN or case manager", "DN/case manager " and "DN and case manager". Does case manager have to be a nurse? If not, why would the manager meet with only case manager every 6 months to review resident status, service plan pharmacy reviews etc. –	10.07.14.14.A(2)(a) states DN or case manager. If the case manager is not the DN, what is the process for including DN in the information discussed at the meeting in addition to requirement for manager to document proceedings. Coordination of care is critical.	Jane Wessely	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".
10.07.14.02	Recommend adding language to definition of Chemical Restraint to indicate chemical restraint may not be used for discipline or convenience.	This form of restraint can be used for reasons other than protecting the resident. CMS definition: Chemical restraints are any drug used for discipline or convenience and not required to treat medical symptoms	Jane Wessely	Private Citizen	Agree
10.07.14.02	Recommend adding language: … training, supervision, evaluation and monitoring; and	COMAR 10.27.11.03D (5) includes: "evaluate the performance of the delegated nursing task".	Jane Wessely	Private Citizen	Agree
10.07.14.02	Recommend deleting language: The death of a resident [from other than natural causes].	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.	Jane Wessely	Private Citizen	No Change
10.07.14.02	Add language: Abuse or neglect of a resident;	In addition to abuse, neglect can also lead to adverse outcomes.	Jane Wessely	Private Citizen	Agree
10.07.14.02	Recommend modifying definition to incorporate person-centered care planning. 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.	This is language from a federal Register release from CMS about impending changes to nursing home regulations: We propose to require facilities to provide a written explanation in a resident's medical record if the participation of the resident and their resident representative is determined to not be practicable for the development of the residents care plan. 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.	Jane Wessely	Private Citizen	No Change
10.07.14.02	Recommend modifying definition to incorporate person-centered care planning. 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.	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."	Jane Wessely	Private Citizen	No Change
10.07.14.02	Recommend modifying definition to incorporate person-centered care planning. 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.	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."	Jane Wessely	Private Citizen	No Change
10.07.14.02	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.	Jane Wessely	Private Citizen	No Change

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		Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree
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		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.02	A definition is needed for emergency		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.02	27 Facilitating access – What does this mean?		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change.
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.	Lynne 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). Or define "hospitalization" to mean non-routine hospitalizations including ER trips, not just being admitted to a floor.		Karen Besaw	Private Citizen	No Change.
10.07.14.02	Change to include the words "and documentation" so it reads: (52) "Nursing assessment" means an assessment completed by a registered nurse that: (c) Includes but is not limited to: . . (i) Extensive initial and ongoing collection and documentation of resident data;	Because DNs don't ever change resident documentation to keep it current. This looks like it was taken directly from the NPA, but since it's in our COMAR's definition section, might as well include documentation in there.	Karen Besaw	Private Citizen	Agree. Add "and documentation"
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 DNs 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. E(5) .

10.07.14.02	Change this to: Take out the words "such as a fall" so it reads: (d) An injury to a resident which may require treatment by a health care practitioner, or an event which could subsequently require treatment; Add (h) A fall; Add (i) Neglect of a resident.	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. Neglect is an incident, just as abuse is an incident.	Karen Besaw	Private Citizen	Agree. Add, "neglect of resident" Question about adding "A fall"?
10.07.14.02	Delete the definition or change it to be correct.	A lavatory is another word that means bathroom. It can also mean a toilet. It's not just a "basin." And why is it defined here anyway? The word is not referenced anywhere else in COMAR so why is it here?	Karen Besaw	Private Citizen	No Change
10.07.14.02	"or from the resident's room" is incorrect.	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!	Karen Besaw	Private Citizen	No Change
10.07.14.02	Hopefully, you really mean "respite" care??? Delete the term "short-term residential care" and change it to "respite" or you will cause us no end of problems! And add that there is no such thing as a TRIAL PERIOD in AL.	There is no such thing as residential care – there is only respite care! 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!	Karen Besaw	Private Citizen	No Change.
10.07.14.02	Changing "agent" to "resident representative" undermines the definition. The regulations would be better off with no definition of "financial exploitation" than the proposed definition.		Alice Hedt	MD Department of Aging	No Change
10.07.14.02	NSERT a new (44) "Licensed Registered Dietitian" means a person who is authorized to practice dietetics under Health Occupations Article, Title 5, Annotated Code of Maryland."		Gill Livleen	Maryland Academy of Nutrition and Dietetics	No Change
10.07.14.02	Change language to read: "Synthesis of biological, mental, behavioral, cognitive, spiritual and social aspects of the resident's condition."	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"	Kim Burton	Mental Health Association of Maryland	Agree
10.07.14.02	Change language to read: Used by assisted living facilities to assess the current physical, cognitive and behavioral health status of prospective and current residents.	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.	Kim Burton	Mental Health Association of Maryland	Agree
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…	The addition of "cognitive, behavioral" is in alignment with the domains of assessment and health review that should be observed for significant change and indication that a resident might have a new need.	Kim Burton	Mental Health Association of Maryland	Agree
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.	This language is more in synch with current terminology and the realms of health that should be assessed and addressed.	Kim Burton	Mental Health Association of Maryland	Agree
10.07.14.02	Pg 13: [(64)] (69) "Resident" means an individual 18 years old or older who requires assisted living services. Add: "A Resident may not be staff."	Stop Medicaid fraud and stop resident abuse. Example: There's a provider who gets a homeless person from a shelter, fills out the paperwork to make them a "resident", and submits that "resident" to Medicaid to collect their PAA money. Then they also make that "resident" a "staff" person and have them work as staff (to avoid having to pay for a real staff person). One of those homeless "residents" working also as "staff" has mental problems and just assaulted several wheelchair-bound (real) residents; and that "staff's" paperwork was submitted to MBON by the delegating nurse who trained that "staff" as a Medication Technician, so now they're about to be given a Med Tech certificate on top of things!	Karen Besaw	Private Citizen	Agree. Add P10.07.14.02 .02 Definitions. A. In this chapter, the following terms have the meanings indicated. B. Terms Defined. ... (11) Assisted Living Program. (a) "Assisted living program" means a residential or facility-based program for two or more residents that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of individuals who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that

10.07.14.02	"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.	Providers never do background checks on cooks or housekeepers because they say "they're not staff, that's the cleaning lady." ALFs use volunteers to do things for residents that normally staff would do, and it's a problem for surveyors writing deficiency statements. Providers argue with us that "they're not staff, they're only a volunteer, so they don't need…" because some providers try to get away with using as many volunteers as they can find so they don't have to pay for regular staff. So, someone needs to straighten out what the definition of what a volunteer really is, and when a provider is allowed to use them and what they're allowed to use them for. Maybe you need to specifically state in the regs different categories of volunteers. Because if you use them for direct resident care and they're unsupervised by regular staff, then they need the same qualifications as staff, and that means they need to have those qualifications before they're allowed to be around the residents (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). 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 18) to do things like read stories to residents as long as they're not left alone with	Karen Besaw	Private Citizen	No Change
10.07.14.02	(b) "Administration of medication" includes: Add: "(v) Charting of medications administered."	Administering meds includes accurate charting of giving/not giving them on the MAR.	Karen Besaw	Private Citizen	No Change
10.07.14.02	Take out "or" and change it to "delegating nurse/case manager's"	The delegating nurse IS the case manager.	Karen Besaw	Private Citizen	No Change
10.07.14.02	We need to make providers get a background check done that requires fingerprinting and goes through CJIS—period! (just like the MBON now requires for all RNs, LPNs, CMTs, CNAs/GNAs, etc.). And a national as well as statewide check should be conducted (because different databases are used)	Please fix this. It's a huge problem for AL surveyors. Stop this business of letting providers go through agencies like Kroll, Global, CertiPhy, First Advantage, etc. , or even get on the internet and do a judiciary case search themselves (which a lot are doing). And many providers are only ordering COUNTY checks from those agencies. And the agencies themselves include a disclaimer on their checks that they don't guarantee the information is right! Make providers go thru CJIS and get national and statewide checks done, period. The references to the two Annotated Code articles are obscure and extremely difficult to find online, so the providers don't know what they actually say. It would just be easier to write in our COMAR that the checks need to include fingerprinting and be run for a statewide check of every home and work address the individual has had for the last seven years. Fingerprinting is easy now. There are places springing up everywhere where it's done electronically and you get pretty much instant results back.	Karen Besaw	Private Citizen	No Change
10.07.14.02	Change the definition to: "Delegating nurse means a registered nurse who is also a delegating nurse/case manager who…" Then change para (b) to read: "(b) Has successfully completed the Board of Nursing's approved training program for registered nurses and delegating nurses/case managers in assisted living."	There's only one course and it's for "delegating nurses/case managers." The way it's written now makes it sound like there's a course for delegating nurses and another course for case managers. This was written incorrectly in the existing set of regs and should be fixed. Actually the wording is still wrong because you're not an RN until you pass the national boards (NCLEX exam) and get a state-issued RN number, not when you complete a registered nurse training program!	Karen Besaw	Private Citizen	Agree. The term delegating nurse/case manager has been replaced with "delegating nurse".
10.07.14.02	Add more duties to this. The DN should be responsible for oversight of the DOCUMENTATION of residents' records too, not just for the "clinical" oversight of a resident (I consider getting the documentation part of it correct to be part of a DN's "oversight" but unless you spell it out, DNs won't do it.)	DNs should be held accountable for a record's documentation. I already listed some of this earlier under "the record must be complete and accurate." Examples: (1) Physicians will fill out the assessment tool completely inaccurately. It's then the responsibility of the DN to re-write it if it's not right, but they won't do it because COMAR doesn't specifically say they have to. (2) They won't check to make sure every medication on the MAR has a reason listed for it. (3) They won't make sure that a person's diagnoses are consistent throughout the record.	Karen Besaw	Private Citizen	No Change
10.07.14.02	Put a definition here.		Karen Besaw	Private Citizen	No Change
10.07.14.02	Provide definition in 10.07.14.02. Primary delegating nurse .02 Definitions.	Maintain consistency and provide definition in identified section of the regulations - Alternate delegating nurse Page 63 .17 Nursing Oversight	Gayle Walter	Willow Brook Square - Thomas B. Finan Center (DHMH / BHA)	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.		Marianne Uphold	Private Citizen	No Change
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 prevalence of dementia and delirium among older adults – both of which include behavioral and psychiatric symptoms and may require attention by behavioral health professionals.	Kim Burton	Mental Health Association of Maryland	Agree
10.07.14.02	LifeSpan will address the changes to definitions in the substantive section of the proposal.		Danna Kauffman	LifeSpan	Agree
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 Equipment3. Safe injection practices 4. Respiratory hygiene and cough etiquette		Brenda Roup	DHMH_Infection and Prevention	Agree
10.07.14.02 B (15)	Amend 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.	Kim Burton	Mental Health Association of Maryland	Agree
10.07.14.02 B.13	Believe end should read "psychosocial needs of an individual".		Sister Irene Dunn	Victory Housing, Inc.	Agree
10.07.14.02 B.18	**Change to – "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.**		Brenda Roup	DHMH_Infection and Prevention	Agree
10.07.14.02 B.21.c	Reconsider expansion of delegating nurse/case manager duties.Delegate appropriate duties to facility licensed nursing personnel (including LPNs).	The expansion of delegating nurse/case manager's duties (as noted in preceding sections) may require increased resources in the position(s). This may increase expenses, thus potentially increase room rates and limit placement options.	Susan Hirsch	HCR ManorCare	No Change
10.07.14.02 B.27	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.	Lynn McCamie	Ombudsman_Baltimore County	Agree
10.07.14.02 B.31	Please include who can be a health care practitioner.	A list of appropriated professions would make the definition much clearer and less likely for a provider to misinterpret the requirement.	Lynn McCamie	Ombudsman_Baltimore County	No Change
10.07.14.02 B.32	Please add behavioral health.	A clear definition of behavioral health should be included.	Lynn McCamie	Ombudsman_Baltimore County	Agree
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.	Lynn McCamie	Ombudsman_Baltimore County	Agree
10.07.14.02 B.6	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.	This definition requires additional services; note .26 Alzheimer's and Dementia Special Care Unit and .27 Alzheimer's/Dementia Special Care. For example, there are increased staffing and training requirements. These increased requirements may cause increased financial and logistical consequences. Additionally, if the facility cannot provide the required services, they will not be able to admit individuals with dementia, thus limiting placement options.	Susan Hirsch	HCR ManorCare	No Change

10.07.14.02 B.9	To ensure people with disabilities may live in the most integrated settings with natural supports, 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. Licensure 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 providing a substantial service to also take legal action to alter the legal relationships	Janice Peterson	The Village at Rockville	No Change
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.)		Alice Hedt	MD Department of Aging	Agree
10.07.14.02 B(31)	In the draft on which MDoA 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 MDoA'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, 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.")	Alice Hedt	MD Department of Aging	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 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.		Alice Hedt	MD Department of Aging	Agree. Change made.
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(76), .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 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.	Alice Hedt	MD Department of Aging	Follow-up required once forms are finalized.
10.07.14.02 B(53)	Given the new definition of "delegating nurse/case manager," please consider whether the regulation should provide for this overview to be done by the delegating nurse/case manager.		Alice Hedt	MD Department of Aging	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 B(6)	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 niece 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.

10.07.14.02 B(6)	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 award 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.")		Alice Hedt	MD Department of Aging	No Change.
10.07.14.02 B(6)	Note that there are other places in the proposed regulations where the word "agent" has not been changed, so such a change would be consistent with them.Another place where the switch from "agent" to "resident representative" will be problematic is in proposed 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.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.02 B(6)	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 MDoA respectfully submits that the phrase "resident representative" may be more problematic.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.02 B(6)	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."	[1]When referring to text that is proposed for deletion and can only be identified by reference to the current regulatory numbering, we refer to the "Existing Regulation." When discussing proposed changes that involve additions, moves, renumbering, or some combination of such changes, including deletions, that can be identified by number in the draft OHCQ distributed, we refer to the "Proposed Regulation."	Alice Hedt	MD Department of Aging	Agree. "Agent" changed to "Resident Representative"
10.07.14.02 B(60)	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.		Alice Hedt	MD Department of Aging	No Change
10.07.14.02 B(71)	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).		Alice Hedt	MD Department of Aging	No Change.
10.07.14.02 B(72)	We would like to see language added to the provisions on restraints that makes clear that drugs (and/or chemicals) may not to be used for 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.		Alice Hedt	MD Department of Aging	Agree
10.07.14.02 B(76)	The proposed new definition reads in part "a written plan incorporated by reference in Regulation .03." Should this instead read 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" undercuts 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.		Alice Hedt	MD Department of Aging	Agree.
10.07.14.02 Definitions	02. Definitions - new .09 This legal reference is no longer current under the Certified Adult Residential Environment Program that is certified by the Department of Human Resources under Article 88A, §140, Annotated Code of Maryland. New legal authority should read Human Services Article, §§6-508—6-513; Health-General Article, §§19-1801—19-1806, Annotated Code of Maryland (Agency Note: Federal Regulatory Reference: 45 CFR Part 1397).		Valarie Colmore	Maryland Department of Human Resources	Agree. Added Human Services Article, §§6-508—6-513; Health-General Article, §§19-1801—19-1806

10.07.14.02 G(3)	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.	Allison DeGravelles	Montgomery County Long Term Care Ombudsperson	Agree
10.07.14.03	The documents regarding assessments, level of care scoring and uniform disclosure will need to be updated once it is determined the direction of level of care (.04), etc. Dates of forms do not correspond with forms listed on website.		Danna Kauffman	LifeSpan	Agree
10.07.14.03	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".)	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 Besaw	Private Citizen	No Change
10.07.14.03	Add the Nurse Practice Act (NPA) into this.	Delegating nurses are bound by everything contained in the NPA, which is COMAR 10.27.00 and the part about delegating to unlicensed staff which is in COMAR 10.27.11.	Karen Besaw	Private Citizen	No Change
10.07.14.03 A	Please note that the draft Resident Assessment Tool provided to the Department (labeled "Revised 6/20/13") contains on the top of the first page the "more than intermittent nursing care" limitation that the proposed changes have eliminated.		Alice Hedt	MD Department of Aging	No Change
10.07.14.03 E	**ADD TO EXISTING LANGUAGE: Centers for Disease Control and Prevention (CDC), Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Facilities, 2005, which is incorporated by reference in COMAR 10.07.02.01-1**		Brenda Roup	DHMH_Infection and Prevention	Agree
10.07.14.04	Support E. and F. about not providing services beyond its licensed capacity	Assisted living facilities should not provide services beyond is licensed capacity	Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree
10.07.14.04	E. A program shall include residents admitted for short-term residential care and family members who are cared for by program staff in the program's census, which shall not exceed the licensed number of beds. Change the word residential to respite. Add residents who are in the hospital have to be included in the count.	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 Besaw	Private Citizen	No Change
10.07.14.04	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 otherwords 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.	The unlicensed provider, generally has had no assisted living training, no knowledge of medication administration, there is no delegating 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 (ie. Fire, zoning, well/septic, etc.). It makes no since 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 appylying 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 individual from knowingly and purposely bringing in residents before being licensed.	Darlene Tyson	Private Citizen	No Change
10.07.14.04	Family members should not be included in the stats for resident count	Many new providers are starting their facility in their own home and have family members that in n o way will affect the service to the residents they will be licensed to provide	Mae Simms	Beyond Care	No Change
10.07.14.04 D & E	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 Kauffman	LifeSpan	No Change
10.07.14.04 E	Delete subsection E.	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.	Danna Kauffman	LifeSpan	Agree. Deleted "in the programs's census".

10.07.14.04 E and F	Support	An ALF should not provide services beyond its licensed capacity.	Lynne McCamie	Baltimore county Ombudsman Program	Agree
10.07.14.04 E/F	Support	An ALF should not provide services beyond its licensed capacity.	Lynn McCamie	Ombudsman_Baltimore County	Agree
10.07.14.05	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 increase, 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	There should be somewhat of some uniformity for having some means of measuring the right fit. Also establishing a fair compensation for the level or degree of care needed. It is needed to distinguish your Medicaid Waiver compensation.	Mae Simms	Beyond Care	Thank you.
10.07.14.05	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 way to long to get the waiver completed . I teach 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 ,who 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 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 ? 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 .		James Rowe	Consultant/Educator/CM/DN	Agree.
10.07.14.05	"Level of care" is a major component of the current law. (See Health-General §19-1805(a), which requires licensing according to level of care, and Human Services §10-444(e), which assumes and builds upon that structure.) There are actually two different, albeit related, types of "level of care," namely, a facility's licensure level of care and an individual resident's level of care. Specifically, facilities are licensed to provide up to Level 1, 2, or 3 care. Individual residents are assessed to determine what level of care they need using the Resident Assessment and Level of Care Scoring Tool, Level 1 (1 to 20 points), Level 2 (21 to 40 points), or Level 3 (41 points or more). See current Regulations .03A and .05. While not opposed to collapsing or eliminating the licensure levels, MDoA is opposed to eliminating the assessment of an individual's level of care needs for the reasons set forth below.	A. Licensure Levels of Care If an estimated 95% of providers are licensed for Level 3 care, we can see that the effort to maintain a three tiered licensure program may not be warranted. However, eliminating the three levels entails more than changing the regulatory language. The licensure levels of care are part of the underlying statutes and (largely due to the Uniform Disclosure Statement) almost all of the existing assisted living contracts. Eliminating the licensure levels requires changing the assisted living statutes and some thought should be given to how it will impact existing assisted living contracts that are posited on the three tier structure. B. Individual Resident Levels of Care Providers base monthly assisted living fees on the Levels 1, 2 and 3 established under the assisted living regulations' Resident Assessment Tool. See (i) the long-standing sample Resident Agreement, which is on the OHCQ web site and which in Section 4 essentially incorporates the UDS pricing structure based on level of care and (ii) the level of care based payment rates for the Medicaid Waiver Program. Unlike the proposed elimination of licensure levels of care, MDoA is concerned from a public policy standpoint and legal standpoint about the proposed elimination of individual resident levels of care. We address public policy first and the legal issues second and third. 1. 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. The other end of the continuum would be to closely regulate contract terms	Alice Hedt	MD Department of Aging	Agree.
10.07.14.05	Continue to remove level of care from the regulation	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.	Danna Kauffman	LifeSpan	Levels of Care was retained due to statute Health-General §19-1805(a), which requires licensing according to level of care .
10.07.14.05	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.	Anne Patterson	Leading Age Maryland	Agree.
10.07.14.05	LifeSpan strongly supports the removal of the levels of care.		Danna Kauffman	LifeSpan	Levels of Care retained due to statute, Health-General §19-1805(a), which requires licensing according to level of care.
10.07.14.05	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 care . 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.		Jim Rowe	Nurse Consultant/Educator/CM/DN	Agree.

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.
10.07.14.05	I would like to see the levels of care remain part of the regulations.	I know that the new RAT has been created to go along with the new regulations, but Medicaid providers and level 2 providers have continued to use the old form while those who can used the new form. I don't see why this can't continue this same way. Everyone can use the new service plan, if people feel that is going to lead to better quality care. I believe if you really care, that will lead to quality of care, not what form you use. Please continue to have the levels of care	Sister Irene Dunn	Victory Housing, Inc.	Agree.
10.07.14.06	C. (2) License Renewal. A licensee shall apply for license renewal: (a) At least [30] 14 days before the expiration of its current license; Keep it 30 days before.	I don't think we can't keep up with the processing we already have now with 30 days in place. We'll never be able to get licenses out with only 14 days' notice.	Karen Besaw	Private Citizen	Agree
10.07.14.06	Change the late fee from $10/per day to per week. Eliminate D(3) on page 28.	There remain issues of timely issuance of licenses and examples where applications have been submitted twice. OHCQ should also revise its policies for receiving and issuing licenses. In addition, why would OHCQ issue a provisional license after someone has filed a sufficient renewal application and paid the fees, even if submitted late – why not simply issue the license?	Danna Kauffman	LifeSpan	Agree D(3) has been removed. No change to the $10 fee. There is a grace period built in with the change C (2)(a) from 14 to 30 days prior to expiration of licens.
10.07.14.06	Comment: Recommend using the existing regulation. By proposing to listi specific sections, you have excluded violations of state law in other states, and you run the risk that this section is not updated when MD state statute, and federal statute is amended. Keep maximum discretion for OHCQ Director and the Secretary, do not limit by proposed limiting list of state and federal statutes.	Listing the sections puts the department at risk of other sections being excluded, a statutory and regulatory construction issue of implied exclusion known as Expressio Unius Est Exclusio Alterius. Please preserve the discretion afforded by the current regulation's language. This discretion was essential to OHCQ and the Secretary being able to take the very rare step of denying an ALF application in 2012. Thank you.	Robert Moore	Private Citizen	No Change
10.07.14.06	Remove fine.	Please note that communities are continuing to have issues with timely license renewal and it may be premature to impose a fine when there have been cases where the license fee check has been cashed and OHCQ states that it does not have the application.	Danna Kauffman	LifeSpan	No Change to the $10 fine.
10.07.14.06	delete the provision to allow OHCQ to issue a provisional license when the licensee initially fails to timely renew the application but subsequently does so and pays all required fees. Why not simply issue the renewal license rather than require the added paperwork on both OHCQ and the provider?		Danna Kauffman	LifeSpan	Agree
10.07.14.06	2. – 4. Support regulations to prevent quality of life and quality of care issues. The new regulations should have language about OHCQ reviewing the appropriateness and effectiveness of an emergency plan. The emergency plan should be reviewed with each survey and upon re-licensure.	Including the review of the emergency preparedness plan should help when an alf has to close or relocate residents especially in the event of an emergency or sudden closure for instance a building is condemned or damaged in a storm.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.06	Please include : (b) Information demonstrating financial [or]and administrative ability to operate [an assisted living] a program in compliance with this chapter, which shall include a business plan and 1-year operating budget; (c) Policies and procedures to be implemented as designated in the application for licensure; and should not be submitted to the Department, but be kept available for review at the facility on initial and subsequent surveys.	The Department is unable to keep all the paperwork submitted by providers. The pre-licensure surveyors review policies and procedures and the business plan at time of intial licensure.	Kim Fiore	Private Citizen	No Change
10.07.14.06	Please state that each owner must state on the application each facility that they currently own, manage or lease on the application. Each facility must be surveyed and any deficiencies or sanctions must be corrected before a new facility can be licensed.	Multiple locations owned and managed by the same person have many deficiencies and yet new locations are allowed to open.	Kim Fiore	Private Citizen	No Change.
10.07.14.06	Please include that the applicant must have an accurate Uniform Disclosure statement that includes the Assisted Living Manage, Alternate Assisted Living Manager and Delegating Nurse to be serving the facility.	The applicant often changes the Assisted Living Manager, Alternate Assisted Living Manager and Delegating Nurse before the Nurse Surveyor has been to the facility to complete the initial survey.	Kim Fiore	Private Citizen	No Change
10.07.14.06	Please include ((7)) (8) A licensee may not: (a) Operate an assisted living program (no residents shall be provided services)until a provisional license or license has been issued…	Unlicensed and change of ownership facilities have been operating (with residents) without a license for extended periods of time and have not been advised to discharge their residents.	Kim Fiore	Private Citizen	No Change
10.07.14.06	Please keep the current text of (a) At least 30 days before the expiration of its current license	This is for office purposes. A turn around time of 14 days is not very feasible for a unit that licenses over 1400 facilities.	Kim Fiore	Private Citizen	Agree. Change to 30 days.
10.07.14.06 B	Support regulations to prevent quality of life and quality of care issues	Should add language about reviewing the appropriateness of an emergency plan. This would help prevent problems when an assist living facility has to close or relocate residents especially during an emergency procedure. This emergency plan should be reviewed on every survey and license renewal.	Lynne McCamie	Baltimore county Ombudsman Program	No Change
10.07.14.06 B	Support regulations to prevent quality of life and quality of care issues	Should add language about reviewing the appropriateness of an emergency plan. This would help prevent problems when an assist living facility has to close or relocate residents especially during an emergency procedure. This emergency plan should be reviewed on every survey and license renewal.	Lynn McCamie	Ombudsman_Baltimore County	No Change

10.07.14.06 B(2)	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 deficiancies during the application process, if denial 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
10.07.14.06 B(2)	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 pergury 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 regulation.	Robert Moore	Private Citizen	No Change
10.07.14.06 B(2)	Recommend adding after "revoked": ,"or license applicant denied,"...	A set period of time needs to 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 timelimit. Thank you.	Robert Moore	Private Citizen	No Change
10.07.14.06 B(2)	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
10.07.14.07	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 notified the program. 2. New Section F(3) – requires that if a renewal application has not been filed at least 14 days before license expired, the program shall cease operations and relocate residents. This section should be deleted.	1. The above qualifier would account for weather related or other emergencies where the program may not be able to provide services for 120 days but has the intent to continue to operate following the emergent event. 2. This provision does not take into account the safety of the residents and seems an extreme response for what could be an unintentionally oversight. In addition, E and F should be moved under the Licensure Procedure regulation. This regulation is about changes in a program that affects licensure.	Danna Kauffman	LifeSpan	Agree
10.07.14.07	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
10.07.14.07	(7) if a licensee intends to relocate its program, the licensee shall apply for a new license . the licensee will have the new facility available for survey by the Department at the time of application to assure continuity o		Kim Fiore	Private Citizen	No Change
10.07.14.07	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) .07 Changes in a Program that Affect the Operating License. B. Voluntary Closure or Change of [Assisted Living] Program Ownership or Location. (1) A licensee shall notify the Department in writing at least [45] 60 days in advance of any intention to: (a) Voluntarily close; (b) Change ownership; (c) Change location; or (d) Sell its assisted living program.	Delegate Will Smth		Agree.
10.07.14.07	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 Smth's office, with the support of several Montgomery County officials.	Delegate Will Smith		
10.07.14.07 A(3)	Please check the grammar of proposed Regulation .07A(3).		Alice Hedt	MD Department of Aging	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 $960 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 ax 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 Crowell	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 "licensee."		Alice Hedt	MD Department of Aging	Agree
10.07.14.09	Please note that this should be .08.		Danna Kauffman	LifeSpan	Agree
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.	Stevanne 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.	Lynne McCamie	Baltimore county Ombudsman Program	No Change.
10.07.14.10	Add fire drills, and emergency and disaster drills.	They need to be onsite because we have to be able to inspect them.	Karen Besaw	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), revise it 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.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change.

10.07.14.11	(1) This section needs more requirements. At least require them to do a root cause analysis when serious events occur – abuse, neglect, falls, deaths. (2) 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 Besaw	Private Citizen	No Change
10.07.14.11	.11 Investigation by the department -clarify that investigation for complaints requires being open to investigation even if there are no residents in the facility		Marianne Uphold	Private Citizen	No Change
10.07.14.11 B	On a number of occasions, the Ombudsman Program has had assisted living providers refuse it access. Human Services Article § 10-905 guarantees the Ombudsmen 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 responsabilities 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 Ombudsmen shall have access to assisted living residents.	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.	Alice Hedt	MD Department of Aging	No Change
10.07.14.12	NOT! at least every 6 month is appropriate, perhaps added in the event of added medications and recommendation of a HCP a review may be conducted sooner	Coincides with QA minimum review and service, The DN is quite capable of making a recommendation of the need for a pharmacy review prior to the six due date	Mae Simms	Beyond Care	No Change
10.07.14.12	The quality assurance meeting between the delegating nurse and assisted living manager should be at least every three months instead of every six months.	The needs of residents in alf are often very complex, and need more frequent oversight, individualized planning, and review.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change.
10.07.14.12 2(A)	We recommend that the quality assurance meeting between the delegating nurse and the case manager occur at least every three months, instead of six months, because of the complex medical needs of most assisted living residents.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.12 A	Recommend that the quality assurance meeting between the delegating nurse and the assisted living manager be at least every three months	The increasing complex medical needs of most assisted living residents.	Lynne McCamie	Baltimore county Ombudsman Program	No Change.
10.07.14.12 A.	Recommend that the quality assurance meeting between the delegating nurse and the assisted living manager be at least every three months	The increasing complex medical needs of most assisted living residents.	Lynn McCamie	Ombudsman_Baltimore County	No Change
10.07.14.12 B(1)	An independent family council can help make a program better by providing a forum for family members to discuss program strengths and challenges, and the opportunity to discuss with staff the concerns they have about their loved one's care. In addition, family councils provide the opportunity for family members to receive support and information from one another and from outside experts, including facility staff, whom they invite to their meetings. Towards that end, we recommend adding the following reinforcements to the proposed regulation as follows: (1) If assisted living program residents' families have 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 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. The program shall consider the family 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 family council when it has received written recommendations, requests, or grievances from the family council.		Alice Hedt	MD Department of Aging	Thank you for 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 reinforcements 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 Hedt	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
10.07.14.13	Recommend deleting and adding language: … shall notify the resident's [physician] health care practitioner …	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.
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. So 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 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 Besaw	Private Citizen	No Change
10.07.14.13	[E.] H. On-Site Nursing Requirements. (1) [An assisted living] A program shall provide on-site nursing when a delegating nurse or [physician] health care practiionter, 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 practioner shall discuss any alternatives that could safely address the resident's (1) Spelling: practitioner (2) Wrong term: delegating nurse or case manager	(2) it's delegating nurse/case manager	Karen Besaw	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". .
10.07.14.13	"new section" between existing (5) "Administer necessary Medication…" and (6)"Monitor and provide…." (6) 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-hawes-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 D (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 I. (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	Maryland Coalition on Mental Health and Aging / Mental Health Association of Maryland	Agree

10.07.14.13 (H.4 or I)	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 McCamie	Ombudsman_Baltimore County	Addressed. The terms, "case manager/delegating nurse", "delegating nurse/case manager" have been removed. These terms are replaced by the term "delegating nurse".
10.07.14.13 C	delete full name of the staff and substitute "identifying name of staff."		Danna Kauffman	LifeSpan	Agree
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 Kauffman	LifeSpan	Agree. Change made added term "available" to section.
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 Kauffman	LifeSpan	Agree
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 B. already states that the staffing plan must meet the 24 hour scheduled and unscheduled needs of the residents.	Danna Kauffman	LifeSpan	No Change
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 practitioner" 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, dietician-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 practitioner" 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 Hedt	MD Department of Aging	No Change.
10.07.14.13 H	new Section (H), it should say delegating nurse/case manager rather than delegating nurse or case manager.		Danna Kauffman	LifeSpan	Addressed. The terms, "case manager/delegating nurse", "delegating nurse/case manager" have been removed. These terms are replaced by the term "delegating nurse".
10.07.14.13 H.2	Correct the phrase "health care fractioned" to "health care practitioner"	Given that H(1) in that same section references "health care practitioner" this must be a typo.	Kristen Neville	DHMH - Health Occupations Boards	Agree
10.07.14.14	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 train in advance NOT AS YOU GO.	We are talking about the quality of life for persons, it is difficult enough with the tools needed to address the challenges of caring for persons with a diversity of problems, illnesses, and issues. To minimize the ability to provide the best quality of care by being untrained going into it is not smart	Mae Simms	Beyond Care	Agree. See 10.07.14.14D(7)
10.07.14.14	On line training should have never have been approved. Never before was it accepted and it appears persons formally from OHCQ after leaving started this How was that allowed, yet everyone is expecting QUALITY CARE as the department is named for.	If an individual to invest the time and energy getting proper training rather that looking for the quickest and easiest way out, they should not be responsible for the lives of anyone. The training that have be required is minimum to so many other job positions	Mae Simms	Beyond Care	No Change
10.07.14.14	The classes included in the 1-5 bed manager affect all providers, the information is needed for all	The training will better equip to be in compliance at all times	Mae Simms	Beyond Care	No Change
10.07.14.14	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. CJIS provides updates to the criminal history requestor and this service should be available from private background check companies.	Obtaining a one-time criminal history report does not sufficiently protect residents from staff who may commit serious crime after the point of employment.	Jane Wessely	Private Citizen	No Change

10.07.14.14	Recommend the manager and DN meet at least every 3 months rather than every 6 months.	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.	Jane Wessely	Private Citizen	No Change
10.07.14.14	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(7) of this regulation for a period of 4 years. Maybe 2 years.	4 years is just too long.	Karen Besaw	Private Citizen	Agree. 2 years
10.07.14.14	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.	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.	Karen Besaw	Private Citizen	No Change
10.07.14.14	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.	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.	Karen Besaw	Private Citizen	No Change
10.07.14.14	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?	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 even 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 Townson Chapter & Mental Health Assoc. of Maryland class which is classroom only and therefore not good for those in far-away counties.	Karen Besaw	Private Citizen	No Change
10.07.14.14	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.	Providers offer a variety of approaches to activities and meals and direct care staff are often part of the process.	Anne Patterson	Leading Age Maryland	No Change.
10.07.14.14	Please note that this should be .12. First, this is an example where the reference should be to the program and/or designee 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.		Danna Kauffman	LifeSpan	Agree. QA from Adult Medical Day Care used.
10.07.14.14	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.	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.	Anne Patterson	Leading Age Maryland	No Change.
10.07.14.14	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 compliance re. within 30 days of hire. Additionally, definitions of "first aid instructor certified by a national organization" and "CPR instructor certified by a national organization" are requested.	A time frame for completion of certification and specific definitions of instructors are not included in this section.	Susan Hirsch	HCR ManorCare	No Change
10.07.14.14	Change the wording "designated unit manager" to "coordinator".	Section .26 Alzheimer's and Dementia Special Care Unit refers to the dedicated person as the "coordinator" – use the same term for clarification purposes.	Anne Patterson	Leading Age Maryland	Agree

10.07.14.14	10.07.14.13B Staffing Plan -clarify what "on site staff sufficient in number" means. This is impossible to prove.		Marianne Uphold	Private Citizen	No Change
10.07.14.14	Change: Have a two-step tuberculosis skin test (TST) or a single tuberculosis 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.		Brenda Roup	DHMH_Infection and Prevention	Thank you for comment. In response OHCQ has re-written this section.
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.	Kim 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.	Kim Burton	Mental Health Association of Maryland	No Change
10.07.14.14		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 that 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 PRIOR to 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 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 discussion on who can perform the training functions. There are two training charts	Danna Kauffman	LifeSpan	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 Switzer	Annapolitan Assisted Living	No Change
10.07.14.14	Requiring the additional 20 hours of of initial training for staff on the care of residents wiwh 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")	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.	Kim Burton	Maryland Coalition on Mental Health and Aging / Mental Health Association of Maryland	No Change.
10.07.14.14 I. (3) (a) and (b)	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.	Kim Burton	Maryland Coalition on Mental Health and Aging / Mental Health Association of Maryland	No Change
10.07.14.14 A. (2) (a)	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	Maryland Coalition on Mental Health and Aging / Mental Health Association of Maryland	No Change
10.07.14.14 A.1	Include in A.(1) The manager or MANAGER's DESIGNEE shall develop and implement a quality assurance plan.	This change reflects that many providers employ or designate a separate individual for this purpose.	Danna Kauffman	LifeSpan	Agree. Change made added term "managers designee"

10.07.14.14 B	The alf 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.	The alf 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.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree
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 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 3 times a day with the next dose due at 6am. Awake overnight staff are not med-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. Residents can experience the side effects of a medication at any time. Non-certified	Jennifer Jackson, Susan Shelton, Carol Clemments	Anne Arundel County Department of Aging	No Change.
10.07.14.14 B	, delete Section (B).	, delete Section (B).	Danna Kauffman	LifeSpan	Agree
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. .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.	Anne Arrington	Carroll County Bureau of Aging and Disabilities	No Change.
10.07.14.14 C	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 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.	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	Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree.
10.07.14.14 C(2)	Section (C)(2) should conform to the transmittal released on August 4, 2010 regarding age requirements.	http://www.dhmh.maryland.gov/ohcq/AL/Docs/Transmittals/al_08042010.pdf	Danna Kauffman	LifeSpan	Agree
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.	Danna Kauffman	LifeSpan	Agree. See .14 C(1)
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.**		Brenda Roup	DHMH_Infection and Prevention	Agree.
10.07.14.14 D.2	That we be able to continue to have the employee self-report having had the disease or having had the vaccination rather than it be evidenced by antibody serology or vaccine history.	This could become extremely expensive if we needed to start testing everyone who did not have available the proper paperwork.	Sister Irene	Victory Housing, Inc.	No Change.
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.		Brenda Roup	DHMH_Infection and Prevention	Agree
10.07.14.14 D.6 and D.7	Recommend removing "prior to assuming responsibilities".	It helps the new employee to be able to put a face to a teaching moment. If you pile everything on them in the beginning, they are not going to remember a lot of it. Allow them to learn and put it into practice and you will have a better employee for a longer period of time.	Sister Irene	Victory Housing, Inc.	No Change.
10.07.14.14 D(10)	delete reference to additional training for Alzheimer's/dementia special care unit in Regulation .27		Danna Kauffman	LifeSpan	Agree.

10.07.14.14 D(3)	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 flu vaccination 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.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.14 D(6)	Given the ever increasing diversity of our State, the training requirements should include training on cultural diversity and cultural sensitivity.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.14 D(6) & D(7)	delete references that trainings must be completed prior to assuming responsibility for resident care.	This is an unattainable standard and a high priority for LifeSpan.	Danna Kauffman	LifeSpan	No Change.
10.07.14.14 D(7)g and D(8)	delete reference to "responding to choking and cardiopulmonary arrests, including hands-on exercises."	Section (D)(8) already specifies that the CPR certification must include a hands-on component.	Danna Kauffman	LifeSpan	Agree
10.07.14.14 D3	D3.Influenza vaccines should be offered to all staff free of charge since it is a highly contagious disease and often more deadly for older individuals and individuals with chronic health conditions		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.14 D6	Training requirements should include training on cultural diversity and sensitivity		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.14 D6, I	Recommend increasing the amount of initial minimum training set forth in 141(1) from 5 hours to 8 hours and the amount of ongoing training for personal care staff under .141(3)(a) from 2 hours to 5 hours and under 141(3)(b) from 1 hour to 3 hours.	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 oftentimes due to illness and disease.	Lynn McCamie	Ombudsman_Baltimore County	Agree.
10.07.14.14 E	reduce the exemption for trainings for those staff completing the 80 hour course from 4 years to 2 years.		Danna Kauffman	LifeSpan	Agree. Change from 4 to 2 years.
10.07.14.14 F	update the proof of training requirements to reflect that more trainings are being done online or through webinars. For example, delete the reference to requiring signatures of the trainer and attendees.	Again, the medical adult day regulations recently updated this provision in the enactment of their recent regulatory changes.	Danna Kauffman	LifeSpan	Agree. Look at AMDC
10.07.14.14 I	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 oftentimes 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 .14I(1) from 5 hours to 8 hours and the amount of ongoing training for personal care staff under .14I(3)(a) from 2 hours to 5 hours and under 14I(3)(b) from 1 hour to 3 hours. Recommend continued discussion about training in cognitive impairment.	Adequate training is essential to the provision of care. Specialized training for staff related to individuals with cognitive impairment leads to better overall care, improved quality of life, less frequent "behavior related" discharges, and can decrease hospitalizations.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree change from 5 to 6.
10.07.14.14 I	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. Adequate training, therefore, is essential to the provision of care. 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 oftentimes 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 .14I(1) from 5 hours to 8 hours and the amount of ongoing training for personal care staff under .14I(3)(a) from 2 hours to 5 hours and under 14I(3)(b) from 1 hour to 3 hours.		Alice Hedt	MD Department of Aging	Agree see change from 5 to 6.
10.07.14.14 I	return to the requirement that an employee has 90 days to receive the initial training on cognitive impairment and mental illness.	Again, high LifeSpan priority.	Danna Kauffman	LifeSpan	Agree
10.07.14.14 I	Recommend that the quality assurance meeting between the delegating nurse and the assisted living manager be at least every three months	Recommend that the quality assurance meeting between the delegating nurse and the assisted living manager be at least every three months	Lynne McCamie	Baltimore county Ombudsman Program	No Change
10.07.14.14. A.1.a	**ADD: The quality assurance plan shall include an annual facility risk assessment for tuberculosis, in accordance with the CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Facilities, 2005, Appendix B.**		Brenda Roup	DHMH_Infection and Prevention	Agree
10.07.14.14.A	A more standardized version of the medicated technician course conducted by medication technician course programs approved by the Board of Nursing. 10.29.14.29.A	The student would not have to be an employee of the assisted living facility to take the course. Allemployees who will administer medication in the various healthcare settings would take the same medication technician certification course and then the medication technician would be oriented their specific setting when they are hired.	Patricia Hemler	Howard Community College	No Change.

10.07.14.14.A	A more standardized version of the medicated technician course conducted by medication technician course programs approved by the Board of Nursing. 10.29.14.29.A	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 hire the delegating nurses to teach the course. This will ensure consistency in how the course is taught.	Patricia Hemler	Howard Community College	No Change.
10.07.14.14B & 10.07.14.29C	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 knowledgable 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.	Paula Currence	AA County Department of Aging and Disabilities	No Change.
10.07.14.14G(3)	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, malnutrition, 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 Audiences:")	Susan Harrington	Harrington Software Associates	Thank you.
10.07.14.15	Recommend deleting language: (c) Outcome of the resident's care that results in an unanticipated consequence; and	13 (a) & (b) address change & adverse outcome. Unclear what (c) is adding.	Jane Wessely	Private Citizen	Agree
10.07.14.15	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 update date as possible for the population admitted.	Lynne McCamie	Baltimore county Ombudsman Program	Agree. Change from 4 years to 2 years.
10.07.14.15	I am unclear how a college degree will impact one's ability to effectively manage an assisted living facility.	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 have served as both an alternate and manager for fifteen years. I understand there are facilities being managed inadequately however if a manager has had the proper training and held the position for a period of time without incident a college degree does not seem necessary.	Dean Eula	Keswick Multi-Care	No Change
10.07.14.15	(c) Completed 10 hrs of continuing education every 2 years from an institute approved by the MHEC…	Make it 10 hrs of continuing education from any college (internet or whatever), as long as it pertains to some subject applicable to providing services to AL residents.	Karen Besaw	Private Citizen	No Change
10.07.14.15	H. The manager shall be on-site or available on call. The alternate manager shall be available to assume the responsibilities described in §I of this regulation when the manager is not available.	Add to this: wording saying that the ALM and AALM can't be gone from the program at the same time. There are a lot of couples who own homes and they go out of town for 2 weeks on vacation together, leaving their homes without an ALM and AALM for that period of time.	Karen Besaw	Private Citizen	No Change
10.07.14.15	G. The Department may determine that an individual is not sufficiently qualified to serve as a manager or alternate manager…Add wording to say: We may determine they aren't qualified if they don't know what we're talking about when we go out on a survey and ask them for the RAT, the service plan, the comprehensive nursing assessment – and they have no idea what we're talking about and we have to explain what everything is to them!	This happens constantly. They should be required to know what it is (i.e., read COMAR! It's your business, you should know what these things are!)	Karen Besaw	Private Citizen	No Change
10.07.14.15	Put in wording on under I. Duties (of the manager) that the manager must notify the delegating nurse that a resident is going to be admitted BEFORE they come into the house.	Lots of provider don't notify their delegating nurse that a resident has been admitted for 1-2 weeks afterward.	Karen Besaw	Private Citizen	No Change

10.07.14.15	(a) 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 lets 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 cite them when we find them without a DN (not just when THEY terminate one).	Karen Besaw	Private Citizen	No Change
10.07.14.15	delete reference to Maryland Higher Education Commission	This is a high priority for LifeSpan.	Danna Kauffman	LifeSpan	No Change
10.07.14.15	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.	Anne Patterson	Leading Age Maryland	No Change
10.07.14.15	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.	Susan Hirsch	HCR ManorCare	No Change
10.07.14.15	Add A. (3) (d) to read: "Completed the Mental Health First Aid Older Adult Module and obtained Mental Health First Aid certification."	Mental Health First Aid (MHFA) is an 8 hour evidence based education curriculum that culminates in MHFA certification. The Older Adult Module is most appropriate for the AL workforce and covers mental health, dementia, delirium and substance use disorders. Given the high prevalence of such behavioral health disorders in ALs, this would be an appropriate requirement.	Kim Burton	Mental Health Association of Maryland	No Change
10.07.14.15	Replace term "psychosocial" with more current terminology, "behavioral health" We recommend that the regulations be combed for the term "psychosocial" and, where appropriate, change it to "behavioral health."	The usage of terminology should be consistent and reflect current language that is more commonly used among state agencies and providers. "Behavioral health" 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.	Kim Burton	Mental Health Association of Maryland	Agree
10.07.14.15	Please state : (b) remove - (c) Completed 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.	Kim Fiore	Private Citizen	Agree
10.07.14.15	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>>>> (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.	Kim Fiore	Private Citizen	Agree. Changed from 4 to 2 years.
10.07.14.15	.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)		Marianne Uphold	Private Citizen	No Change
10.07.14.15	Please change from "5 beds or more" to "1 bed or more"	All managers (1 bed or more) should be required to undergo the 80 hours managers training course because all residents are entitled to have caregivers that have been properly trained through all of the topics, especially 12 hrs. of Dementia and Mental Illness as well as Management and Operation.	Mary Dent	ABC TRAINING CENTER	No Change.
10.07.14.15	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.		Wendy Harris	AA County Dept. of Aging and Disabilities	No Change
10.07.14.15	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 update date as possible for the population admitted.	Lynn McCamie	Ombudsman_Baltimore County	Agree. Change from 4 years to 2 years.
10.07.14.15 A. (3)	Add A. (3) (d) to read: "Completed the Mental Health First Aid Older Adult Module and obtained Mental Health First Aid certification."	Mental Health First Aid (MHFA) is an 8 hour evidence based education curriculum that culminates in MHFA certification. The Older Adult Module is most appropriate for the AL workforce and covers mental health, dementia, delirium and substance use disorders. Given the high prevalence of such behavioral health disorders in ALs, this would be an appropriate requirement.	Kim Burton	Maryland Coalition on Mental Health and Aging / Mental Health Association of Maryland	No Change
10.07.14.15 I.(5)	Replace term "psychosocial" with more current terminology, "behavioral health". We recommend that the regulations be combed for the term "psychosocial" and, where appropriate, change it to "behavioral health."	The usage of terminology should be consistent and reflect current language that is more commonly used among state agencies and providers. "Behavioral health" 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.	Kim Burton	Maryland Coalition on Mental Health and Aging / Mental Health Association of Maryland	Agree.

10.07.14.15 A (1)(c)(i)	Add "or RN"	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	Cyndi Rogers	Winters Growth Inc	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.
10.07.14.15 A. 2.a	Add the word "or"	1. The requirement to limit the position of Assisted Living Manager and that 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 prevents RN's who may not have a 4 yr college degree from applying for this position.	Susan Rodgers	The Cottage at Curry Manor	No change.
10.07.14.15 A.3.a	Please remove the phrase that the 80 hour ALM course must be approved by the Maryland Higher Education Commission and leave the phrase "approved by department." If unwilling, please AT A MINIMUM, "grandfather" in current department-approved trainers ("or those vendors approved prior to this regulation change.") The same issue applies to the 20 hour update course. If you choose to ignore these concerns, please at least allow current vendors 5 years to obtain Higher Education Commission Approval, because it is very costly and takes more than a year.	Caraway Manor in rural Cecil County is currently a department-approved vendor for the 80 and 20 hour ALM courses. We have been able to help fill a huge deficit in availability of these courses in the rural areas of the state. We can meet this need because I did my due diligence years back and went through a two year process to have our curriculum approved by your department. We spent years and substantial funds to develop this curriculum and to obtain approval and have earned the right to continue teaching this fully compliant course. Simply stated, we are able to teach and meet an urgent training need for the community—all of our courses are at the request of the participants who cannot find suitable courses elsewhere. I also have a Master's in nursing with a college level education focus, so I am highly qualified. I am constantly receiving calls and requests for me to teach the 80 hour ALM course in our rural area and bordering counties because there is a total lack of availability for the 80 hour course. The local colleges (higher learning centers) say they offer the course but do not really offer the course because they require large classes—which is nearly impossible in a rural area. I, on the other hand, will teach the class for a few participants in the area who need it at any given time. The closest option typically is in Baltimore, offers inflexible scheduling for working participants, is much more costly, creates work and travel barriers, and are extremely slanted toward larger, urban facilities instead of local rural concerns. In summary, we already have a dire, significant access barrier to the 80 and 20 hour courses for potential managers and this proposed change will only serve to worsen the already miniscule training site options in the rural areas of the state. I looked into obtaining the Higher Education Commission approval and it is very time consuming and costly. I would have to	Betty Battaglia	Caraway Manor Assisted Living	No Change.
10.07.14.15 A(3)(a) ALM 80 hour training	Please remove the phrase that the 80 hour ALM course must be approved by the Maryland Higher Education Commission and leave the phrase "approved by department." If unwilling, please AT A MINIMUM, "grandfather" in current department-approved trainers ("or those vendors approved prior to this regulation change.") The same issue applies to the 20 hour update course. If you choose to ignore these concerns, please at least allow current vendors 5 years to obtain Higher Education Commission Approval, because it is very costly and takes more than a year.	Caraway Manor in rural Cecil County is currently a department-approved vendor for the 80 and 20 hour ALM courses. We have been able to help fill a huge deficit in availability of these courses in the rural areas of the state. We can meet this need because I did my due diligence years back and went through a two year process to have our curriculum approved by your department. We spent years and substantial funds to develop this curriculum and to obtain approval and have earned the right to continue teaching this fully compliant course. Simply stated, we are able to teach and meet an urgent training need for the community—all of our courses are at the request of the participants who cannot find suitable courses elsewhere. I also have a Master's in nursing with a college level education focus, so I am highly qualified. I am constantly receiving calls and requests for me to teach the 80 hour ALM course in our rural area and bordering counties because there is a total lack of availability for the 80 hour course. The local colleges (higher learning centers) say they offer the course but do not really offer the course because they require large classes—which is nearly impossible in a rural area. I, on the other hand, will teach the class for a few participants in the area who need it at any given time. The closest option typically is in Baltimore, offers inflexible scheduling for working participants, is much more costly, creates work and travel barriers, and are extremely slanted toward larger, urban facilities instead of local rural concerns. In summary, we already have a dire, significant access barrier to the 80 and 20 hour courses for potential managers and this proposed change will only serve to worsen the already miniscule training site options in the rural areas of the state. I looked into obtaining the Higher Education Commission approval and it is very time consuming and costly. I would have to	Betty Battaglia	Caraway Manor	No Change.
10.07.14.15 B	B. Should not be exempt from continuing education	It is important for all alf managers to have regular continuing education to ensure quality of care and quality of life for alf residents.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree. Addressed change from 4 years to 2 years.
10.07.14.15 I	Section (I), change "within 2 hours" to 24 hours for when the manager (should be program) should notify the delegating nurse/case manager.		Danna Kauffman	LifeSpan	No Change
10.07.14.15 I	Section (I)(14) delete. (14) Ensuring all residents and staff are aware of the option of an annual influenza vaccine as evidenced by documented acceptance or refusal of the vaccine, and documented surveillance of non-immune staff during the recognized flu season.		Danna Kauffman	LifeSpan	Thank you for comment. In response OHCQ has re-written this section.
10.07.14.15 I.1	Consider changing the requirement of notifying the delegating nurse within two hours of all significant changes, hospitalizations, and returns to the facility.	Two hours is very unreasonable and even in LTC this is not a requirement. Residents have changes at all hours of the day and night and it is impossible in a large facility for the manager to be aware immediately as well as to then notify the delegating nurse.	Amanda Baker	Homewood	No Change.
10.07.14.15 I(13)	delete "or interested family member" in the notification requirements for changes of conditions, etc. due to HIPPA issues and possible resident right issues.		Danna Kauffman	LifeSpan	Agree

10.07.14.15A	Insert an "and" or an "or" after Regulation .15A(2)(c)	As written, we don't know if an individual is required to have met the requirements of (1), (2), AND (3) under A or (1), (2), OR (3) under A. It seems the intent is OR, but as written it is confusing.	Kristen Neville	DHMH - Health Occupations Boards	Agree
10.07.14.15A(3).a & c.	(a) Change "Maryland Higher Education Commission" to "The Department – OHCQ" (c) 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.	After submitting my OHCQ approved curriculum for the 80 hours Managers Training Course to MHEC for consideration for a private career school, I was advised on May 7, 2014 by Maryland Higher Education Commission, that the Assisted Living Manager courses do not meet the requirements as needed educational training to enable a layperson to secure gainful training-related employment. "Your organization is not currently subject to Commission oversight in offering these particular courses in Maryland." (copy available upon request) ABC's prospective students are seeking to become entrepreneurs of their facilities with the ability to provide a better quality of life to seniors and provide jobs for their staff. It would pose a significant hardship to this particular approved training vendor should we have to seek approval through MHEC. ABC has diligently stressed to all of its students the importance of being compliant with all COMAR 10.07.14 and making life better for the at-risk seniors and the disabled.	Mary Dent	ABC TRAINING CENTER	No Change
10.07.14.16	Recommend adding fall prevention to training requirements.	The number of American seniors who die from fall-related injuries has nearly doubled since 2000, a new report from the U.S. Centers for Disease Control and Prevention reveals. 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
10.07.14.16	Recommend deleting reference to level of care assessments	Regulation consistency	Jane Wessely	Private Citizen	Levels of Care retained due to statute, Health-General §19-1805(a), which requires licensing according to level of care.
10.07.14.16	Recommend adding language: Development of [individualized] person-centered service plans.	Change is consistent with concept of person-centered care planning which is a more contemporary and comprehensive individualized approach to care planning. See previous comment on 10.07.14.02.B(76).	Jane Wessely	Private Citizen	No Change
10.07.14.16	Recommend adding language: Development of individualized, person-centered, service plans	Consistent with national cultural change movement to promote person-centered care.	Jane Wessely	Private Citizen	No Change
10.07.14.16	(4) Is licensed as a nursing home administrator in this State. They should be exempt from the 20 hrs continuing ed. requirement also (.16 C).	I'm not sure whether I'm reading this correctly, but a nursing home administrator should be exempt from the 20 hrs continuing ed. requirement because I believe they already have to do enough hours continually to keep their NHA license.	Karen Besaw	Private Citizen	No Change.
10.07.14.16	D. 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"	It's assisted living manager, not assisted manager.	Karen Besaw	Private Citizen	No Change.
10.07.14.16	Delete the word "non-immune".	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.
10.07.14.16	(12) Quality assurance, 4 hours, including: (a) Incident report processes; and (b) Quality improvement processes; and Add: (c) Root cause analysis And this should be added to the QA section also.	Providers 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.
10.07.14.16	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 topic requirements in this section thus reducing the hour assignment. We can negotiate this as there is no reason to repeat education.	The MHFA certification course is nationally embraced as a comprehensive curriculum that addresses several behavioral health issues common to AL residents. The course is designed with the principles of adults learning, it is interactive and has received many accolades in Maryland as it has been used for DHMH, MDoA and DHR workforce education.	Kim Burton	Mental Health Association of Maryland	No Change
10.07.14.16	Add Manager / Alternate Manager	Regulations indicate both the Manager & Assistant Manager will require the same training (80 hour course) and renewal course work	Gayle Walter	Willow Brook Square - Thomas B. Finan Center (DHMH / BHA)	No Change
10.07.14.16	It should remain with OHCQ with possible periodic survey of actual training and content of class material	Nurse surveyors know exactly what the prospective providers should walk away with relating to meeting the COMAR regualtions	Mae Simms	Beyond Care	No Change

10.07.14.16 –	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 in 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 timelier updates. Establishing a four- year interval without receiving updates is untimely 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 pathogen standard Hand hygiene Safe injection practices Use of personal protective equipment Cleaning and disinfection of equipment and the environment**		Brenda Roup	DHMH_Infection and Prevention	Agree
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.	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
10.07.14.17	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 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.	Mae Simms	Beyond Care	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 provide 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	(8) competency done by the DN. Add wording to say that the DN must do a competency on all non-CNA/GNA personnel initially and then annually.	The NPA requires an RN to continually assess the personnel she delegates to. 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.	There are some large facilities that let LPNs do everything (they don't employ med techs), and for the most part LPNs 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 Besaw	Private Citizen	No Change.
10.07.14.17	Overall, this new regulation, along with other proposed changes throughout the Chapter, gives much more responsibility to the delegating nurse. The changes arguably make the delegating nurse more powerful than the manager. MDoA understands that these changes are being proposed to improve the quality of care in assisted living and to improve the safety and welfare of assisted living residents. We share these goals. However, we are concerned as to whether this new model is practicable in the real world. Delegating nurses are usually consultants to an assisted living provider. As consultants how will they have the power to "assure" and "ensure" all the things the new proposed regulations require of them? If the delegating nurse is an employee of the assisted living provider, the balance of power is even worse. These new requirements look good on paper, but we are concerned about how well they can be implemented in the entrepreneurial world of assisted living.		Alice Hedt	MD Department of Aging	Agree
10.07.14.17	Duties: "Perform an initial assessment at the time of the resident's admission", Please add an accepted timeframe such as "within 48 hours" as opposed to "at the time of the resident's admission".	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 (3) (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 Assisted living facility as a respite care almost every other week, and spends 2-3 days each time. 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, rewrites 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 dawn on them that it's part of their duties of oversight and COMAR doesn't explicitly say you have to.	Karen Besaw	Private Citizen	No Change
10.07.14.17	Please add: Each Delegating Nurse shall Delegate to no more than 30 residents total.	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.	The initial nursing assessment must be completed before the resident enters the facility.	Kim Fiore	Private Citizen	No Change
10.07.14.17 C.	May contracting nurse choose not to have an alternate. If so how are ohcq surveyors to acknowledge this choice. Can delegating nurse use a nursing agency to fulfill this requirement Independent Delegating nurse contractor should have choice	Many 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 nurses to under bid or break contracts	Kim Bryant Washington	kimease 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 is being provide as the residents age in place.	Lynn McCamie	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.	Danna Kauffman	LifeSpan	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.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	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 overnight staff will be determined from the nursing assessment, but new Regulation .13F provides that the need for overnight staff will be determined from the Resident Assessment Tool.		Alice Hedt	MD Department of Aging	Follow-up required once forms are finalized.
10.07.14.17 F(2) and F(8)	Section (F)(2) and (8): LifeSpan is opposed to the mandatory requirement that the DN/CM to 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 invasive request on a very difficult day, particularly for residents with dementia.	Danna Kauffman	LifeSpan	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.		Alice Hedt	MD Department of Aging	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?		Alice Hedt	MD Department of Aging	Thank you for comment. In response OHCQ has re-written this section.
10.07.14.17 F8	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	Susan Hirsch	HCR ManorCare	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.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.17 G(1)	This provision exempts the delegating nurse from the requirement in .17F(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.		Alice Hedt	MD Department of Aging	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.	Alice Hedt	MD Department of Aging	No Change.
10.07.14.18	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.	Karen Besaw	Private Citizen	No Change
10.07.14.18	C.(1) – change wording to be "at least every 6 months"	Because it's more accurate.	Karen Besaw	Private Citizen	Agree

10.07.14.18	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.	Karen Besaw	Private Citizen	No Change
10.07.14.18	Change the word Residential to Respite.	It's not the right term. It should be respite care. Short-term residential care implies that they can have a "trial" of assisted living, which a lot of our providers think they can do. There is no such thing as a trial, there's only respite.	Karen Besaw	Private Citizen	No Change
10.07.14.18	Change wording to make it more accurate. Like "…subsequent short-term (respite) admissions…" or "…subsequent respite admissions…"	See previous. Otherwise they'll think they can do "trial" admissions.	Karen Besaw	Private Citizen	No Change
10.07.14.18	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 meds have changed since the last time, and what those changes are.		Karen Besaw	Private Citizen	No Change
10.07.14.18	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.	Susan Hirsch	HCR ManorCare	No Change.
10.07.14.18	Lists professional	Are these the professions that should be list in the definition of health practitioner rather than just citing the law (the law is too broad).	Lynne McCamie	Baltimore county Ombudsman Program	No Change
10.07.14.18	Lists professional	Are these the professions that should be list in the definition of health practitioner rather than just citing the law (the law is too broad).	Lynn McCamie	Ombudsman_Baltimore County	No Change.
10.07.14.18 A.1	Is the resident assessment tool taking the place of the healthcare practitioner form	Rarely do small facilities admit patients 30 days in advance. Oftentimes when patients are being transferred/ Discharged from hospitals from 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 cant give discharge summary	Kim Bryant Washington	kimease assisted living nurse services	Follow-up required once forms are finalized.
10.07.14.18 A.1	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.	Diana Ponterio	Country Meadows	No Change
10.07.14.18 A(1)	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.	Cyndi Rogers	Winters Growth Inc	Follow-up required once forms are finalized.
10.07.14.18 A(3) AND E	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.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.18 D	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.	Danna Kauffman	LifeSpan	Thank you for comment. In response OHCQ has re-written this section.
10.07.14.18 E		Section E of Regulation .18 should be combined with the other provisions related to emergency services for clarity.	Danna Kauffman	LifeSpan	No Change.
10.07.14.19	Ok, I'm confused now. This section is a repeat from the one I made the recommendation to delete para (I.) on earlier. Around pg 44??? So what I said was -- Para I: 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.	Karen Besaw	Private Citizen	No Change.

10.07.14.19	B. 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.	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 DN/CM 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)!	Karen Besaw	Private Citizen	No Change
10.07.14.19	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.	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.	Karen Besaw	Private Citizen	No Change
10.07.14.19	Delete "to a sufficient number of staff". Just make it so that CPR is required for everybody.	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.	Karen Besaw	Private Citizen	No Change
10.07.14.19	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 [(ix), (b), (i), (ii), (iii), (iv), (c), (i), (ii), (iii), (iv)]and a bunch of others? Somebody needs to take a look at this.	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…	Karen Besaw	Private Citizen	No Change
10.07.14.19	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.	Karen Besaw	Private Citizen	No Change
10.07.14.19	(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.	Karen Besaw	Private Citizen	No Change

10.07.14.19	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 interpretations 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 "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 B, an assisted living program may not admit or provide services…"		Alice Hedt	MD Department of Aging	Thank you for comment. In response OHCQ has re-written this section.
10.07.14.19	Better define "dangerous"	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.	Kim Burton	Mental Health Association of Maryland	No Change
10.07.14.19	Resident Specific Waiver. We are concerned that this definition allows for subjective determinations by assist living provider of when an individual is "dangerous" and what " appropriate treatment modalities" are.	This is of particular concern because assisted living residents have no right to a hearing on the issue of whether a reason for proposed discharge exists. As such a resident has no method of defending herself if accusations of dangerousness are unfounded. There is also no remedy for a resident who believes that "appropriate treatment modalities" have not been used to treat behaviors.	Anne Hurley	Legal Aid	No Change
10.07.14.19	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 saftey complications which cannot be adequately managed" is a medical determination and as such should require a phsician certification that a resident meets this criterion.		Anne Hurley	Legal Aid	No Change
10.07.14.19	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	I have been a delegating nurse since the first nurses were trained at the Board of Nursing. I taught the delegating nurse course at the American Red Cross to the assisted living surveyors when the role was first adopted. I have been a health care consumer caring for both of my parents with dementia for seven years. I have been teaching certified nurse assistants, delegating nurses and medication technicians for many years. Through my experience I have been aware of many problems and abuses due to poorly trained direct care staff. Many of the family members of assisted living residents are surprised and dismayed when they learn that the direct care staff are not required to be certified. Over the years assisted living facilities are allowing the residents to age in place which means caring for increasingly medically complex residents. It places an undue burden on the delegating nurses to be responsible for inadequately trained staff. 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. Nursing Assistant Certification can also ensure a standardized level of training.	Patricia Hemler	Howard Community College	No Change
10.07.14.19 A.5	**Change to : Being treated for a disease or condition that requires more than contact precautions.**		Brenda	DHMH_Infection and Prevention	Agree
10.07.14.19 A(4) and B(2)	LifeSpan would like to better understand the rationale of the Department allowing an individual to be serve an individual with a permanent intravenous access device with a resident specific device but not allowing the program care for an individual utilizing a temporary intravenous access device. Individuals are often sent home on IV devices with antibiotics.		Danna Kauffman	LifeSpan	Thank you for comment. In response OHCQ has re-written this section.

10.07.14.19 B.6.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!	Janice Peterson	The Village at Rockville	No Change
10.07.14.20	.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 LPN 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 return to the facility. Taking into consideration input and recommendations should be considered, but not mandated	The owner and or manger 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	Mae 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 OHCQ and DHMH 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 room.	Individuals should have the right to privacy. Any exceptions to this requirement for a resident based on resident safety issues, must be documented in the individualized service plan. 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 Waiver, 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 Besaw	Private Citizen	No Change
10.07.14.20	Alf 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 in 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 transport 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.

10.07.14.20 & 10.07.14.21	These two sections need to be redrafted.	First, these are agreements or contracts between the program and the resident. The information contained in the regulations goes beyond the scope of agreements and contains either program policies or substantive requirements. For example, On page 92, it requires the DN/CM to perform and document an assessment in the hospital. On this note, there was a commentator who suggested that this assessment be done by a physician. LifeSpan would disagree and opines that, if this requirement was to remain, it should be completed by the program, in consultation with the DN/CM, who understands the resident and the abilities of the staff. On page 96, it requires the community to provide 30 days notice prior to discharge to the Department of Aging and APS. These are substantive requirements being placed on the program and are not appropriate to be included under "agreement content." More importantly, both requirements will unduly burden the program and the DN/CM. As far as policies, the regulations require information on several policies, including the administration of medication, compliant or grievance procedures, bed hold, discharge policies, availability of medical adult day, and burial arrangements. Again, these are not appropriate for placement in an agreement but should be handled separately. It is important to point out that if a program is required to hold a bed for 72 hours, there should be a similar provision that a resident is required to pay for that bed being reserved. Lastly, page 90, requires the resident agreement to have a listing of services provided by the program and those not provided. Why not just reference the Uniform Disclosure Act?	Danna Kauffman	LifeSpan	Thank you for comment. In response OHCQ has re-written this section.
10.07.14.20 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 sign, before or at the time of a admission, a resident agreement that: Change this to read the assisted living manager or designee		Patricia Anderson	Brooke Grove Foundation, Inc	Agree
10.07.14.20 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.	The text at the top of page 70 is the same text as at the bottom of page 69; obviously a typo.	Kristen Neville	DHMH - Health Occupations Boards	Agree
10.07.14.20 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	Kim Bryant Washington	kimease assisted living nurse services	Agree. Section re-written.
10.07.14.20 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
10.07.14.20 D(3)	The reference here and throughout to "domestic partner" may be obsolete in light of recent legislative enactments.		Alice Hedt	MD Department of Aging	No Change.
10.07.14.20 D(6)(d)	This provision needs some editing. "Emergently"? See the Style Manual for Maryland Regulations: http://www.dsd.state.md.us/stylemanual.pdf.		Alice Hedt	MD Department of Aging	Agree. Regulatin revised.
10.07.14.21	Add wording to make it "known allergies to medications, foods, and environmental factors."	Because it's not a complete allergy assessment if you only assess them for allergies to foods and medications. And because that's what our forms have printed on them – medications, foods, and environmental factors. Tons of people are allergic to tomatoes, nuts, pollen, cat dander, etc. You have to assess people for allergies to EVERYTHING.	Karen Besaw	Private Citizen	No Change
10.07.14.21	.25 Resident Agreement – Financial Content. Add that the Resident Agreement must contain who pays for the resident's medications as well as the pharmacy reviews.	I've 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!	Karen Besaw	Private Citizen	No Change.
10.07.14.21 B	In .21.B(1) the word "agent" is changed to "representative." Please see MDoA's comment on this proposed change in Comment A above. In .21B(2)(g) 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.

10.07.14.21 D	Overnight staff should be required to be awake. At the very least, this should be the exception, not the rule. .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.	Anne Arrington	Carroll County Bureau of Aging and Disabilities	No Change
10.07.14.21 Resident Agreement	[.25] .21 Resident Agreement — Financial Content. (g) The procedures the [assisted living] program will follow in the event the resident or [agent] resident's representative can no longer pay for services provided for in the resident agreement or for services or care needed by the resident; including at least 30 days notice prior to discharge to the Department of Aging and if there is reason to believe that the resident is a victim of financial exploitation, a report shall be made to the Adult Protective Services Program of the local department of social services;		Valarie Colmore	Maryland Department of Human Resources	No Change.
10.07.14.22	Recommend adding language: D.(1)(d) ensure the resident's choice regarding services and providers to the extent possible	In concert with person-centered care planning, the resident should be involved in planning and choosing services as well as who provides them to reflect the resident's desired preferences and goals.	Jane Wessely	Private Citizen	Agree and re-wrote to add resident's preference.
10.07.14.22	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 (76), 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, and independence of each resident. The resident, and if applicable, one or more of resident's representatives, shall participate in the development of the initial service plan and any subsequent service plans. With the resident's consent, family member or other individuals may be invited to participate. A service plan for each resident shall be developed and maintained in a manner that enhances the principles of dignity, privacy, resident choice, resident capabilities, individuality, and independence without compromising health or reasonable safety of other residents.	Lynne McCamie	Baltimore county Ombudsman Program	No Change
10.07.14.22	Sync 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.	Lynne McCamie	Baltimore county Ombudsman Program	Follow-up required once forms are finalized.
10.07.14.22	Resident involvement in the development of the Service Plan is central to resident focused and directed care. The Service Plan becomes the foundation for determining how the resident's preferences and needs are addressed so that the resident can experience quality of care and quality of life. We recommend that the following language be added in section .22A 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. A. The manager, or designee, shall ensure that all services are provided in a manner that respects and enhances the dignity, privacy, and independence of each resident. The resident, and if applicable, one or more of resident's representatives, shall participate in the development of the initial service plan and any subsequent service plans. With the resident's consent, family members or other individuals may be invited to participate. A service plan for each resident shall be developed and maintained in a manner that enhances the principles of dignity, privacy, resident choice, resident capabilities, individuality, and independence without compromising the health or reasonable safety of other residents. 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. Finally, it needs to be made clear that the resident is to be involved in making an updates to the service plan so we recommend the following additions to Section .22D(3): D. (3) The service plan is reviewed by staff, and updated if needed, at least every 6 months, and updated if needed, unless a resident's condition or preferences significantly change, in which case the assisted living manager, or designee, and delegating nurse/case manager shall review and		Alice Hedt	MD Department of Aging	Agree. Adding :The resident, and if applicable, one or more of resident's representatives, shall participate in the development of the initial service plan and any subsequent service plans. With the resident's consent, family members or other individuals may be invited to participate. (4) If a review under section D(3) of this regulations indicates a service plan needs to be updated, the manager, or designee, and delegating nurse/case manager shall update the service plan in conjunction with the resident, and if applicable on or more of resident's representatives.
10.07.14.22	Include the resident's right to contribute to the development, review and update of his / her service plan	Per patient-centered values, the resident should be included among the individuals who develop, review and update the plan	Kim Burton	Mental Health Association of Maryland	Agree
10.07.14.22	Updated at least every 6 months and involve resident and resident representative.	Updated at least every 6 months and involve resident and resident representative.	Lynne McCamie	Baltimore county Ombudsman Program	Agree
10.07.14.22 D.3	Updated at least every 6 months and involve resident and resident representative.	Specific language: Resident involvement in the development of the Service Plan is central to "resident focused and directed care." The Service Plan becomes the foundation for determining how the resident's preferences and needs are addressed so that the resident can experience quality of care and quality of life.	Lynn McCamie	Ombudsman_Baltimore County	Agree. Follow-up to re-work section added by Alice Hedt and Lynn.

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 (76), 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, and independence of each resident. The resident, and if applicable, one or more of resident's representatives, shall participate in the development of the initial service plan and any subsequent service plans. With the resident's consent, family member or other individuals may be invited to participate. A service plan for each resident shall be developed and maintained in a manner that enhances the principles of dignity, privacy, resident choice, resident capabilities, individuality, and independence without compromising health or reasonable safety of other residents.	Lynn McCamie	Ombudsman_Baltimore County	Agree.
10.07.14.22 C	Sync 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 McCamie	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 Wessely	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 Medication Management. Medications and treatments shall be administered consistent with current signed medical orders and using professional standards of practice.
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 appt 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 run into this with larger facilities often. The care notes are generally awful. But the DN 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. We need the initial dates of things to be able to tell if the admission paperwork was done correctly. Most of the providers thin the files and the stuff is never there.	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 absences (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 Nurse'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." (8) 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 Dietetics in Health Care Communities	Agree.

10.07.14.23 A	The list of documents to be included in a resident's record should include an advance directive if the resident has one.		Alice Hedt	MD Department of Aging	No Change
10.07.14.23 D.1.a	Eliminate weekly care notes	Charting is done on admission and any event or significant change. Weekly is very cumbersome and time consuming and adds nothing to quality care.	Diana Ponterio	Country Meadows	No Change
10.07.14.24	Recommend deleting language: … three meals [in a common dining area] ..	Residents should have the choice to have meals in their rooms or other locations in the house. Residents should not be forced to eat in a common dining area or at a specific meal time decided upon by the facility.	Jane Wessely	Private Citizen	No Change
10.07.14.24	Recommend deleting and adding language: … snacks or food supplements during [the evening hours] each 24-hour period.	In concert with person-centered care and resident rights, a resident should have flexible access to snacks during each 24-hour period, not just during evening hours.	Jane Wessely	Private Citizen	No Change.
10.07.14.24	Recommend adding language: ... as determined in the resident assessment and according to resident preferences, including …	Residents should have the right to choose from available services according to personal needs and preferences.	Jane Wessely	Private Citizen	No Change
10.07.14.24	Recommend adding language: … and leisure activities which reflect resident choice and preferences and which promote the …	Choice of social and leisure activities should reflect what is meaningful and enjoyable to the resident as opposed to what is decided by staff.	Jane Wessely	Private Citizen	Agree
10.07.14.24	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."		Karen Besaw	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".
10.07.14.24	**RESTORE Subsection (2) (a) (b) and (c) in their entirety and in (2)(c) REPLACE "licensed dietician or nutritionist" with "LICENSED REGISTERED DIETITIAN". DELETE the proposed language under new subsections "(2)" and "(3)" in their entirety.**	Maintaining the role of licensed registered dietitians in the menu planning for residents helps to preserve continuity and quality of care. The regulations as proposed may have the unintended consequence of eliminating individualized menu planning for residents. The original regulatory language should remain.	Gill Livleen	Maryland Academy of Nutrition and Dietetics	No Change
10.07.14.24	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.		Danna Kauffman	LifeSpan	Agree
10.07.14.24	delete Section (H) on special care needs as redundant.		Danna Kauffman	LifeSpan	No Change
10.07.14.24	(1)The manager shall ensure that: Recommendation - Add a new section after section (e) "Residents have access to snack as…" as (f) "A Copy of the State Diet Manual, free of charge as a download, shall be available for resident and family review."	Residents and families have a right to understand the medical basis for therapeutic diets. This information should be readily available at all times.	Phyllis McShane	Maryland Dietetics in Health Care Communities	Agree.
10.07.14.24	(1) The manager shall ensure that: Recommendation - Revise (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…."	Residents need to be offered the basic minimum requirements as established by USDA as necessary for the health of adults.	Phyllis McShane	Maryland Dietetics in Health Care Communities	Thank you for comment. In response OHCQ has re-written this section.
10.07.14.24	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.	As the (sickness) acuity level has increased in Assisted Living Facilities over the past 10 years, it has become even more important that clients living in these facilities receive and regularly consume nutritious foods to ensure they remain adequately nourished and optimally able to conduct their activities of daily living.	Phyllis McShane	Maryland Dietetics in Health Care Communities	Agree with (a) and (b)
10.07.14.24	change practioner to practitioner	typo	Gayle Walter		Agree
10.07.14.24	Change wording from "special diets" to "therapeutic diets" Recommendation – (ii) 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.		Phyllis McShane	Maryland Dietetics in Health Care Communities	No Change
10.07.14.24	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) decubitus breakdown, residents receiving enteral (tube) feedings and monthly weight records for all residents.	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-hawes-assisted-living-is-a-ticking-time-bomb/).	Phyllis McShane	Maryland Dietetics in Health Care Communities	No Change

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 unexplanned 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.	1. In the past 10-15 years the "average" sickness acuity of persons residing in Assisted Living Facilities has increased in part due to waivers that allow residents to age in place beyond the licensing of the facility IF the facility COULD provide the additional "higher levels/ more skilled" services required by individual clients. 10-15 years ago the population living in ALF did not include persons who were receiving every other day dialysis, receiving tube feedings (or intravenous feeding) and diagnosed with severe wounds including stage 3 and stage four decubitus ulcers. 2. Identification of medical problems at the earliest possible stage provides an opportunity to address these problems while they are more easily treatable rather than waiting for worsening situations that could lead to injuries, hospitalizations or unplanned deaths. Monthly weight change (loss) is a common harbinger of impending medical status change making weight change monitoring/tracking in (at least) level 2 and level 3 residents necessary. 3. Medical Nutrition Therapy (MNT) is a key, recognized component in the management of persons receiving dialysis, tube feedings, intravenous nutrition feedings, and in wound healing as well as in patients who develop malnutrition related to chronic disease. MNT is most effectively provided by the licensed registered dietitian.	Phyllis 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 Servcies. This regulation states that as part of the licensure approval and renewal process, all licensees 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.	Licensed dieticians and nutritionists are qualified to choose well-balanced meals that adequately provide the nutritients necessary for residents to stay healthy. Inadeuqte meals may lead to malnutrition, unintended weight loss and dehydration and can increase the likelihood of pressure ulcers, infections, poor wound healing, anemia and hypotension. Pre-planned prevention of these ailments would save the State by reducing unnecessary hospilaztions and nursing home admissions. Our most vulnerable population resides in these Assisted Living Facilities, and their health is crucial to the families of those residents, as well as our economy. Residents and their family members have the right as consumers to view the posted menus. This encourages managers to comply with the nutritionally adeuqate approved menus. out of the 106 Assisted Living Programs in Anne Arundel county, there are 1,579 residents that deserve to be provided nutritious meals to assist in improving their health and overall quality of life.	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 detrment of those residents and their families, the proposed revisions replace concise, enforceable language with vague standards, subject to intrepatation by the operators of these facilies and the regulators alike. As regulators, it is imperative that we have the tools to ensure that operators are serving nutritious, balanced meas and that the appropriate dietary recrods are develoepd and maintained. As propsed, the language eliminates some of those 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	MDoA 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 licensee
10.07.14.24 A(2)	MDoA 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 dietician 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 dietician/nutritionist. Removing this requirement will serve only those providers who refuse 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 dietician 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

10.07.14.24 A(4)	Special Diets INSERT a new (ii) ARRANGE for at least Quarterly Visits by A Licensed Registered Dietitian; AND		Gill Livleen	Maryland Academy of Nutrition and Dietetics	No Change
10.07.14.24 F	INSERT after "services" in (8) "PROVIDED BY A LICENSED REGISTERED DIETITIAN ON AT LEAST A QUARTERLY BASIS;"		Gill Livleen	Maryland Academy of Nutrition and Dietetics	No Change
10.07.14.25	"Can be complex" should that be the case let it be the decision of the owner with input from the DN 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.	The population is a diverse population and considering nine (9) or medications may consist of PRNs and over the counter. The staff, manager, and DN in their monitoring recognize the need to have additional consultations	Mae Simms	Beyond Care	Agree. Will remain 6 months.
10.07.14.25	Change "delegating nurse or case manager" again.		Karen Besaw	Private Citizen	Agree. Addressed. The terms, "case manager/delegating nurse", "delegating nurse/case manager" have been removed. These terms are replaced by the term "delegating nurse".
10.07.14.25	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, diagnoses, and allergies.	Because that's what should be on every MAR.	Karen Besaw	Private Citizen	No Change.
10.07.14.25	Change wording to "Two staff shall count and sign their names…"	Because that's the standard to prevent drug diversion. Two staff must count and document the count with their signatures, the offgoing staff and the oncoming staff. If it's a small place and it's the same person over and over, then you can let them slide and only sign with one???	Karen Besaw	Private Citizen	No Change
10.07.14.25	(4) Add wording to say that they have to get a CDS license initially in order to be issued a license, and then they need to renew it as often as Div. of Drug Control says.	They need to have that license to be able to administer CDSs, and you never know when a physician will prescribe one for someone. So they should always be prepared beforehand.	Karen Besaw	Private Citizen	No Change.
10.07.14.25	It shouldn't be left up to them how to do it. It should be according to how the Div. of Drug Control says to do it.	What Div. of Drug Control says will ensure that the CDSs can't be put back together again and then used or sold. If it's left up to them they'll just dump it down the toilet or throw something in the wastebasket.	Karen Besaw	Private Citizen	No Change.
10.07.14.25	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 medicine.		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.25	change "their health care provider" to "DN/CM" for documenting the resident's competency and ability to safely administer medications to their spouse or domestic partner.		Danna Kauffman	LifeSpan	Agree
10.07.14.25	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 "PRN" 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?		Danna Kauffman	LifeSpan	No Change.
10.07.14.25	We recommend changing the review requirement from every 6 months to every 3 months for any resident receiving 9 or more medications.	Medication issues are a primary driver of ED visits for older adults as well as the consequences of delirium e.g., falls, weight loss, apathy, somnolence and more. Given the high number of medications and the high risk for drug / drug interactions, residents deserve this level of oversight. Most states require medication reviews every 3 months – despite the number of medications	Kim Burton	Mental Health Association of Maryland	No Change
10.07.14.25	(b) Narcotics and controlled drugs be destroyed as directed by regulation.	State law already directs destruction of narcotics. OSHA, EPA, MOSH etc... are continuously revising requirements for destruction of medications and list of medications requiring special disposal "Hazardous Drug Waste" continues to increase	Gayle Walter		No Change.
10.07.14.25	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.		David Jones	Board of Pharmacy	No Change
10.07.14.25 F.1	x: 1. Suggest a 7 day rather than 14 day time frame.		David Jones	Board of Pharmacy	No Change
10.07.14.25 F.1	Medication Review upon admission. (1) states [the assisted living manager shall consult within 14 days of a resident's admission with the individuals set forth in G(2) of this regulation to review a new resident's medication regime.] Change to read the Assisted Living Manager or designee.	Rationale: Each assisted living has such different staffing available to them. The delegating nurse in our scenario is reviewing the medications with the LPN in charge. With LPN's on staff 24/7 and CMA's administering medications, it is more valuable for the review of medications to be done with the clinical staff than with the ALM. The ALM review's the medications on the service plan. which is completed by a designee in our case the social worker.	Patricia Anderson	Brooke Grove Foundation, Inc	No Change

10.07.14.25 G	I saw that the pharmacist was pushing their service to visit the homes more frequently. This service should be done on as needed basis.	If they visit a home and identify that their is a need for more training with medication administration. They should be able to give this information in writing to the ALM. I am a nurse/Nurse practitioner and do not see the need for for more than 2 visits in my homes as previously recommended. I agree some homes may need more visits from the Pharmacist.	Dawn Buckmire	Caribbean Breeze Assisted Living	No Change
10.07.14.25 G.1	Pharmacy Review: Support a review every 3 months, not 6, and regardless off number of medications.		David Jones	Board of Pharmacy	No Change
10.07.14.25 G.1	Instead of having a pharmacy review every 6 months; why not have resident's PMD 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 I.c	c. Reason for the medication.	Physicians do not consistently include the reason for a medication on the prescription.	Constance Smith	Mercy RIdge, Inc.	No Change.
10.07.14.25 I.h	Labeling: Delete "refill limits"; any such information should be on the POS. Suggest keeping existing BOP legislation. Also, allow interim medications to better meet resident needs.		David Jones	Board of Pharmacy	No Change
10.07.14.25 J	1. no pill boxes for self medicators -	what is the reasoning? If you look at what "normal " people do in their homes is to use pill box dispensers. If one is on multiple meds and vitamins it is much more efficient and accurate for one to fill it for a week instead of opening multiple bottles every day(this is when they get confused of which one they took and which one they did not).	Gina Campanella Cooper	Pickersgill Retirement	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 Hedt	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.	Not having an interim box provided by the pharmacy could result in a significant delay in care to residents.	Constance Smith	Mercy RIdge, Inc.	Remove statement that facilities may not have interim medications.
10.07.14.25 J.	The proposed regulation under medications, {.29} .25 {M{ J states no interim medications box . We find it necessary as even STAT deliveries are a minimum of 4 hours. Having an interim box can alleviate an ER 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 "narcotics". C-II and II contain non-opioid drugs.		David Jones	Board of Pharmacy	No Change
10.07.14.25I	Insert language permitting the storage of medication in a refrigerator that is not also used for the storage of food, drink, etc.	Medications that need to be refrigerated should not be stored in the same refrigerator as lunch, food, drink, etc. to prevent contamination.	Kristen Neville	DHMH - Health Occupations Boards	No Change
10.07.14.26	.26 Service Plan (2) (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 manager or designee shall provide necessary information and support to ensure the resident directs the process to the maximum extent possible.	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(4): 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.	There may be residents that have health and safety issues that would prevent them from having the ability to exercise certain rights such as having keys to lock doors. It is critical that any exceptions be based on a thorough, individualized assessment rather than the manager preference.	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 this 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 Besaw	Private Citizen	No Change
10.07.14.26	A(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 there places where you can get that many hours? Because I don't know of any…just wondering.		Karen Besaw	Private Citizen	Agree. See .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.	Take all the Sunrise facilities. Their ALMs ("Executive Directors") might be degreed health care professionals or even licensed people, but they know NOTHING about a special Alzheimer's unit. Sometimes I wonder if they know anything about being an ALM to normal residents because they're so awful at it! The person who runs the facility should NOT be allowed to also head the Alzheimer's unit.	Karen Besaw	Private Citizen	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 (it's on p 117), but for INTIAL 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).		Danna Kauffman	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*/room 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

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*/room 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.
10.07.14.26	The recommendation is to include the wording "anyone passing meds" as the LPN, RN or CMA could be passing meds. Include the wording "unless there is an emergency or the individual receiving the medication requests something from the medication administrator.	More than one "title" can pass meds, in an emergency the person should be able to offer direct care and if the person receiving medications requests assistance (such as "can you assist me to the bathroom") the caregiver should be able to assist.	Anne Patterson	Leading Age Maryland	No Change
10.07.14.26	When the resident census includes with or more residents etc… 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.	The staffing levels should be determined based on the need and not on numbers.	Anne Patterson	Leading Age Maryland	No Change
10.07.14.26	Suggested that the word "designee" be replaced with Alternate Manager and or Case Manager.	The designee is not referenced as part of the team to view the Service Plan.	Anne Patterson	Leading Age Maryland	No Change.
10.07.14.26	D. (2) The service plan is developed within 30 days of admission to the program; and	Allow ample time to become familiar with resident, hopefully engage residents support system if they have one	Gayle Walter		No Change
10.07.14.26 C.b.2	Eliminate this regulation	Direct care staff needs to be able to provide occasional housekeeping and laundry assistance to residents. The universal worker is an effective care model in many communities.	Diana Ponterio	Country Meadows	No Change
10.07.14.26 C.b.2	Direct care staff shall not have housekeeping, laundry, food preparation, or maintenance duties as primary responsibilities.	Direct care staff have resident care as primary responsibilities however they are often assigned other responsibilities as appropriate like laundry, light clean up after meals etc. There is down time for the care staff when residents are in activities or when residents are sleeping and the direct care staff have the time to do additional work.	Patricia Anderson	Brooke Grove Foundation, Inc	No Change
10.07.14.26 C.b.3	Eliminate this sentence	Certified medication technicians should be expected to provide direct care after the medication pass is complete or in an emergency situation such as a fall.	Diana Ponterio	Country Meadows	No Change
10.07.14.26 C.b.3	Certified medication technicians shall not be responsible for any direct care activities while administering medication during the assigned times.	Again, each facility is staff so very differently. A blanket requirements like this makes successful organizations suffer. In our scenario, CMA's are in addition to care givers on day shift to pass meds, evening shift their are CMT's and night shift has CMT's. In some places LPN's pass meds as well. CMT's must be free to respond to resident needs while they are passing medications. This is part of good customer service. If it is not creating problems with accuracy and the time medications are delivered, the organization should not have to make adjustments to the way they do business.	Patricia Anderson	Brooke Grove Foundation, Inc	No Change
10.07.14.26 & 10.07.14.27	Add other dementias to the language of both of these regulations. Recommend a closer look and further discussion about the care for individuals with dementia and the special care unit.	Individuals with dementia have specialized needs, and the environment, staff training, and overall care should be looked at closely to ensure the best quality of care.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.26 A	Remove the requirement for a coordinator.	The regulation does not differentiate based on the size of the special care unit. Therefore, a coordinator would be required for an 8 bed unit as well as a 40 bed unit. The cost of running a small special care unit would be prohibitive. And the industry model is toward small units.	Patricia Younger	Sagepoint Gardens Assisted Living	No Change
10.07.14.26 A.1	Clarify the phrase "degreed health care professional"	Most health care professionals not only need a degree, but also a license or certification in order to practice. Those who would be responsible for an Alzheimer's unit should not just have a degree, but should be licensed by a licensing board.	Kristen Neville	DHMH - Health Occupations Boards	No Change
10.07.14.26 A1	Managers should not be required to be a licensed or degreed health care professional.	Many managers are in these positions doing a great job. They would be eliminated by this regulation.	Diana Ponterio	Country Meadows	No Change
10.07.14.26 A1	Specify requirements for "substantially equivalent training and experience" and include opportunity for "grandfathering" into the position.	The qualifications of the manager may effect individuals' career growth and development, i.e. limit promotions within the field. Item #3 does not provide specific requirements.	Susan Hirsch	HCR ManorCare	No Change
10.07.14.26 C	Change C. To read The service plan shall be completed utilizing the HCPPA, full assessment, and ALM form. Included in the service plan should be the active diagnosis, allergies, code status, behaviors, fall risk, pain present or potential, ADL's.	By giving the Assisted Living's the opportunity and guidance of what should be in the service it would better reflect on the resident's need. I have not found the current state service plan meets the needs of the residents with dementia.	Rosann DeRosier	Intergrace Fairhaven	Follow-up required once forms are finalized.
10.07.14.26 C.1.a	Change the 20 hours of training to be done within the first thirty (30) days and not prior to providing care.	The eight (8) hours of dementia training is fine but the additional twenty hours means new co-workers will not be able to start providing care for two weeks. This presents both cost and care challenges for providers.	Diana Ponterio	Country Meadows	No Change
10.07.14.26 C.1.a	Remove the requirement of training prior to providing care.	The best way to learn is to combine instruction with interaction with residents. 20 hours prior to giving care is an incredible training burden that is too much overload of information at one time.	Patricia Younger	Sagepoint Gardens Assisted Living	No Change

10.07.14.26 C.b.2	Remove .26 C (b) (2)	Best practices indicates that universal workers are the best model for dementia care. This proposed regulation makes that impossible.	Patricia Younger	Sagepoint Gardens Assisted Living	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 dementias to the language	Language not clear and consistent throughout sections E,F,G	Lynn McCamie	Ombudsman_Baltimore County	Agree.
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.		Danna Kauffman	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.	The requirements included in the assessment are extensive and time-consuming. If the requirements remain, a sample assessment/chart is recommended to ensure 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.	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.	There is no basis for this staffing ratio. 1:8 on night shift is unnecessary and cost prohibitive. Just because residents have dementia, that doesn't mean they are up all night. This will make it impossible for small units to function due to the staffing costs.	Patricia Younger	Sagepoint Gardens Assisted Living	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 hourAdditional 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.	Jane Wessely	Private Citizen	No Change.
10.07.14.28	Recommend adding language: Abuse or neglect;	Deaths resulting from neglect should be reported according to same policy as abuse.	Jane Wessely	Private Citizen	Agree
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	Agree, 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 Besaw	Private Citizen	No Change

10.07.14.28	Who fills out incident reports. Insert some other wording.	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 recording – 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	Private Citizen	No Change.
10.07.14.28	Number of care staff – minimum of one staff to eight residents. It's not enough. You need a minimum of TWO staff, especially at night.	What are they going to do when the one staff on the unit has to handle an emergency, and some resident crashes and needs CPR? There should never be just one staff on the unit.	Karen Besaw	Private Citizen	No Change.
10.07.14.28	Delete med error, and any injury. Or else you need to really define those more to keep them in. Like maybe a med error resulting in hospitalization or death. Or an injury requiring a trip to the hospital/ED/urgent care, etc. (which I think it what they have to do now anyway)	Do we really want them to tell us every single time a med error occurs? Or any injury? Like we don't have enough paperwork to get through already? Seriously? We'd be inundated with reports all day long and we don't have time to process them. Ridiculous	Karen Besaw	Private Citizen	No Change.
10.07.14.28	Add-program should notify Department about injuries of unknown origin as well as sending Ombudsman program the written incident report.	This allows for consistency of resident advocacy for resident rights and quality of care.	Anne Arrington	Carroll County Bureau of Aging and Disabilities	Agree. See .28 B.
10.07.14.28 D	Add-program should notify Department about injuries of unknown origin as well as sending Ombudsman program the incident report	This allows for consistency of resident advocacy for resident rights and quality of care.	Lynn McCamie	Ombudsman_Baltimore County	No Change
10.07.14.29	We suggest adding a section between 10.07.14.29 B and C that reads: When the resident is discharged to home or to a non-facility setting, the assisted living program shall provide the resident and the resident's representative any information related to the resident that is necessary to ensure continuity of care and services, including at a minimum the: (1) Current medication and treatment orders; (2) Medication administration records, (3) Most current Resident Assessment Tool.	The resident agreement must provide that a resident cannot be discharged based on suggestions, complaints, or grivances made to the assisted living manager, government agencies including but not limited to OHCQ, Office of the Inspector General, Medicaid Fraud Control Unit, and LTC Ombudsman program, or other persons in accordance with the right to be free of retaliations set forth in COMAR 10.07.14.29	Anne Hurley	Legal Aid	Agree
10.07.14.29	Recommend strengthening discharge planning component of regulation on Relocation and Discharge. There needs to be a discharge planning process for all individuals with continuing care needs which: 1. Requires assessment of the resident's continuing care needs, including resident or representative's preferences 2. Available services and how they can be accessed 3. Plan should address how resident's needs will be met after discharge, including resident and family/caregiver education needs	Discharges and discharge process currently is almost exclusively decided by the ALM manager with insufficient protections for the resident. Also refer to comments under 10.07.14.20., page 88 of 168.	Jane Wessely	Private Citizen	Agree
10.07.14.29	Discharge protections is Maryland Legal Aid's main focus. This is the most common problem that clients ask about ane where we see the most frequent abuse. In the midst of the regulatory review, CMS issued the final HCBS Community settings Rule in 2014, which requires full State compliance by 2019. The Rule requires, among other things that any assisted living provider accepting HCBS funds must sign a lease witht he same protectisions that tenants throughout the State have agains eviction. This means that all assisted living residents that pay their provider using teh Medicaid Waiver or other HCBS program will have eviction rights. For several reasons we must seize this opportunity and extend the same discharge rights to all assiste living residents.		Anne Hurley	Legal Aid	No Change.
10.07.14.29	Please put something in the new regs somewhere that says that it HAS to be in the resident agreement that the ALF can discharge somebody without notice if they become dangerous to the ALF/other residents. It should say that an ALF has the right to discharge somebody without notice in that case.	Because it causes problems with it's not in there, and nobody puts it in there. We just dealt with several of those.	Karen Besaw	Private Citizen	No Change.
10.07.14.29	It sounds like both are needed. If they have a MOLST, they don't need an EMS/DNR form, right? And currently the regs say that if you have an old EMS/DNR form, then you don't have to have a MOLST. So is this a change from that?		Karen Besaw	Private Citizen	Agree. Regulations revised.
10.07.14.29	Change wording to make it clear that "diagnoses" mean every condition the resident is currently being treated for.	The DNs are very bad at documenting all of a resident's diagnoses. (And so are the docs.)	Karen Besaw	Private Citizen	No Change
10.07.14.29	We recommend amending COMAR 10.07.14.33.B (Proposed Regulation .29.B).	Assisted living residents should have the same minimal protections against improper or sloppy discharges or transfers as nursing home residents.	Lynn McCamie	Ombudsman_Baltimore County	No Change
10.07.14.29	Suggest medication "ordered for" the resident, rather than "taken by" to better reflect the full med profile.		David Jones	Board of Pharmacy	Agree
10.07.14.29	In this section, we would like to simply echo the recommendations offered via email from Anne Hurley, Project Director of the Long Term Care Assistance Project at Maryland Legal Aid Bureau to Frank Johnson on 12/14/15.	Like the recommendations, we 100% concur with the rationale offered by Maryland Legal Aid, including the need to coordinate this section with the forthcoming HCBS rules.	Kim Burton	Mental Health Association of Maryland	Thank you.
10.07.14.29	We recommend amending COMAR 10.07.14.33.B (Proposed Regulation .29.B).	Assisted living residents should have the same minimal protections against improper or sloppy discharges or transfers as nursing home residents.	Lynne McCamie	Baltimore county Ombudsman Program	No Change

10.07.14.29	OHCQ should clarify what constitutes a safe and appropriate discharge. There should be an appeal process when residents receive an involuntary discharge letter.	The Ombudsman Program believes that assisted living residents should have the same minimal protections against improper and unsafe discharges or transfers as nursing home residents. The resident should have a right to appeal a discharge.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.29 B	We recommend amending COMAR 10.07.14.33.B (Proposed Regulation .29.B).	Assisted living residents should have the same minimal protections and rights regarding valid reasons for a resident to receive an involuntary notice of discharge. - Resident's needs cannot be met in the assisted living facility - Resident's presence endangers the health or safety of other individuals in the assisted living facility. - Resident has failed after reasonable and appropriate notice to pay. - Assisted living ceases to operate	Anne Arrington	Carroll County Bureau of Aging and Disabilities	No Change.
10.07.14.29 B	Both the Department and the Ombudsman Program believe that assisted living residents should have the same minimal protections against improper or sloppy discharges or transfers as nursing home residents. 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 shall be in accordance with the resident agreement, which must comport with this regulation. (2) Except as provided in subsection (4) of this section B, a resident of a facility may not be discharged or transferred from the facility involuntarily except for the following reasons: (a) The transfer or discharge is necessary for the 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 because the 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 provide a resident or and 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; (c) The right of the resident to consult with		Alice Hedt	MD Department of Aging	No Change
10.07.14.29 B	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 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 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 include at least one of the reasons stated in §B(2) of this (d) The effective date of dismissal or discharge, which shall be at least 60 days from the date the subscriber receives the notice.regulation; (c) 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, establish just cause for a dismissal or discharge		Allison DeGravelles	Montgomery County Department of Health & Human Services	No Change
10.07.14.30 A(5)	The citation needs to be updated to "Estates and Trusts Article, Title 17, Annotated Code of Maryland."		Alice Hedt	MD Department of Aging	Agree
10.07.14.31	NO ONE but the owner/manager, and or their designee make a determination of whether a resident care needs exceed what the facility can provide. A treating physician cannot make that call for the facility. Strongly suggested that every effort be may to ensure a safe and appropriate admission to a facility that will meet the individuals needs	If the facility for any reason recognize that the resident is no longer an appropriate fit for the facility they should be able to have the option of not having to keep the resident, that would not be a good thing for either parties	Mae Simms	Beyond Care	No change.
10.07.14.31	Delete and add language: …the resident chooses at a time the resident chooses [, subject to reasonable restrictions on visiting hours and places, which shall be posted by the assisted living manager].	CMS 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 Medicaid Waiver participants must comply with Medicaid regulations and COMAR 10.07.14. Requiring facilities to post visitation hours would result in facilities serving Medicaid participants being deemed by Medicaid as non-compliant with federal funding requirements.	Jane Wessely	Private Citizen	No Change

10.07.14.31	Recommended new language: New (2): services and supports which ensure full access to the benefits of community living New (3): services and supports that optimize autonomy and independence and personal choice	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 (6): 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
10.07.14.31	Recommend new language: Any [case discussion] health information, consultation …	All protected health information is confidential.	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.	Lynne 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. Timely access is critical to the Ombudsmen's ability to perform their mandate. 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 Ombudsman, 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 ombudsman 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 OHCQ 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 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 Ombudsman, and language about the next available ALF bed	18-currently says have access for procedures to meet with the ombudsman.	Lynne McCamie	Baltimore county Ombudsman Program	No Change
10.07.14.31	Add a right to appeal for involuntary discharge. Add a right to have ombudsman access and visitation including meeting privately with the ombudsman, and procedures to provide information about ombudsman access to the residents 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	[.35] .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;		Valarie Colmore	Maryland Department of Human Resources	Agree. Amanda Follow-up to look for places where APS is located. Add "the local deparment of social services".
10.07.14.31	Include a right to appeal for discharge, meet privately and have access to procedures with meeting with Ombudsman, and language about the next available ALF bed	18-currently says have access for procedures to meet with the ombudsman.	Lynn McCamie	Ombudsman_Baltimore County	No Change
10.07.14.31 A.4	Suggest rewording 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)	OHCQ 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 Ombudsman Program has been having difficulty with some providers who will not allow, or resist allowing, an Ombudsman 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

10.07.14.31 A(25)	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?		Alice Hedt	MD Department of Aging	Agree.
10.07.14.31 E	Exiting Regulation .35E basically requires the residents' rights to be posted and provided on admission. This is an important consumer protection. Thus, the existing Regulation .35E should become Regulation .31E of the renumbered regulations, instead of being deleted as proposed.		Alice Hedt	MD Department of Aging	Agree. Added back in.
10.07.14.32	Recommend adding language: … been subjected to abuse, neglect, financial or other form of exploitation shall report …	While financial exploitation is of great concern in this setting, other forms of exploitation are reportable.	Jane Wessely	Private Citizen	No Change
10.07.14.32	Change from optional and include notifying APS as well OHCQ about incidents	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.	Lynne McCamie	Baltimore county Ombudsman Program	Agree
10.07.14.32	Health General 19-347 and Family Law 14-302 require that abuse be reported to APS, the proposed regulations would make that optional, and it would be a violation of the Maryland statue. The language should be reporting to OHCQ, APS, and one of the following. APS is also supposed to be notified about incidents, and this is also considered an incident.	To ensure abuse is reported and investigated properly.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree
10.07.14.32	Please add behavioral health.	A clear definition of behavioral health should be included.	Lynne McCamie	Baltimore county Ombudsman Program	Agree.
10.07.14.32	Include wording to require them to do a "root cause analysis" as part fo the investigation in order to at least attempt to identify what caused the problem and how they might be able to prevent future cases from occurring.	Serious cases of abuse, neglect, and death are occurring and they're not doing a root cause analysis to try to figure out if they did anything wrong.	Karen Besaw	Private Citizen	No Change.
10.07.14.32 C	Assisted living facilities and providers are subject to both Health-General §19-347 and Family Law §14-302. Current Regulation .36C was carefully drafted to comply with both statutes. The proposed changes would violate Family Law §14-302 because a report to Adult Protective Services is not optional under §14-302 as it currently is written.		Alice Hedt	MD Department of Aging	Agree
10.07.14.32 C.1	Change from optional and include notifying APS as well OHCQ about incidents	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.	Lynn McCamie	Ombudsman_Baltimore County	Agree
10.07.14.33	Recommend reconsidering use of terminology " restraints" in this regulation is confusing. 10.07.14.31.A(8) specifies that residents have the right to "be free from physical and chemical restraints". Please clarify.	The term "protective device" helpfully clarifies what is acceptable. 10.07.14.33 addresses physician orders for restraints, etc. when it seems that it has been established that restraints are not permissible.	Jane Wessely	Private Citizen	No Change
10.07.14.33	You need to be more specific. This drives us surveyors crazy because we can't get a straight answer out of anybody! Spell it out. Is it ok to put bed rails up in order to keep someone from falling out of bed or not? In the past bed rails were always a restraint. Has that now changed? Now it's may be considered a restraint? We'd all like to know when it's not -- ?		Karen Besaw	Private Citizen	No Change.
10.07.14.33 C.4	Add "risk" for adverse events as a means to avoid actual occurrence		David Jones	Board of Pharmacy	No Change.
10.07.14.34	Can we add something like if you're the Medicare Rep Payee then you MUST use some of that money to pay for the resident's medications, orthopedic shoes the doc says they need, pay for trips to medical appointments, etc.???	I already talked about the manager who got named Rep Payee and immediately all the resident's Social Security checks got deposited into the manager's bank account and she wouldn't use any of it for the resident.	Karen Besaw	Private Citizen	No Change.
10.07.14.34	Concern about the conflict of interest when an alf program managing a resident's funds.		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change.
10.07.14.34 I	Proposed Regulation .34I(1) is missing text that is not shown as missing. See the corresponding Regulation .38I(1) for the text that has been deleted without being shown as deleted.		Alice Hedt	MD Department of Aging	Agree
10.07.14.35	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.	Lynne McCamie	Baltimore county Ombudsman Program	Agree
10.07.14.35	[.39] .35 Misuse of Resident's Funds. (4) Local offices of the Department of Human Resources or the Adult Protective Services Program.		Valarie Colmore	Maryland Department of Human Resources	Agree. Amanda Follow-up to look for places where APS is located. Add "the local deparment of social services".
10.07.14.36	Can we just say hazard?	I've had several instances where whatever the ALF did (I don't remember now), it wasn't exactly a "health hazard" but was another kind of a hazard that could possible hurt someone.	Karen Besaw	Private Citizen	No Change

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	The safety and well being is the number one call, and as long as it does not pose a danger should be used	Mae Simms	Beyond Care	No Change
10.07.14.39	B. 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.	Those receptionists get busy and then they're not watching. I've been on surveys to large places and watched it happen.	Karen Besaw	Private Citizen	No Change.
10.07.14.39	While we're on the subject of security… I'm dealing with a large place that wants to open up an Alzheimer's unit which is located right next to their front door. And their idea of great security is that they're going to have their "concierge" watch the door all day and night for anybody who tries to elope off that unit.	If that isn't a crock I don't know what is. Human beings can't possibly watch a doorway for 8 solid hours while doing their real job at the same time. And what happens when the UPS guy comes and they get busy signing for packages?… Can we write something about that please?	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.	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.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.39	Add language and training in the regulation	Concerned about resident safety, ADDING language in the regulation for residents that could elope. Make sure the doors other than the main door have an alert system, ADD training for staff related to this type of safety issue both for those that elope and for others that enter the facility	Lynne McCamie	Baltimore county Ombudsman Program	No Change.
10.07.14.39	Add language and training in the regulation	Concerned about resident safety, ADDING language in the regulation for residents that could elope. Make sure the doors other than the main door have an alert system, ADD training for staff related to this type of safety issue both for those that elope and for others that enter the facility	Lynn McCamie	Ombudsman_Baltimore County	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.	Lynne McCamie	Baltimore county Ombudsman Program	Agree
10.07.14.41	Emergency plans should be available for all alf staff to review on each shift. Emergency plans should be reviewed upon licensure, re-licensure, and as needed. More information is needed in the regulation about the AL Emergency Preparedness Packet.	All staff should be informed about the emergency plan since emergencies can happen at any time. Emergency plans should be reviewed to see if the plan is viable and current.	Stevanne Ellis	Office of the State Long Term Care Ombudsman	Agree
10.07.14.41	Emergency Preparedness Packet? Where did this come from? We've never heard of it before.		Karen Besaw	Private Citizen	Agree. Section re-written to clarify what's required in the packet.
10.07.14.41	B(1)(d) – add wording to say that service tags have to be on the extinguishers (rather than "documentation has to be maintained on-site").	We don't need to wait more than we already have to for them to figure out what they did with it. The standard is that the service tags be ON THE EXTINGUISHERS. If it's not on the extinguishers, they'll lose it.	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.	Just telling them to instruct their staff isn't going to get it done.	Karen Besaw	Private Citizen	No Change
10.07.14.41	(4)Brief medical fact sheet. Include wording to say that it must exist in paper format, not electronic.	PCs and laptops won't do you any good if electricity isn't available.	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. They need to document how long it took to get all the residents out, how many residents they evacuated, where they evacuated to, etc. Maybe the regs meant to say…"(v) Document the reaction of residents during the drill;" – typo?	They won't actually conduct the drill unless you make them. We have a lot of providers who think you can do a "table top" fire drill, i.e., just talk about it.	Karen Besaw	Private Citizen	No Change.
10.07.14.41	(1) They should have to document on what they did with, or how they handled, the residents. (2) Also, (v) says "Document the reaction of staff during the drill or training." Don't you mean "residents", not staff?	I get E/D Drills that document nothing about what staff did with the residents during actual drills. Now, do you really think they actually did a drill when they don't describe how staff handled a whole building full of residents?	Karen Besaw	Private Citizen	No Change.
10.07.14.41	Fire drills. Be more specific about "conduct fire drills at least quarterly on all shifts" because different surveyors are requiring different things. What exactly does that mean? Spell it out. Can we accept it if the ALF does the first quarterly drill on the day shift, then the second quarterly drill on the eve shift, and the third on the night shift, and keep rotating like that? Or do you mean they must do every quarterly drill on all three shifts?	We have no end of trouble with providers on this one.	Karen Besaw	Private Citizen	No Change.
10.07.14.41	(iii) – change language to (ii) Procuring goods, food, water, equipment and services to sustain operations for 72 hours.	In an emergency food and safe drinking water need to be available.	Phyllis McShane	Maryland Dietetics in Health Care Communities	Agree (ii)

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 McCamie	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	Mae Simms	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 residents space based on their preference	Mae Simms	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].	Addressed under 10.07.14.20.D.5(e), page 91 of 168.	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 renters in with a resident.	Karen Besaw	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 Besaw	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 if 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	Mae Simms	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 Besaw	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		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change
10.07.14.47	Delete this. D(2)(e)	You already stated you can't have indoors smoking rooms.	Karen Besaw	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	Consumers have the right to know what facilities have been sanctioned as they make choices about where their loved ones or themselves are going to live.	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		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 McCamie	Baltimore county Ombudsman Program	No Change.
10.07.14.56 & 10.07.14.58	D3 Relocation – Clarification is needed on how to access funds in an emergency		Stevanne Ellis	Office of the State Long Term Care Ombudsman	No Change.
10.07.14.56 & 10.07.14.58	E. 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 assisting with the relocation of residents	Lynn McCamie	Ombudsman_Baltimore County	No Change.
10.07.14.57	[.62] Emergency Suspension. (4) The [assisted living] manager or alternate manager shall immediately notify the local department of social services Adult Protective Services Program in the event of an [the] emergency action where the relocation or cause of the relocation involving the resident is a result of abuse, neglect or exploitation.		Valarie Colmore	Maryland Department of Human Resources	Agree. Amanda Follow-up to look for places where APS is located. Add "the local deparment of social services".
10.07.14.58	[.63] .58 Revocation of License. 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. (a) The local department of social services Adult Protective Services Program staff will make every reasonable effort to assist them in making other assisted living arrangements. The Department may assist in the relocation of residents.		Valarie Colmore	Maryland Department of Human Resources	Agree. Amanda Follow-up to look for places where APS is located. Add "the local deparment 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

COMAR 10.07.14.40 - Assist Rails	Add wording to para A to state that an assist rail for a toilet cannot be mounted behind the toilet; the rail has to actually be usable!	The majority of elderly residents need assistance lowering themselves to the toilet, as well as raising themselves up from a toilet. If you mount an assist rail on a wall behind the toilet, it's impossible to use it for its intended purpose because nobody can reach it!			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 those issues		Alice Hedt	MD Department of Aging	No Change
General	MDoA 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 Hedt	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 Hedt	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 Kauffman	LifeSpan	Agree.
General	Case Manager/Delegating Nurse- Term used needs to be decided.		Gwen and Carol	OHCQ	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 Kauffman	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 Kauffman	LifeSpan	Agree. No change was made.
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".	Anne Jones	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.	Gina Campanella Cooper	Pickersgill Retirement	Out of scope. This question would be best addressed by the Board of Nursing.
General	Background and Criminal Check		Gwen and Carol		No Change
General	3. Why is the documentation more in AL than in SNF-referring to the weekly notes.		Gina Campanella Cooper	Pickersgill Retirement	No Change
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 it. 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.		Danna Kauffman	LifeSpan	No change.
General	Can we require providers to have their staff trained so that when we arrive whoever is there will know where the records are, will be able to get them and give them to us--???	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	Private Citizen	No change.
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 places that don't have a license and they've kept their residents for years.	Karen Besaw	Private Citizen	No Change.
General	Limit the number of residents that a delegating nurse can care for – in ALL the programs she does – to 30 residents.	Delegating nurses are taking on a caseload of as many residents as they can get for the money. And then the residents aren't being taken care of properly because it's impossible to really know and care for that many residents at one time. We have nurses tell us all the time that by the time you get to 50 residents, it's really impossible to keep track of them all.	Karen Besaw	Private Citizen	No Change.
General	We need to write something (under .17 Nursing Oversight?) prohibiting agencies from springing up who provide delegating nurses to facilities; or else we need to write specific guidelines for them.	We're now seeing for the first time the phenomenon of agencies springing into being who are in the business of providing delegating nurses to facilities. But they send a different delegating nurse out each time, and that means there's no continuity of care for the resident when you do that. And each of those delegating nurses is not doing an initial nursing comprehensive assessment on each resident, which is a violation of the Nurse Practice Act. Something needs to be in writing for these situations—maybe something that says you must have a contract with each delegating nurse who's going to come into the facility, and that person's contract must list specific residents each of those delegating nurses is going to take care of.	Karen Besaw	Private Citizen	No Change.
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	Private Citizen	No Change.
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.	iCareManager 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	Private Citizen	No Change.
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	Private Citizen	No Change.
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	Private Citizen	No Change.
General	Emergency and disaster tracking system – require them to have that resident information on paper, not electronic records.	We have a transmittal 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	Private Citizen	No Change.
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 meds. And if that one staff isn't there that day, then no one is available to give meds. Also, ALFs will employ a caregiver (not a med tech) to monitor the residents overnight. In this case, again, that caregiver won't be able to give out meds should a resident need something in the middle of the night.	Karen Besaw	Private Citizen	No Change.
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	Private Citizen	No Change.

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 til 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 dawn 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…	Karen Besaw	Private Citizen	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."?	Karyna Balbuena	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;		Sharon Banks-Tarr	Private Citizen	No Change.
General	New regulations 10.07.14 should clearly state that the presence of a Medication Technician is required in the ALF setting 24x7. 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 CM/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.		Simi 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 regulation 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.		Charilyn Wade	The Chalet ALF	Thank you.
General	LifeSpan supports the format of the Uniform Disclosure Statement being 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 dietician services. Again, this is examples of increased regulations than can unduly burden programs and increase costs. If a specified program has significant issues in these and any other areas, it should be addressed individually by OHCQ through its enforcement powers.		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		Kate Ricks	Voices	Thank you.
General	Hope you are well, and I'm sure that you are very busy finalizing these regulations. After my one on one meeting with you and Carol Fenderson 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 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		Mary McSweeney	Towson University	Thank you.
General	Not knowing the specifics, - and wouldn't you want to require that at least one (?) individual has a current AED certifiation from a national organization is onsite? - here is an example of how this can be done: A. An assisted living faclity 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. B. ..... * at the time of final action we would do a non-substantive change to insert the actual dates.		Michele Phinney		Agree
General	2. Why does AL regs require every year 1st aid when the certificate is good for 2 years?	Makes no sense, especially when a facility has 24 hr. licensed staff who are CPR certified and ALL first aid is performed by them.	Gina Campanella Cooper	Pickersgill Retirement	Agree.

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		Mary Helen	Towson University, Towson MD	No Change.
Reg: COMAR 10.07.14.36 - General Physical Plant Requirements	Change: Add a number (3) to Para C and have it read something like "Able to be reached and operated by the resident without assistance."	Reason: A large ALF just installed lockboxes in everyone's room on a new dementia unit by bolting them to the floor of the far corner of the resident's closet. This makes them completely unreachable, as each resident would have to get on their knees to reach the box, and then try to fit a tiny key in a tiny lock in the dark to open it.			Agree