CABINET FOR HEALTH AND FAMILY SERVICES

Office of Inspector General

Division of Health Care

(Amended After Comments)

902 KAR 20:480. Assisted living communities.

RELATES TO: KRS 194A.700—194A.729, **209.030(2)–(4),** 209.032, 216.515, 216.530, 216.532, 216.595, 216.718, 216.765, 216.789, 216B.015(13), 216B.020(1), 216B.105, 216B.160, 216B.165, 218A.200(6), **314.011(3),** 21 C.F.R. Part 1317, 45 C.F.R. Parts 160, 164, 42 U.S.C. 1320d-2–1320d-8

STATUTORY AUTHORITY: KRS 194A.707(1) and (9), 216B.042(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 194A.707(1) requires the Cabinet for Health and Family Services to promulgate administrative regulations under KRS Chapter 13A for an initial and re-licensure review process for assisted living communities. KRS 194A.707(9) permits the cabinet to promulgate administrative regulations to establish an assisted living community and assisted living community with dementia care licensure fee that shall not exceed costs of the program to the cabinet. KRS 216B.042(1) requires the cabinet to promulgate administrative regulations necessary for the proper administration of the licensure function, which includes establishing licensure standards and procedures to ensure safe, adequate, and efficient health facilities and health services. This administrative regulation establishes the minimum licensure requirements for the operation of social model assisted living

communities **(ALC)**, assisted living communities that provide basic health and health-related services **(ALC-BH)**, and assisted living communities with a secured dementia care unit **(ALC-DC)**.

Section 1. Definitions. (1) “Activities of daily living” is defined by KRS 194A.700(1).

(2) “Ambulatory” is defined by KRS 194A.700(2).

(3) “Assistance with activities of daily living and instrumental activities of daily living” is defined by KRS 194A.700(3).

(4) “Assistance with self-administration of medication” is defined by KRS 194A.700(4).

(5) “Assisted living community” is defined by KRS 194A.700(5).

(6) “Assisted living community with dementia care” is defined by KRS 194A.700(6).

(7) “Assisted living services” is defined by KRS 194A.700(7).

(8) “Basic health and health-related services” is defined by KRS 194A.700(8).

(9) “Dementia” is defined by KRS 194A.700(10).

(10) “Dementia care services” is defined by KRS 194A.700(11).

(11) “Dementia-trained staff” is defined by KRS 194A.700(12).

(12) “Direct care service” is defined by KRS 216.718(4).

(13) **“Immediate family member” means a:**

(a) Spouse:

(b) Child;

(c) Stepchild;

(d) Son-in-law;

(e) Daughter-in-law; or

(f) Grandchild.

(14) "Hands-on assistance" is defined by KRS 194A.700(13).

(15) [~~(14)~~] "Health facility" is defined by KRS 216B.015(13) to include assisted living communities.

(16) [~~(15)~~] "Instrumental activities of daily living" is defined by KRS 194A.700(15).

(17) [~~(16)~~] "Legal representative" means a person legally responsible for representing or standing in the place of the resident for the conduct of the resident's affairs.

(18) "Licensed health professional" means a person who:

(a) Possesses a current Kentucky license or multistate licensure privilege to practice in Kentucky; and

(b) Provides services to ALC-BH or ALC-DC residents, including the delegation of tasks pursuant to KRS 194A.700(7)(h) as authorized under the professional's scope of practice.

(19) [~~(17)~~] "Living unit" is defined by KRS 194A.700(16).

(20) [~~(18)~~] "Managing agent" means an individual or legal entity designated by the licensee through a management agreement to act on behalf of the licensee in the on-site management of the assisted living community.

(21) [~~(19)~~] "Medication administration" is defined by KRS 194A.700(17).

(22) [~~(20)~~] "Medication management" is defined by KRS 194A.700(18).

(23) [~~(21)~~] "Medication reconciliation" means the process of identifying the most accurate list of all medications the resident is taking, including the name, dosage, frequency, and route, by comparing the resident record to an external list of medications

obtained from the resident, hospital, prescriber, or other provider.

(24) [~~(22)~~] "Medication setup" is defined by KRS 194A.700(19).

(25) "Nurse" is defined by KRS 314.011(3).

(26) "Nursing task" is defined by 201 KAR 20:400, Section 1(11).

(27) [~~(23)~~] "Person-centered care" is defined by KRS 194A.700(21).

(28) [~~(24)~~] "Resident" is defined by KRS 194A.700(22).

(29) [~~(25)~~] "Secured dementia care unit" is defined by KRS 194A.700(23).

(30) [~~(26)~~] "Service plan" is defined by KRS 194A.700(24).

(31) [~~(27)~~] "Significant financial interest" is defined as the lawful ownership of an out-of-state or a Kentucky-licensed health facility or health service, or other entity regulated by the cabinet, whether by share, contribution, or otherwise in an amount equal to or greater than twenty-five (25) percent of total ownership of the out-of-state or Kentucky-licensed health facility or health service, or other cabinet-regulated entity.

(32) [~~(28)~~] "Temporary condition" is defined by KRS 194A.700(26).

(33) [~~(29)~~] "Unlicensed personnel" is defined by KRS 194A.700(27).

(34) "Volunteer" means a person who has duties that are equivalent to the duties of an employee providing direct care services and the duties involve, or may involve, one-on-one contact with a resident. A volunteer does not include a member of a community-based or faith-based organization or group that provides volunteer services that do not involve unsupervised interaction with a resident.

Section 2. Licensure categories. (1) The licensure categories established by this administrative regulation include the following:

(a) A social model assisted living community (ALC) license for any facility that

provides assisted living services, excluding basic health and health-related services;

(b) An assisted living community with basic health care (ALC-BH) license for any facility that:

1. Provides assisted living services, including basic health and health-related services directly to its residents; and

2. Does not have a secured dementia care unit; and

(c) An ALC with dementia care (ALC-DC) license for any facility that provides assisted living services and dementia care services in a secured dementia unit.

(2) In accordance with KRS 194A.710(3), a license issued under this administrative regulation shall not be assignable or transferable.

(3) In accordance with KRS 194A.704, a personal care home that is in substantial compliance with KRS 194A.703 shall convert its license to an ALC-BH or ALC-DC license, if applicable, by submitting the application, accompanying documentation, and fee required by Section 3(2) of this administrative regulation at least sixty (60) days prior to the date of annual renewal of the facility's personal care home license.

Section 3. Licensure application and fees. (1) In accordance with KRS 216B.020(1), an ALC, ALC-BH, or ALC-DC shall be exempt from certificate of need.

(2) An applicant for a provisional, initial license or annual renewal as an ALC, ALC-BH, or ALC-DC shall submit to the Office of Inspector General:

(a) A completed Application for License to Operate an Assisted Living Community at least sixty (60) days prior to the:

1. Planned opening; or

2. Annual renewal date;

(b) Proof of approval by the State Fire Marshal's office;

(c) A copy of a blank lease agreement that includes the elements required by KRS 194A.713 and any documentation incorporated in the agreement;

(d) An organizational chart that identifies all entities and individuals with a significant financial interest in the prospective or existing licensee, including the relationship with the licensee and with each other;

(e) A description of any special programming that may be provided in accordance with KRS 194A.713(11);

(f) If applying for a provisional, initial license, or if changes have been made since the date of the previous renewal, a copy of the facility's floor plan that shall identify the:

1. Living units, including features that meet the requirements of KRS 194A.703(1);

2. Central dining area;

3. Laundry facility; and

4. Central living room;

(g) Whether in the preceding seven (7) years any individual with a significant financial interest in the entity seeking initial licensure or renewal as an ALC, ALC-BH, or ALC-DC had a significant financial interest in an out-of-state or a Kentucky-licensed health facility or health service, or other entity regulated by the cabinet, that had its license or certificate to operate denied, suspended, revoked, or voluntarily relinquished as the result of an investigation or adverse action that placed patients, residents, or clients at risk of death or serious harm;

(h)1. A copy of the applicant's compliance history for any other care facility the applicant operates if applying for a provisional, initial license as an:

a. ALC or ALC-BH; or

b. ALC-DC that did not have a dementia unit in operation prior to July 14, 2022.

2. Documentation of the applicant's compliance history shall include a copy of all enforcement action issued by the regulatory agency against the care facility including violations, fines, or negative action against the facility's license during the seven (7) year period prior to application for a provisional, initial license; and

(i) A nonrefundable fee made payable to the Kentucky State Treasurer in accordance with the following fee schedule:

Number of Units	Initial and Annual Fee
<25	$500 + $40 per unit
25-49	$1,000 + $40 per unit
50-74	$1,500 + $40 per unit
75-99	$1,750 + $40 per unit
100 or more	$2,000 + $40 per unit

(3)(a) Name change. An ALC, ALC-BH, or ALC-DC shall:

1. Notify the Office of Inspector General in writing within ten (10) calendar days of the effective date of a change in the facility's name; and

2. Submit a processing fee of twenty-five (25) dollars.

(b) Change of location. An ALC, ALC-BH, or ALC-DC shall not change the location of the facility until an Application for License to Operate an Assisted Living Community accompanied by the documentation and fees required by subsection (2) of this section have been submitted to the Office of Inspector General.

(c) Change in number of living units. 1. An ALC, ALC-BH, or ALC-DC shall submit an Application for License to Operate an Assisted Living Community to the Office of Inspector General:

a. At least sixty (60) days prior to an increase in the number of living units; and

b. Accompanied by a fee of sixty (60) dollars per each additional unit.

2. If there is a decrease in the number of living units, an ALC, ALC-BH, or ALC-DC shall notify the Office of Inspector General within sixty (60) days of the decrease.

(d) Change of ownership. 1. The new owner of an ALC, ALC-BH, or ALC-DC shall submit an Application for License to Operate an Assisted Living Community accompanied by a fee of $500 within ten (10) calendar days of the effective date of the ownership change.

2. A change of ownership for a license shall be deemed to occur if more than twenty-five (25) percent of an existing facility or capital stock or voting rights of a corporation is purchased, leased, or otherwise acquired by one (1) person from another.

(e) Change of managing agent. An ALC, ALC-BH, or ALC-DC shall submit an updated Application for License to Operate an Assisted Living Community accompanied by a fee of twenty-five (25) dollars within ten (10) calendar days of the effective date of a change of managing agents.

(f) Information shared with lending institutions relative to financing for ALC projects. The cabinet's fee for providing information in accordance with KRS 194A.729 shall be $250.

(g) Voluntary termination of operations. 1. An ALC or ALC-BH shall:

a. Notify the Office of Inspector General at least sixty (60) days prior to voluntarily

relinquishing its license; and

b. Notify residents at least sixty (60) days prior to closure unless there is a sudden termination due to:

(i) Fire;

(ii) Natural disaster; or

(iii) Closure by a governmental agency.

2. An ALC-DC that elects to voluntarily terminate operations shall:

a. Relinquish its license; and

b. Comply with notification requirements and other the steps for voluntary relinquishment established by KRS 194A.7063.

(4) Upon receipt of an application accompanied by the documentation and fees required by subsection (2) or subsection (3)(b), (c), or (d) of this section, the Office of Inspector General shall:

(a) Review the application for completeness; and

(b) Return the application and accompanying licensure fee if:

1. An individual having a significant financial interest in the facility, within the seven (7) year period prior to the application date, had a significant financial interest in an out-of-state or a Kentucky-licensed health facility or health service, or other entity regulated by the cabinet, that had its license or certificate to operate denied, suspended, revoked, or voluntarily relinquished as the result of an investigation or adverse action that placed patients, residents, or clients at risk of death or serious harm; or

2. The cabinet finds that the applicant misrepresented or submitted false information on the application.

Section 4. Regulatory functions and authority to enter upon the premises. (1) In accordance with KRS 216.530, inspection of an ALC, ALC-BH, or ALC-DC shall be unannounced.

(2) Licensure review inspections shall be conducted in accordance with the survey intervals established by KRS 194A.707(2).

(3) Nothing in this administrative regulation shall prevent the cabinet from:

(a) Conducting an investigation related to a complaint; or

(b) Making an on-site survey of an ALC, ALC-BH, or ALC-DC more often if the cabinet deems necessary.

(4) An ALC, ALC-BH, or ALC-DC shall be subject to the:

(a) Inspection requirements of 902 KAR 20:008, Section 2(12);

(b) Procedures for correcting violations established by 902 KAR 20:008, Section 2(13); and

(c) Civil monetary penalties imposed under KRS 194A.722(5) for any violation that poses imminent danger to a resident in which substantial risk of death or serious mental or physical harm is present.

Section 5. License requirements. (1) In accordance with KRS 194A.707(3), an entity shall not operate as ALC, ALC-BH, or ALC-DC unless it is licensed.

(2) The licensee shall be legally responsible for:

(a) The management, control, and operation of the facility in accordance with KRS 194A.710(1), regardless of the existence of a management agreement or subcontract; and

(b) Compliance with federal, state, and local laws and administrative regulations

pertaining to the operation of the ALC, ALC-BH, or ALC-DC.

(3) An ALC, ALC-BH, or ALC-DC shall not represent that the facility provides any service other than a service it is licensed to provide.

(4) (a) Upon approving an application, the cabinet shall issue a single license for each building that is operated by the licensee as an ALC, ALC-BH, or ALC-DC, except as provided under paragraph (b) of this subsection.

(b)1. Upon approving an application for an ALC, ALC-BH, or ALC-DC, the cabinet shall issue a single license for two (2) or more buildings on a campus if operated by the same licensee.

2. A license for two (2) or more buildings on a campus shall identify the:

a. Address;

b. Licensed resident capacity of each building;

c. Whether any building has residents that receive basic health and health-related services from the licensee; and

d. Whether any building has a dementia care unit.

Section 6. Physical plant requirements. (1) An ALC, ALC-BH, and ALC-DC shall comply with the requirements for living units as established by KRS 194A.703, including compliance with applicable building and safety codes as determined by the enforcement authority with jurisdiction.

(2) Pursuant to KRS 216.595(3), an ALC-DC may request a waiver from the cabinet regarding building requirements to address the specialized needs of individuals with Alzheimer's disease or other brain disorders.

(3) The request for a waiver shall follow the same process as a facility’s request for

a variance pursuant to 902 KAR 20:008, Sections 5 and 6.

Section 7. Operations and services. (1) Resident criteria. (a) In accordance with KRS 194A.711, a resident of an ALC, ALC-BH, or ALC-DC shall be ambulatory unless due to a temporary condition.

(b) An ALC, ALC-BH, or ALC-DC shall require a medical examination in accordance with KRS 216.765(1) prior to admission of a resident.

(c)1. An ALC, ALC-BH, or ALC-DC shall complete a functional needs assessment in accordance with KRS 194A.705(6) and provide a copy to the resident:

a. Upon move-in; and

b. As needed with updated information if there is a change in the resident's condition, but no later than once every twelve (12) months.

2. The functional needs assessment shall be adminstered by a staff person with at least:

a. A bachelor's degree in health or human services or a related field;

b. An associate's degree in health or human services or a related field and at least one (1) year of experience working with the elderly or conducting assessments; or

c. A high school diploma or its equivalency and two (2) years of experience working with the elderly or conducting assessments.

3. The functional needs assessment shall be used to ensure that the prospective or current resident:

a. Meets the eligibility criteria pursuant to KRS 194A.711;

b. Has at least minimal ability to verbally direct or physically participate in activities of daily living (ADL) or instrumental activities of daily living (IADL) during the time in

which assistance is provided;

c. Is free from signs and symptoms of any communicable disease that is likely to be transmitted to other residents or staff;

d. Does not have any special dietary needs that the facility is unable to meet; and

e. Does not require twenty-four (24) hour nursing supervision.

(2) Minimum requirements. Each ALC, ALC-BH, and ALC-DC shall:

(a) Provide each resident with a copy of the resident's rights established by KRS 216.515;

(b) Provide each resident with access to the services required by KRS 194A.705(1) according to the lease agreement;

(c) Except for a social model ALC, provide each resident with access to basic health and health-related services;

(d) Permit a resident to arrange for additional services under direct contract or arrangement with an outside party pursuant to KRS 194A.705(3) if permitted by the policies of the ALC, ALC-BH, or ALC-DC;

(e) Utilize a person-centered **care** planning and service delivery process;

(f) Provide an emergency response system or personal medical alert device for residents to request assistance twenty-four (24) hours per day, seven (7) days per week;

(g) Allow residents the ability to furnish and decorate the resident's unit within the terms of the lease agreement;

(h) Allow the resident the right to choose a roommate if sharing a unit;

(i) Except for a resident of a secured dementia unit in an ALC-DC, notify the

resident that the living unit shall have a lockable entry door in accordance with KRS 194A.703(1)(b). The licensee shall:

1. Provide the locks on the unit;

2. Ensure that only a staff member with a specific need to enter the unit shall have access to the unit and provide advance notice to the resident before entrance, if possible; and

3. Not lock a resident in the resident's unit;

(j) Develop and implement a staffing plan for determining staffing levels that:

1. Includes an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility;

2. Ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' functional needs assessments and service plans on a twenty-four (24) hour per day basis; and

3. Ensures that the facility can respond promptly and effectively to:

a. Individual resident emergencies; and

b. Emergency, safety, and disaster situations affecting staff or residents in the facility;

(k) Ensure that one (1) or more staff are available twenty-four (24) hours per day, seven (7) days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs;

(l) Upon the request of the resident, provide directly or assist with arranging for transportation to:

1. Medical and social services appointments;

2. Shopping; and

3. Recreation;

(m) Upon the request of the resident, provide assistance with accessing available community resources and social services;

(n) Provide culturally appropriate programs that help:

1. Residents remain connected to their traditional lifeways; and

2. Promote culturally sensitive interactions between staff and residents; and

(o) Allow residents to voluntarily engage in one (1) or more IADLs without assistance or with minimal assistance as documented in the resident's service plan, but shall not force a resident to perform IADLs such as housekeeping, shopping, or laundry.

(3) Lease agreements. (a) Upon entering into a lease agreement, each ALC, ALC-BH, and ALC-DC shall inform the resident in writing according to KRS 194A.705(4) about policies relating to the provision of services and contracting or arranging for additional services.

(b) A lease agreement entered into between a resident and an ALC, ALC-BH, or ALC-DC shall meet the minimum content requirements of KRS 194A.713.

(4) Policies and procedures. Each ALC, ALC-BH, and ALC-DC shall maintain written policies and procedures that are up-to-date and address the following:

(a) Reporting and recordkeeping of alleged or actual cases of abuse, neglect, or exploitation of an adult in accordance with KRS 194A.709 **and KRS 209.030(2) – (4) to the:**

1. Office of Inspector General, Division of Health Care; and

2. Department for Community Based Services;

(b) A description of dementia or other brain disorder-specific staff training as required by KRS 216.595(2)(i) if the faciltiy provides special care for persons with a medical diagnosis of Alzheimer's disease or other brain disorders;

(c) How priority will be given to assist a resident during an emergency if evacuation of the facility is necessary and the resident requires hands-on assistance from another person to walk, transfer, or move from place to place with or without an assistive device pursuant to KRS 194A.717(5);

(d) Grievance policies required by KRS 194A.713(14);

(e) Except for a social model ALC, a method that incorporates at least four (4) components in an ongoing resident assessment done by a registered nurse or manager’s (director) designee in accordance with KRS 216B.160(7);

(f) Conducting a functional needs assessment pursuant to KRS 194A.705(6);

(g) Infection control practices that address:

1. The prevention of disease transmission; and

2. Cleaning, disinfection, and sterilization methods used for equipment and the environment;

(h) Reminders for medications, treatments, or exercises, if applicable;

(i) Except for a social model ALC, ensuring that all nurses and **[~~licensed~~]** health professionals have current and valid licenses to practice;

(j) Medication and treatment management, if the facility provides these services;

(k) Except for a social model ALC, delegation of**:**

a. Nursing tasks **in accordance with 201 KAR 20:400; [~~by registered nurses~~]** or

b. Therapeutic or other tasks assigned by other licensed health professionals;

(l) Except for a social model ALC, supervision of **[~~registered~~]** nurses and licensed health professionals;

(m) Except for a social model ALC, supervision of unlicensed personnel performing delegated tasks**, which shall include how the facility ensures compliance with the supervision requirements of 201 KAR 20:400, Section 4 if nursing tasks are delegated**;

(n) Cardiopulmonary resuscitation unless the policies of the facility state that this procedure is not initiated by its staff, and each resident or prospective resident is informed of the facility's policy pursuant to KRS 194A.719(1)(d); and

(o) Compliance with the requirements of KRS 216B.165, including assurance that retaliatory action shall not be taken against a staff member who in good faith reports a resident care or safety problem.

(5) Resident grievances. (a) Each ALC, ALC-BH, and ALC-DC shall post in a conspicuous place:

1. Information about the facility's grievance procedures; and

2. The name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances.

(b) The notice shall also have:

1. Contact information for the **state** long-term care ombudsman; and

2. Information for reporting suspected abuse, neglect, or exploitation of an adult.

Section 8. Business operations. (1) Display of license. The original current license shall be displayed at the main entrance of each ALC, ALC-BH, and ALC-DC.

(2) Quality management. (a) For purposes of this section, "quality management activity" shall mean evaluating the quality of care by:

1. Periodically reviewing resident services, complaints made, and other issues that have occurred; and

2. Determining whether changes in services, staffing, or other procedures need to be made to ensure safe and competent services to residents.

(b) Each ALC, ALC-BH, or ALC-DC shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided.

(c) Documentation about the facility's quality management activity shall be:

1. Maintained for at least two (2) years; and

2. Available to the Office of Inspector General at the time of the survey, investigation, or renewal.

(3) Restrictions. (a) An ALC, ALC-BH, ALC-DC, or staff person shall not:

1. Accept a power-of-attorney from a resident for any purpose or accept appointment as a guardian or conservator; or

2. Borrow a resident's funds or personal or real property or convert a resident's property to the possession of the facility or staff person.

(b) An ALC, ALC-BH, ALC-DC, or staff person shall not serve as a resident's designated contact person or legal representative **unless the staff person is an immediate family member of the resident**.

(4) Resident finances and property. (a) An ALC, ALC-BH, or ALC-DC may assist a resident with household budgeting, including paying bills and purchasing household goods, but shall not otherwise manage a resident's property except as described in this

subsection.

(b) If an ALC, ALC-BH, or ALC-DC accepts responsibility for managing a resident's personal funds as evidenced by the facility's written acknowledgment, the facility shall comply with KRS 216.515(8).

(c) Within thirty (30) days of the effective date of a facility-initiated or resident-initiated termination of housing or services or the death of the resident, the ALC, ALC-BH, or ALC-DC shall:

1. Provide to the resident, resident's legal representative, or resident's designated contact person a final statement of account;

2. Provide any refunds due; and

3. Return any money, property, or valuables held in trust or custody by the facility.

Section 9. Dietary services. (1)**(a)** Dining area. **Access to central dining shall be provided** **[~~A dining area shall be available~~]** for residents of an ALC, ALC-BH, or ALC-DC **in accordance with KRS 194A.703(2), including three (3) meals and snacks made available each day in accordance with KRS 194A.705(1)(b) with flexibility for residents in a secure dementia care unit**.

(b) In addition to subsection (1) of this section, subsections (2) to (5) of this section of this administrative regulation shall apply to facilities licensed to operate as an ALC-BH or ALC-DC.

(2) Therapeutic diets. If the facility provides therapeutic diets and the staff member responsible for food services is not a licensed dietician or certified nutritionist, the responsible staff person shall consult with a licensed dietician or certified nutritionist.

(3) Menu planning. (a) Menus shall be planned in writing and rotated to avoid

repetition.

(b) An **[~~ALC,~~]** ALC-BH**[~~,~~]** or ALC-DC shall meet the nutritional needs of residents.

(c) Meals shall correspond with the posted menu.

(d) Menus shall be planned and posted one (1) week in advance.

(e) If changes in the menu are necessary:

1. Substitutions shall provide equal nutritive value;

2. The changes shall be recorded on the menu; and

3. Menus shall be kept on file for thirty (30) days.

(4) Food preparation and storage. (a) There shall be at least a three (3) day supply of food to prepare well-balanced, palatable meals.

(b) Food shall be prepared with consideration for any individual dietary requirement.

(c) Modified diets, nutrient concentrates, and supplements shall be given only on the written order of a **licensed health professional** **[~~physician~~]**.

(d) At least three (3) meals per day shall be served with not more than a fifteen (15) hour span between the evening meal and breakfast.

(e) At least two (2) hot meals daily shall be offered.

(f) Between-meal snacks, including an evening snack before bedtime shall be offered to all residents.

(g) Adjustments shall be made if medically contraindicated.

(h) Food shall be:

1. Prepared by methods that conserve nutritive value, flavor, and appearance; and

2. Served at the proper temperature and in a form to meet individual needs.

(i) A file of tested recipes, adjusted to appropriate yield, shall be maintained.

(j) Food shall be cut, chopped, or ground to meet individual needs.

(k) If a resident refuses food served, substitutes of equal nutritional value and complementary to the remainder of the meal shall be offered and recorded.

(l) All opened containers or leftover food items shall be covered and dated when refrigerated.

(m) Drinking water shall be readily available to the residents at all times.

(n) Food services shall be provided in accordance with 902 KAR 45:005.

(5)(a) Nothing in this administrative regulation shall be construed as taking precedence over the resident's right to make decisions regarding his or her eating and dining.

(b) Information about the resident's eating and dining preferences shall be included in the resident's service plan based on the resident's preferences.

(c) If the resident's eating and dining preferences have a potential health risk, staff shall inform the resident and the resident's designated contact person or legal representative.

Section 10. Employee records and requirements. (1) **[~~Employee records.~~]** (a) Each ALC, ALC-BH, or ALC-DC shall maintain a current record of each:

1. Staff person employed by the facility directly or by contract; and

2. Regularly scheduled volunteer providing **direct care** services.

(b) The record **for each staff person** shall include the following:

1. Evidence of current professional licensure, registration, or certification, if applicable;

2. Documentation of orientation completed within thirty (30) days from the date of

hire and annual training;

3. Documentation of annual performance evaluations;

4. Current job description, including qualifications, responsibilities, and identification of each staff person who provides supervision;

5. Documentation of background checks in accordance with Section 14(1) of this administrative regulation; and

6. Record of any health exams related to employment, including compliance with the tuberculosis testing requirements of 902 KAR 20:205.

(2) The record for each regularly scheduled volunteer shall include documentation of background checks in accordance with Section 14(1) of this administrative regulation.

(3)[(c)1.] Each **[employee]** record shall be retained for at least three (3) years after an employee or volunteer ceases to be employed by or provides services at the facility.

(4)[2.] If a facility ceases operation, **[employee]** records shall be maintained for three (3) years after facility operations cease.

Section 11. Prevention and control of tuberculosis and other communicable diseases. (1) Each ALC, ALC-BH, and ALC-DC shall maintain written evidence of compliance with the screening and testing requirements of:

(a) 902 KAR 20:200, Tuberculosis (TB) testing for residents in long-term care settings: and

(b) 902 KAR 20:205, Tuberculosis (TB) testing for health care workers.

(2) An ALC, ALC-BH, and ALC-DC shall follow current requirements related to communicable diseases pursuant to KRS 194A.717(4).

(3) In accordance with KRS 194A.707(6), each ALC, ALC-BH, and ALC-DC may provide residents or their designated representatives with educational information or educational opportunities on influenza disease by September 1 of each year.

Section 12. Disaster planning and emergency preparedness plan. (1) Each ALC, ALC-BH, and ALC-DC shall:

(a) Have a written emergency disaster plan that:

1. Contains a plan for evacuation, including the written policy required by Section 7(4)(c) of this administrative regulation and KRS 194A.717(5);

2. Addresses elements of sheltering in place or provides instructions for finding a safe location indoors and staying there until given an all clear or told to evacuate;

3. Identifies temporary relocation sites; and

4. Details staff assignments in the event of a disaster or an emergency;

(b) Post an emergency disaster plan prominently;

(c) Provide building emergency exit diagrams to all residents;

(d) Post emergency exit diagrams on each floor; and

(e) Have a written policy and procedure regarding missing tenant residents.

(2)(a) Each ALC, ALC-BH, and ALC-DC shall:

1. Provide emergency and disaster training to all staff during the initial staff orientation and annually; and

2. Make emergency and disaster training available to residents annually.

(b) Staff who have not received emergency and disaster training shall be allowed to work only if trained staff are also working on site.

Section 13. Resident records. (1) Each ALC, ALC-BH, and ALC-DC shall maintain a

record for each resident.

(2) Entries in the resident record shall be current, legible, permanently recorded, dated, and authenticated with the name and title of the staff person making the entry.

(3) Resident records, whether written or electronic, shall be protected against loss, tampering, or unauthorized disclosure.

(4) Each resident record shall include the following:

(a) Resident's name, date of birth, address, and telephone number;

(b) Name, address, and telephone number of the resident's legal representative or designated contact person;

(c) Names, addresses, and telephone numbers of the resident's health and medical service providers, if known;

(d) Health information, including medical history, allergies, tuberculosis test results, vaccination information, and if the provider is managing medications, treatments, or therapies, documentation of the administration of all medications or delivery of treatments or therapy services;

(e) The resident's advance directives, if any;

(f) Copies of any health care directives, guardianships, powers of attorney, or conservatorships;

(g) The resident's current and previous functional needs assessments and service plans;

(h) All records of communications pertinent to the resident's services;

(i) Documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor

or **licensed** health **[~~care~~]** professional;

(j) Documentation of any incident or accident involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or **licensed** health **[~~care~~]** professional;

(k) Documentation that services have been provided as identified in the service plan and according to any required orders received from the resident's health care practitioner;

(l) Documentation of administration of medications and delivery of therapeutic services;

(m) Documentation of all verbal prescription orders received by phone and signed by the authorized health **professional** **[~~care practitioner~~]** within thirty (30) days;

(n) Documentation that the resident has received and reviewed the resident's rights;

(o) Documentation of complaints received and any resolution;

(p) Documentation of move-out or transfer to another setting, if applicable; and

(q) Other documentation relevant to the resident's services or status.

(5) With the resident's knowledge and consent, if a resident is relocated to another facility or if care is transferred to another service provider, the ALC, ALC-BH, or ALC-DC shall convey to the new facility or provider the:

(a) Resident's full name, date of birth, and insurance information;

(b) Name, telephone number, and address of the resident's designated contacts or legal representatives, if any;

(c) Resident's current documented diagnoses that are relevant to the services being provided;

(d) Resident's known allergies that are relevant to the services being provided;

(e) Name and telephone number of the resident's physician, if known, and the current physician orders that are relevant to the services being provided;

(f) All medication administration records and treatment sheets that are relevant to the services being provided;

(g) Most recent functional needs assessment; and

(h) Copies of health care directives, "do not resuscitate" orders, and any guardianship orders or powers of attorney.

(6)(a) Following a resident's move-out or termination of services, an ALC, ALC-BH, or ALC-DC shall retain a resident's record for at least six (6) years.

(b) Arrangements shall be made for secure storage and retrieval of resident records if the facility ceases to operate.

(7) Ownership. (a) Any medical records shall be the property of the ALC, ALC-BH, or ALC-DC.

(b) The original medical record shall not be removed except by court order.

(c) Copies of medical records or portions thereof may be used and disclosed in accordance with the requirements established in this administrative regulation.

(8) Confidentiality and Security: Use and Disclosure. (a) The ALC, ALC-BH, or ALC-DC shall maintain the confidentiality and security of resident records in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d-2 to 1320d-8, and 45 C.F.R. Parts 160 and 164, as amended, including the security requirements mandated by subparts A and C of 45 C.F.R. Part 164, or as provided by applicable federal or state law.

(b) The ALC, ALC-BH, or ALC-DC may use and disclose resident records. Use and disclosure shall be as established or required by HIPAA, 42 U.S.C. 1320d-2 to 1320d-8, and 45 C.F.R. Parts 160 and 164, or as established in this administrative regulation.

(c) An ALC, ALC-BH, or ALC-DC may establish higher levels of confidentiality and security than those required by HIPAA, 42 U.S.C. 1320d-2 to 1320d-8, and 45 C.F.R. Parts 160 and 164.

Section 14. Staff requirements. (1) Background checks. (a) All owners**, [~~and~~]** staff**,** **and regularly scheduled volunteers** in a position that involves providing direct care services to residents**, which may include access to the belongings, funds, or personal information of residents** shall:

1. Have a criminal record check performed pursuant to KRS 216.789(3);

2. In accordance with KRS 216.789(1), not have a criminal conviction or plea of guilty to a felony offense related to:

a. Theft;

b. Abuse or sale of illegal drugs;

c. Abuse, neglect, or exploitation of an adult; or

d. A sexual crime;

3. In accordance with KRS 216.789(2), not have a criminal conviction or plea of guilty to a misdemeanor offense related to abuse, neglect, or exploitation of an adult;

4. Not have a criminal conviction or plea of guilty to a felony or misdemeanor offense related to abuse, neglect, or exploitation of a child;

5. In accordance with KRS 209.032, not be listed on the caregiver misconduct registry established by 922 KAR 5:120; and

6. In accordance with KRS 216.532, not be listed on the nurse aide abuse registry established by 906 KAR 1:100.

(b) Staff in a position that involves providing direct care services to residents shall submit to a:

1. Criminal background check upon initial hire and no less than every two (2) years thereafter; and

2. Check of the following registries upon initial hire and annually thereafter:

a. Caregiver misconduct registry;

b. Nurse aide abuse registry; and

c. Central registry established by 922 KAR 1:470.

(c) An ALC, ALC-BH, or ALC-DC may use Kentucky's national background check program established by 906 KAR 1:190 to satisfy the background check requirements of paragraphs (a) and (b) of this subsection.

(d) In accordance with KRS 216.789(4), an ALC, ALC-BH, or ALC-DC may temporarily employ an applicant pending receipt of the results of a criminal record check performed upon initial hire.

(2) Licensed health professionals and nurses. **[~~Except for a social model ALC,~~]** A licensed health professional or nurse who provides services to residents of an ALC-BH or ALC-DC shall possess a current Kentucky license **or multistate licensure privilege** to practice **in Kentucky**.

(3) Staffing. (a) In accordance with KRS 194A.717(1), staffing in an ALC, ALC-BH, or ALC-DC shall be sufficient in number and qualifications to meet the twenty-four (24) hour scheduled needs of each resident pursuant to the lease agreement, functional

needs assessment, and service plan.

(b) In accordance with KRS 194A.717(2), at least one (1) staff person shall be awake and on-site at all times at each:

1. Licensed entity; or

2. Building on the same campus for two (2) or more buildings operated by the same licensee.

(c) The designated manager (director) of the facility shall meet the requirements of KRS 194A.717(3).

(4) Availability of nurse. **[~~(a)~~]** An ALC-BH and ALC-DC shall have a **[~~registered~~]** nurse **readily** available **[~~for consultation by staff performing delegated nursing tasks. (b) The registered nurse shall be readily available~~]** in person, by telephone, or by other means **of live, two-way communication** to **unlicensed** **[~~the~~]** staff at times the staff is providing delegated **nursing tasks[~~services~~]**.

(5) Delegation of assisted living services. (a)**1. [~~Except for a social model ALC,~~]** A **nurse in an ALC-BH or ALC-DC[~~registered nurse or licensed health professional~~]** may delegate tasks in accordance with **201 KAR 20:400.**

2. A licensed health professional in an ALC-BH or ALC-DC may delegate tasks in accordance with the **professional's** **[~~practitioner's~~]** scope of practice standards only to those staff who possess the knowledge and skills consistent with the complexity of the tasks delegated.

(b) The ALC-BH or ALC-DC shall establish and implement a system to communicate up-to-date information to the **[~~registered~~]** nurse or **appropriate** licensed health professional regarding current available staff so the **[~~registered~~]** nurse or

licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual resident needs and preferences.

(c) If the **[~~registered~~]** nurse or licensed health professional delegates tasks to unlicensed personnel, the **[~~registered~~]** nurse or health professional shall ensure that prior to the delegation the unlicensed staff person is trained in the proper methods to perform the tasks and demonstrates competence in performing the tasks.

(d) If an unlicensed staff person has not regularly performed the delegated assisted living task during the previous twenty-four (24) month period, the unlicensed staff person shall demonstrate competency in the task to the **[~~registered~~]** nurse or appropriate licensed health professional.

(e) The **[~~registered~~]** nurse or licensed health professional shall document **delegated nursing or other assigned tasks**[~~instructions for the delegated tasks~~] in the resident's record.

(6) Supervision of staff providing non-health related services. (a) Staff who provide only those assisted living services identified in KRS 194A.700(7)(a)-(f), (i) or (n) shall be supervised periodically to:

1. Verify that the work is being performed competently; and

2. Identify problems and solutions to address issues relating to the staff's ability to provide the services.

(b) The supervision of unlicensed personnel shall be done by staff who:

1. Have the authority, skills, and ability to provide the supervision of unlicensed personnel;

2. Can implement changes as needed; and

3. Can train staff.

(c) Supervision **may include** **[~~includes~~]**:

1. Direct observation of an unlicensed staff person while the unlicensed staff person is providing the services; and

2. Indirect methods of gaining input such as gathering feedback from the resident.

(d) Supervisory review of unlicensed staff shall be provided at a frequency based on the unlicensed staff person's knowledge, skills, and performance.

(7) Supervision of staff providing delegated nursing or therapy tasks. (a) An unlicensed staff person who performs**:**

1. Delegated nursing **tasks shall be supervised by a nurse pursuant to the requirements of 201 KAR 20:400, Section 4;** or

2. Therapy tasks shall be supervised by **[~~a registered nurse or~~]** an appropriate licensed health professional according to the facility's policy to:

a. **[~~1.~~]** Verify that the work is being performed competently; and

b. **[~~2.~~]** Identify problems and solutions related to the staff person's ability to perform the tasks.

(b) Supervision of an unlicensed staff person performing medication or treatment administration **[~~shall~~]**:

1. **Shall** be provided by a **[~~registered~~]** nurse or appropriately licensed health professional; and

2. **May** include observation of the staff person administering the medication or treatment and the interaction with the resident.

(c) The direct supervision of an unlicensed staff person performing a delegated task

shall be provided the first time the staff person performs the delegated task and on an as needed basis thereafter based on performance.

(8) Orientation and annual training. (a) Prior to working independently with residents and within thirty (30) days from the date of hire, all staff and management shall receive orientation education that addresses the topics required by KRS 194A.719(1) with emphasis on those most applicable to the employee's assigned duties.

(b) All staff and management shall receive annual training in accordance with KRS 194A.719(2), which shall include in-service education regarding Alzheimer's disease and other types of dementia.

Section 15. Medication management. (1) Medication management services.

(a) This section of this administrative regulation applies to facilities licensed to operate as an ALC-BH or ALC-DC.

(b) Medications or therapeutic services shall not be administered or provided to any resident except on the order of a licensed health care practitioner as authorized under the practitioner's scope of practice.

(c) Each facility subject to this section shall develop, implement, and maintain written medication management policies and procedures developed under the supervision and direction of a **[~~registered~~]** nurse, **appropriate** licensed health professional, or pharmacist consistent with scope of practice standards and guidelines.

(d) The policies and procedures shall address:

1. Requesting and receiving prescriptions for medications;

2. Preparing and giving medications;

3. Verifying that prescription drugs are administered as prescribed;

4. Documenting medication management activities;

5. Storage of medications, which shall include compliance with the following requirements:

a. All medications shall be kept in a locked place;

b. All medications requiring refrigeration shall be kept in a separate locked box in the refrigerator in the medication area; and

c. Drugs for external use shall be stored separately from those administered by mouth or injection;

6. Monitoring and evaluating medication use;

7. Resolving medication errors;

8. Communicating with the prescriber, pharmacist, resident and if applicable, designated contact person or legal representative;

9. Disposing of unused medications; and

10. Educating residents and designated contacts or legal representatives about medications.

(e) If controlled substances are being managed, the policies and procedures shall identify how the facility ensures security and accountability for the overall management, control, and disposition of those substances in accordance with subsection (21) of this section.

(f) All resident medications shall be plainly labeled with the:

1. Resident's name;

2. Name of the drug;

3. Strength;

4. Name of the pharmacy;

5. Prescription number;

6. Date;

7. Prescriber's name; and

8. Caution statements and directions for use, unless a modified unit dose drug distribution system is used.

(2) Provision of medication management services. Prior to providing medication management services to a resident pursuant to orders from the resident's health care practitioner in accordance with KRS 194A.708(1)(d), **the facility shall have** a **[~~registered~~]** nurse or **other licensed health professional** **[~~prescribing practitioner shall~~]** conduct an assessment that shall:

(a) Be face-to-face with the resident;

(b) Determine what medication management services will be provided and how the services will be provided;

(c) Include an identification and review of all medications the resident is known to be taking. The review and identification shall include:

1. Indications for medications;

2. Side effects;

3. Contraindications; and

4. Possible allergic or adverse reactions, and actions to address these issues;

(d) Identify interventions needed in the management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and

(e) Provide instructions to the resident and designated contacts or legal representatives on interventions to prevent diversion of medications such as misuse, theft, or illegal or improper disposition of medications.

(3) Individualized medication monitoring and reassessment. The ALC-BH or ALC-DC shall reassess the resident's medication management services in accordance with subsection (2) of this section:

(a) If the resident presents with symptoms or other issues that may be medication-related; and

(b) No later than every twelve (12) months.

(4) Resident refusal. The ALC-BH or ALC-DC shall:

(a) Document in the resident's record any refusal for an assessment for medication management; **[~~and~~]**

(b) Discuss **[~~with the resident~~]** the possible consequences of the resident's refusal **with the:**

1. Resident;

2. Resident's designated contact person or legal representative; or

3. Both individuals identified by subparagraph 2. and 3. of this paragraph; and

(c) Document the discussion in the resident's record.

(5) Individualized medication management plan. (a) For each resident receiving medication management services, the ALC-BH or ALC-DC shall develop and maintain a current individualized medication management record for each resident based on the resident's assessment.

(b) The medication management record shall be updated if there is a change and contain:

1. A statement describing the medication management services that will be provided to the resident;

2. A description of storage of medications that:

a. Is based on the resident's needs and preferences;

b. Reduces risk of diversion; and

c. Is consistent with the manufacturer's directions;

3. Documentation of specific instructions relating to the administration of medications to the resident;

4. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

5. Identification of medication management tasks that may be delegated to unlicensed personnel;

6. Procedures for staff to notify a **[~~registered~~]** nurse or appropriate licensed health professional if a problem arises with medication management services; and

7. Any resident-specific requirements related to:

a. Documenting medication administration;

b. Verification that all medications are administered as prescribed; and

c. Monitoring of medication use to prevent possible complications or adverse reactions.

(c) Medication reconciliation shall be completed by a **[~~registered~~]** nurse, licensed health **professional** **[~~care practitioner~~]** acting within the **professional's**

[~~practitioner's~~] scope of practice, or authorized prescriber for each resident receiving medication management services.

(6) Administration of medication. A licensed health **[~~care~~]** professional may:

(a) Administer medications as authorized under the professional's scope of practice; or

(b) Delegate medication administration tasks in accordance with subsection (7) of this section.

(7) Delegation of medication administration.

(a) Unlicensed personnel **who meet the requirements of subparagraph 1. of this paragraph** may only administer oral or topical medication**, or preloaded injectable insulin** if delegated to them by a **nurse or appropriate** licensed health **[~~care~~]** professional. If medication **administration** is delegated to unlicensed personnel, the ALC-BH or ALC-DC shall ensure that the **[~~registered~~]** nurse or licensed health **[~~care~~]** professional has:

1. [~~(a)~~] Delegated medication administration to a staff person who**:**

a. Is a certified medication aide; or

b. Has **[~~: 1.~~]** successfully completed **a:**

i. [~~the Kentucky~~] Medication aide training program **accepted by the Kentucky Board of Nursing (KBN)**; and

ii. Skills competency evaluation;

2. **[~~Demonstrated the ability to competently follow the procedures;~~**

~~(b) Instructed the unlicensed personnel in the proper methods to administer oral or topical medications;~~

~~(c)~~] Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and

3. **[~~(d)~~]** Communicated with the unlicensed personnel about the individual needs of the resident.

(b) The ALC-BH or ALC-DC shall ensure that a nurse or licensed health professional is readily available during times the unlicensed staff administers medications in accordance with Section 14(4) of this administrative regulation.

(8) Documentation of administration of medications. (a) Each medication administered shall be documented in the resident's record.

(b) The documentation shall include the:

1. Signature and title of the staff person who administered the medication;

2. The medication name, dosage, date, and time administered; and

3. Method and route of administration.

(c) The staff person shall document the:

1. Reason why medication administration was not completed as prescribed, if applicable; and

2. Any follow-up procedures that were provided to meet the resident's needs if medication was not administered as prescribed and in compliance with the resident's medication management plan.

(9) Documentation of medication setup. At the time of medication setup, the authorized health **professional** **[~~care practitioner~~]** shall document the following in the resident’s record:

(a) Date of medication setup;

(b) Name of medication;

(c) Quantity of dose;

(d) Times to be administered;

(e) Route of administration; and

(f) Name of the staff person completing the medication setup.

(10) Medication management for residents who will be away from the facility. (a) An ALC-BH or ALC-DC shall develop and implement policies and procedures for giving accurate and current medications to the resident for planned or unplanned times away from the facility according to the resident's individualized medication management plan.

(b) The policies and procedures shall state that:

1. For planned time away, the medications shall be obtained from the pharmacy or set up by the **[~~registered~~]** nurse or authorized health **professional** **[~~care practitioner~~]**;

2. For unplanned time away, if the pharmacy is not able to provide the medications, a **[~~registered~~]** nurse or authorized health **professional** **[~~care practitioner~~]** shall provide medications in the amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days.

(c) The ALC-BH or ALC-DC shall:

1. Provide the resident with written information on medications, including any special instructions for administering or handling the medications;

2. Place the medications in a medication container or containers appropriate to the provider's medication system; and

3. Label the container or containers with the:

a. Resident's name; and

b. The dates and times that the medications are scheduled.

(11) Over-the-counter drugs and dietary supplements not prescribed. (a) An ALC-BH or ALC-DC providing medication management services for over-the-counter drugs or dietary supplements shall retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration.

(b) The ALC-BH or ALC-DC shall verify that the medications are up to date and stored as appropriate.

(12) Prescriptions. There shall be a current written or electronically recorded prescription for all prescribed medications that the ALC-BH or ALC-DC is managing for the resident.

(13) Renewal of prescriptions. Prescriptions shall be renewed at least every twelve (12) months or more frequently as indicated by the assessment in subsection (2) of this section.

(14) Verbal prescription orders. If an order is received by telephone, the order shall be:

(a) Recorded in the resident's medication management record; and

(b) Signed by the physician or health care practitioner as authorized under the practitioner's scope of practice within thirty (30) days.

(15) Written or electronic prescription. At the time a written or electronic prescription is received, it shall be:

(a) Communicated to the **[~~registered~~]** nurse in charge; and

(b) Recorded or placed in the resident's record.

(16) Medications provided by resident or family members. If a staff person becomes

aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff person shall advise the **[~~registered~~]** nurse and document that in the resident record.

(17) Storage of medications. Except for the storage of controlled substances that shall be kept under a double lock in accordance with subsection (21)(b) of this section, an ALC-BH or ALC-DC shall store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.

(18) Prescription drugs. A prescription drug, prior to being set up for immediate or later administration, shall be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.

(19) Prohibitions. No prescription drug supply for one (1) resident may be used or saved for use by anyone other than the resident.

(20) Disposition of medications. (a) Any current medications being managed by the ALC-BH or ALC-DC shall be provided to the resident if:

1. The resident's service plan ends; or

2. Medication management services are no longer part of the service plan.

(b) The ALC-BH or ALC-DC shall dispose of any medications remaining with the facility:

1. That are discontinued or expired; or

2. Upon termination of the service plan or the resident's death.

(c) Upon disposition, the facility shall document in the resident's record the

disposition of the medication, including:

1. The medication's name, strength, prescription number as applicable, and quantity;

2. How the medication was disposed of or to whom the medications were given;

3. Date of disposition; and

4. Names of staff and other individuals involved in the disposition.

(21) Controlled substances. (a) Controlled substances. An ALC-BH or ALC-DC shall not keep any controlled substances or other habit forming drugs, hypodermic needles, or syringes except under the specific direction of a prescribing practitioner.

(b) Controlled substances shall be kept under double lock, for example, stored in a locked box in a locked cabinet, and keys or access codes to the locked box and locked cabinet shall be accessible to designated staff only.

(c) There shall be a controlled substances bound record book with numbered pages that includes:

1. Name of the resident;

2. Date, time, kind, dosage, and method of administration of each controlled substance;

3. Name of the practitioner who prescribed the medications; and

4. Name of the nurse who:

a. Administered the controlled substance; or

b. Supervised self-administration by a resident whose medical record includes a written determination from **an appropriately authorized** **[a]** health **professional** **[~~care practitioner~~]** that the resident is able to safely self-administer a controlled substance

under supervision.

(d) **An appropriately authorized** **[~~A~~]** licensed **health professional** **[~~practitioner~~]** with access to controlled substances shall be responsible for maintaining a recorded and signed:

1. Schedule II controlled substances count daily; and

2. Schedule III, IV, and V controlled substances count at least one (1) time per week.

(e) All expired or unused controlled substances shall be disposed of, or destroyed in accordance with 21 C.F.R. Part 1317 no later than thirty (30) days:

1. After expiration of the medication; or

2. From the date the medication was discontinued.

(f) If controlled substances are destroyed on-site:

1. The method of destruction shall render the drug unavailable and unusable;

2. The administrator or staff person designated by the administrator shall be responsible for destroying the controlled substances with at least one (1) witness present; and

3. A readily retrievable record of the destroyed controlled substances shall be maintained for a minimum of eighteen (18) months from the date of destruction and contain the:

a. Date of destruction;

b. Resident name;

c. Drug name;

d. Drug strength;

e. Quantity;

f. Method of destruction;

g. Name and signature of the person responsible for the destruction; and

h. Name of the witness.

(g) For purposes of this paragraph, an ALC-BH or ALC-DC shall be treated the same as a licensed personal care home that stores and administers controlled substances in an emergency medication kit (EMK) in which case the facility shall comply with the same:

a. Requirement for licensed personnel established by 201 KAR 2:370, Section 2(4)(i);

b. Requirements for storage and administration established by 902 KAR 55:070, Section 2(2), (5), (7), (8), and (9); and

c. Limitation on the number and quantity of medications established by 902 KAR 55:070, Section 2(6).

(22) Emergency drugs for non-controlled substances in an EMK. (a) For purposes of this paragraph, an ALC-BH or ALC-DC shall be treated the same as a licensed personal care home that stores and administers non-controlled substances in an EMK in which case the facility shall comply with the same:

1. Requirement for licensed personnel established by 201 KAR 2:370, Section 2(4)(i); and

2. Limitation on the number and quantity of medications established by 201 KAR 2:370, Section 2(4)(b).

(b) An ALC-BH or ALC-DC that stores and administers non-controlled substances

from a long-term care facility (LTCF) drug stock shall comply with the limitation on the number and quantity of medications established by 201 KAR 2:370, Section 2(5)(b).

(23) Loss or spillage. (a) An ALC-BH or ALC-DC shall develop and implement procedures to address loss or spillage of all controlled substances.

(b) The procedures shall require that if spillage of a controlled substance occurs, a notation shall be made in the resident's record explaining the spillage and the actions taken.

(c) The notation shall be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of.

(d) The procedures shall require that the ALC-BH or ALC-DC:

1. Investigate any known loss or unaccounted for prescription drugs;

2. Document the investigation in required records; and

3. Provide a copy of the detailed list of controlled substances lost, destroyed, or stolen to the Office of Inspector General:

a. Division of Audits and Investigations as soon as practical pursuant to KRS 218A.200(6); and

b. Division of Health Care.

Section 16. Assisted living communities with dementia care. (1) An applicant for licensure as an ALC-DC shall provide services in a manner that is consistent with the requirements of KRS 194.7061(1) – (3).

(2) An ALC-DC shall comply with KRS 194A.7065 and KRS 216.595.

(3) The manager (director) of an ALC-DC shall complete ten (10) hours of annual dementia-specific training in the topics established by KRS 194A.7201(2).

(4) An ALC-DC shall:

(a) Develop policies and procedures in accordance with KRS 194A.708(1); and

(b) Provide a copy of the policies and procedures to the resident and the resident's designated contact person or legal representative at the time of move-in.

(5) An ALC-DC shall ensure that the facility complies with the staffing standards established by KRS 194A.7203, including the requirement for only dementia-trained staff to care for residents on its secured dementia unit unless a temporary emergency situation exists.

(6) An ALC-DC shall:

(a) Provide all of the services listed in KRS 194A.7052(1);

(b) Evaluate each resident on its secured dementia unit for engagement in activities and develop an individualized activity plan pursuant to KRS 194A.7052(2) and (3);

(c) Provide a selection of daily structured and non-structured activities for residents on its secured dementia unit in accordance with KRS 194A.7052(4);

(d) Evaluate behavioral symptoms that negatively impact residents on its secured dementia unit and others in the facility and comply with the requirements of KRS 194A.7052(5);

(e) Offer support services to the families of residents on its secured dementia unit and others with significant relationships at least every six (6) months in accordance with KRS 194A.7052(6); and

(f) For dementia care units constructed after July 14, 2022, offer access to secured outdoor space in accordance with KRS 194A.7052(7).

(7) In addition to the training requirements of Section 14(8) of this administrative

regulation, an ALC-DC shall meet the training requirements of KRS 194A.7205 for direct care staff who work in the facility's secured dementia care unit.

Section 17. Violation of standards. An ALC, ALC-BH, or ALC-DC shall be subject to any applicable enforcement actions authorized by KRS 194A.722 and 902 KAR 20:008, Sections 7 and 8 for violations of the standards established by this administrative regulation, KRS 194A.700—194A.729, KRS 216.532, or KRS 216.789.

Section 18. Denial and Revocation. (1) In addition to the reasons for denial or revocation of a license in accordance with 902 KAR 20:008, Section 8, the cabinet shall deny or revoke an ALC, ALC-BH, or ALC-DC license if it finds that:

(a) There has been a substantial failure by the facility to comply with the provisions of:

1. KRS 194A.700—194A.729, KRS 216.532, or KRS 216.789; or

2. This administrative regulation;

(b) The facility permits, aids, or abets the commission of any illegal act in the provision of assisted living services;

(c) The facility performs any act detrimental to the health, safety, or welfare of a resident;

(d) The facility obtains licensure by fraud or misrepresentation, including a false statement of a material in fact in:

1. The Application for License to Operate an Assisted Living Community; or

2. Any records required by this administrative regulation;

(e) The facility denies a representative of the cabinet access to any part of the facility's books, records, files, employees, or residents;

(f) The facility interferes with or impedes the performance of the duties and responsibilities of the long-term care ombudsman;

(g) The facility interferes with or impedes a representative of the cabinet in the enforcement of this administrative regulation or fails to fully cooperate with a survey or investigation by the cabinet;

(h) The facility destroys or makes unavailable any records or other evidence relating to the facility's compliance with this administrative regulation;

(i) The facility refuses to initiate a background check or otherwise fails to comply with the requirements of KRS 216.789;

(j) The facility fails to timely pay any fines assessed by the cabinet;

(k) The facility violates any applicable building or safety codes as determined by the building code or safety code enforcement authority with jurisdiction;

(l) There have been repeated incidents in the facility of personnel performing services beyond their competency level;

(m) The facility continues to operate beyond the scope of the facility's license after the timeframe specified for correction of the violation; or

(n) An individual with a significant financial interest in the facility:

1. Is convicted of a felony or gross misdemeanor that relates to the operation of the facility or directly affects resident safety or care; or

2. Had the application returned in accordance with Section 3(4) of this administrative regulation.

(2) The cabinet shall follow the notification requirements of 902 KAR 20:008, Section 8(2) and (3) for denial or revocation.

(3) In accordance with KRS 216B.105(2), the denial or revocation shall become final and conclusive thirty (30) days after notice is given, unless the applicant or licensee files a request in writing for a hearing with the cabinet within thirty (30) days after the date of the notice.

Section 19. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) Form OIG – 20:480, "Application for Licensure to Operate an Assisted Living Community", November 2022 edition; and

(b) Form OIG – 20:480-A, "Functional Needs Assessment", **March 2023** **[~~November 2022~~]** edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Office of Inspector General, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. This material may also be viewed on the Office of Inspector General's Web site at: https://chfs.ky.gov/agencies/os/oig/dhc/Pages/ltcapplications.aspx.

902 KAR 20:480

REVIEWED:

3/8/2023
Date

DocuSigned by:
Adam Mather
CCB53CB0B2CA4FA...
Adam Mather, Inspector General
Office of Inspector General

APPROVED:

3/8/2023
Date

DocuSigned by:
Eric Friedlander
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Eric C. Friedlander, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation: 902 KAR 20:480
Agency Contact: Kara Daniel; Stephanie Brammer-Barnes
Phone Number: (502) 564 – 2888
Email: karal.daniel@ky.gov; sbrammerbarnes@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-6746
Email: CHFSregs@ky.gov

(1) Provide a brief summary of:

(a) What this administrative regulation does: This new administrative regulation establishes the minimum licensure requirements for the operation of social model assisted living communities (ALC), health care model assisted living communities that provide basic health and health-related services (ALC-BH), and assisted living communities with a secured dementia care unit (ALC-DC).

(b) The necessity of this administrative regulation: This new administrative regulation is necessary to comply with the passage of SB 11 during the 2022 regular session.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This new administrative regulation conforms to the content of KRS 194A.700—194A.729 by establishing an initial and re-licensure review process. This new administrative regulation also conforms to the content of KRS 216B.042(1) by establishing the licensure standards and procedures to ensure safe, adequate, and efficient health facilities which is defined by KRS 216B.015(13) to include assisted living communities.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This new administrative regulation assists in the effective administration of KRS 194A.700—194A.729 by establishing minimum licensure requirements for the operation of social model ALCs, ALCs-BH, and ALCs-DC.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: In response to comments received during the public comment period, this amended after comments regulation includes the following changes:

Adds “immediate family member”, “licensed health professional”, “nurse”, “nursing task” and “volunteer” to Section 1, Definitions.

Clarifies that reports of abuse, neglect, or exploitation must be made to the Office of Inspector General and Department for Community Based Services.

Clarifies that the delegation of nursing tasks and the supervision of unlicensed personnel performing delegated tasks in an ALC-BH or ALC-DC must be in compliance with 201 KAR 20:400.

Adds an exemption from the prohibition against being a contact person or legal

representative only if a staff person is an “immediate family member” of the resident.
Clarifies that social model ALCs must continue to comply with the current requirements for dietary services in accordance with KRS 194A.703(2) and KRS 194A.705(1)(b) while ALCs-BH and ALCs-DC must comply with the remaining subsections of Section 9, Dietary services, which mirror the same requirements established by the PCH regulation, 902 KAR 20:036, Section 4(3)(c) for dietary services.
Replaces “physician” with “licensed health professional” in Section 9(4)(c) to align with KRS 194A.700(7)(f).
Clarifies that a record shall be maintained for each regularly scheduled volunteer and shall include documentation of a background check.
Clarifies that employees with access to residents’ belongings, funds, or personal information are subject to the same background checks required of direct care staff.
Replaces all references to “health care professional” with “licensed health professional” as newly defined in Section 1.
Replaces all references to “registered nurse” with “nurse” so that a licensed practical nurse (LPN) who provides services pursuant to KRS 194A.700(7)(g) in an ALC-BH or ALC-DC may delegate nursing tasks.
Clarifies that a nurse in an ALC-BH or ALC-DC must be readily available in person, by telephone, or by other means to unlicensed staff at times the staff is providing delegated nursing tasks; deletes the requirement for a registered nurse to be available for consultation by staff performing delegated nursing tasks.
Replaces the requirement for a nurse or licensed health professional in an ALC-BH or ALC-DC to document instructions for the delegated tasks in the resident’s record with a requirement for the nurse or licensed health professional to document delegated tasks in the resident’s record.
Clarifies that the nurse or other licensed professional in an ALC-BH or ALC-DC shall be responsible for conducting a face-to-face assessment with the resident prior to providing medication management services.
Clarifies that an ALC-BH or ALC-DC shall discuss the possible consequences of a resident’s refusal of an assessment for medication management with the resident, resident’s designated contact person or legal representative, or both.
Clarifies that unlicensed staff who administer medications in an ALC-BH or ALC-DC under the delegation of a nurse must be: (1) a certified medication aide; or (2) have successfully completed a medication aide training program accepted by KBN and a skills competency evaluation. This change assures that unlicensed personnel are not limited solely to the Kentucky medication aide training program offered by the Kentucky Community and Technical College System. The use of properly trained and competent medication aides leads to fewer errors with drug use and medication administration, thereby enhancing liability protections for the facility and helping ensure fewer negative outcomes for residents.
Allows certified medication aides in an ALC-BH or ALC-DC to administer preloaded injectable insulin in addition to oral or topical medications.
Makes changes to the Functional Needs Assessment as described under the Summary of Material Incorporated by Reference.

(b) The necessity of the amendment to this administrative regulation: This amended after comments regulation is necessary to address issues brought forth during the public comment period.

(c) How the amendment conforms to the content of the authorizing statutes: This amended after comments regulation conforms to the content of KRS 194A.700 - 194A.729 by establishing an initial and re-licensure review process. This amended after comments regulation also conforms to the content of KRS 216B.042(1) by establishing the licensure standards and procedures to ensure safe, adequate, and efficient health facilities which is defined by KRS 216B.015(13) to include assisted living communities.

(d) How the amendment will assist in the effective administration of the statutes: This amended after comments regulation assists in the effective administration of KRS 194A.700 - 194A.729 by establishing minimum licensure requirements for the operation of social model ALCs, ALCs-BH, and ALCs-DC.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: This administrative regulation affects ALCs. There are approximately 114 ALCs certified by the Department for Aging and Independent Living that will convert to licensed facilities regulated by the Office of Inspector General after adoption of this administrative regulation.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: In accordance with SB 11 and this administrative regulation, entities that convert their certification status or otherwise seek licensure as an ALC, ALC-BH, or ALC-DC will be required to submit an initial and annual renewal application to the cabinet with accompanying documentation. They will have to comply with the minimum licensure standards established by KRS 194A.700—194A.729 and this administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): This administrative regulation was promulgated in accordance with the passage of SB 11, a measure brought forward by Kentucky’s three long-term care associations.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): In accordance with the passage of SB 11 during the 2022 regular session, this administrative regulation will replace the current structure of certification of ALCs, which are currently prohibited from providing health services, with a framework that will allow ALCs to seek licensure to provide basic health and health-related services, including dementia care services. The overall goal of converting the current “social model” to a “health care model” will allow more seniors who reside in assisted living communities to age in place to the extent that basic health and health-related services are needed, which may also include dementia care services.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: The OIG anticipates an estimated cost of approximately $352,000 to

cover four (4) new staff positions that will be needed to absorb the workload associated with inspecting and monitoring licensed assisted living communities.

(b) On a continuing basis: The OIG anticipates an estimated ongoing cost of approximately $352,000 to cover the four (4) staff positions necessary to inspect and monitor licensed assisted living communities.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: State general funds and agency monies will be used to implement and enforce this new administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: ALCs are currently subject to the fee schedule established by 910 KAR 1:240, Section 2(1)(e) for initial certification and Section 3(2)(c) for annual renewal. This new administrative regulation retains the same fee schedule for ALCs and therefore does not increase fees.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This new administrative regulation establishes fees as authorized by KRS 194A.707(9) and retains the same fee structure as currently established by 910 KAR 1:240.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is used because entities may seek licensure as a social model assisted living community, health care model assisted living community, or as an assisted living community with a secured dementia care unit defined by KRS 194A.700(6).

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation: 902 KAR 20:480
Agency Contact: Kara Daniel; Stephanie Brammer-Barnes
Phone Number: (502) 564 – 2888
Email: karal.daniel@ky.gov; sbrammerbarnes@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-6746
Email: CHFSregs@ky.gov

(1) What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? This administrative regulation impacts assisted living communities (ALC), apartment-style personal care homes that convert to ALC licensure, and the Cabinet for Health and Family Services, Office of Inspector General.

(2) Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 194A.707(1) and (9), 216B.042(1)

(3) Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? Revenue is based on the number of licensed ALCs subject to the following fee schedule:

Number of Units	Rate
<25	$500 + $40 per unit
25-49	$1,000 + $40 per unit
50-74	$1,500 + $40 per unit
75-99	$1,750 + $40 per unit
100 or more	$2,000 + $40 per unit

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Ongoing revenue is based on the number of licensed ALCs subject to the above fee schedule.

(c) How much will it cost to administer this program for the first year? The OIG anticipates an estimated cost of approximately $352,000 to cover four (4) new staff positions that are needed to absorb the workload associated with inspecting and monitoring licensed ALCs during the first year.

(d) How much will it cost to administer this program for subsequent years? The OIG anticipates an estimated ongoing cost of approximately $352,000 to cover the four (4) staff positions necessary to inspect and monitor licensed ALCs.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-):
Expenditures (+/-):
Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year? This administrative regulation will not generate cost savings for regulated entities during the first year.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years? This administrative regulation will not generate cost savings for regulated entities during subsequent years.

(c) How much will it cost the regulated entities for the first year? This administrative regulation imposes no additional costs on regulated entities.

(d) How much will it cost the regulated entities for subsequent years? This administrative regulation imposes no additional costs on regulated entities during subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Cost Savings(+/-):
Expenditures (+/-):
Other Explanation:

(5) Explain whether this administrative regulation will have a major economic impact, as defined below. *"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)]*

The annual licensure fees paid by the roughly 114 assisted living communities is not anticipated to exceed $500,000. Therefore, this new administrative regulation is not expected to have a major economic impact on the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation: 902 KAR 20:480
Agency Contact: Kara Daniel; Stephanie Brammer-Barnes
Phone Number: (502) 564 – 2888
Email: karal.daniel@ky.gov; sbrammerbarnes@ky.gov

Contact Person: Krista Quarles
Phone Number: (502) 564-6746
Email: CHFSregs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 21 C.F.R. Part 1317, 45 C.F.R. Parts 160, 164, 42 U.S.C. 1320d-2–1320d-8

2. State compliance standards. KRS 194A.707(1) and (9), 216B.042(1)

3. Minimum or uniform standards contained in the federal mandate. 21 C.F.R. Part 1317, 45 C.F.R. Parts 160, 164, 42 U.S.C. 1320d-2–1320d-8

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This administrative regulation does not impose requirements that are stricter than federal laws or regulations.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Not applicable.

SUMMARY OF MATERIAL INCORPORATED BY REFERENCE

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

902 KAR 20:480. Assisted living communities.
Amended After Comments

The Form OIG – 20:480-A, "Functional Needs Assessment", March 2023, is the form that all ALCs are required to use to determine a prospective resident or current resident's ability to perform activities of daily living and instrumental activities of daily living and otherwise determine whether the individual meets the criteria for residing in an ALC.

Changes to the form include the following:

Page 2, under "Exclusions", amend Question 7 and Question 9 as follows:

7. Does the individual/resident have a history of frequent falls **with major injuries** that would put them in *constant* danger?

9. If incontinent (bowel or bladder), is the **facility able to provide assistance to the** individual/resident **to manage incontinence [~~incapable of self-managing with minimal assistance~~]**?

Page 2, under "Exclusions", after "may be considered for admission in an", add "**ALC-BH**".

Page 3, under "Dietary", add a box to document food allergies.

Page 4, under "Medication", after "Needs medication", insert "**administration**". Delete "management".

Page 4, under "TO BE COMPLETED BY STAFF PERSON COMPLETING THE FNA", after "your", delete "professional".

Page 4, under the signature of the staff person completing the FNA, add the following statement: **The FNA shall be completed by a staff person who meets the qualifications of 902 KAR 20:480, Section 7(1)(c)2.**

The total number of pages incorporated by reference is four (4) pages.

STATEMENT OF CONSIDERATION
Relating to 902 KAR 20:480

Cabinet for Health and Family Services, Office of Inspector General,
Division of Health Care
(Amended After Comments)

I. The public hearing on 902 KAR 20:480 was held on January 23, 2023, at 9:00 a.m. in a Zoom meeting format by the CHFS Office of Legislative and Regulatory Affairs. In addition to the public hearing, written comments were received during the public comment period.

II. The following people submitted comments:

Name and Title	Agency/Organization/Entity/Other
Susan Abercrombie Regional Executive Director	Sterling Meadows Assisted Living
Carla Austin Executive Director	Barrington Independent and Assisted Living
Adam Bailey Executive Director	Cedar Ridge Health Campus
Patrick Beaven Owner	The Homeplace of Henderson
Michael Berg Director of Operations Management	Magnolia Springs Senior Living
Kathy Bevil Executive Director	Dogwood Retreat Inc.
Lisa Biddle Puffer Director of Regulatory Affairs	Kentucky Association of Healthcare Facilities/Kentucky Center for Assisted Living (KAHCF/KCAL)
Beth Blair Executive Director	The Willows at Fritz Farm
Charlotte Bowling Housing Manager	Laurel Senior Living Communities
Roy Bowling Board of Directors	Laurel Senior Living Communities

Eric Bryant Executive Director	Cooper Trail Senior Living
Mary Nell Bouvier Owner	Bee Hive Homes of Grayson County
Jennifer Brown Executive Director	Arcadia Communities
Hannah Bruenderman Long-Term Care Pharmacy Services Provider	Kentucky Senior Living Association and Kentucky Association of Health Care Facilities Board Member
Ted Burfict Executive Director	Belmont Village
Sheila Carter Founder/President	Heartsong Memory Care
Conjuna Collier Senior VP of Risk Management & KAHCF Regulatory Chair	Masonic Homes of Kentucky
Pat Cranmer Executive Director	Arcadia Communities
Sherry Culp State Ombudsman	Kentucky State Long-Term Care Kentucky Ombudsman Program
Rachel Dadisman Executive Director	The Willows at Harrodsburg
Sharon Davis Executive Director	Mayfair Village Retirement Community
Catherine M. Deist Counsel to Charter Senior Living	Ernest Law Group, PLC
Raymond Dickison, Jr. President	Wesley Manor Retirement Community
Brian P. Durbin President	Arcadia Communities
Mandy Emmons Community Coordinator and Program	McDowell Place of Danville

Manager	
Eric Evans State Advocacy Manager	AARP Kentucky
Brittany Faucher Executive Director	Shelby Farms Senior Living
Lindsey Foster Executive Director	Walker's Trail Senior Living
Sam Frazier Executive Director	The Willows
Sharon Garland Board of Directors	Laurel Senior Living Communities
Jennifer Gish Executive Director	Gaither Suites at West Park
Angela Goodlett Resident Service Manager	McDowell Place of Danville
Candie Gray Executive Director	Arcadia Communities
Carol Gregory Housing Manager	Laurel Senior Living Communities
Bobby Greene Assisted Living Director	Sayre Christian Village
Marty Hawkins Executive Director	Glen Ridge Health Campus
Mark Hegele Kentucky Area Director	BeeHive Assisted Living Homes
James Hepner Owner/Executive Director	Dogwood Estates
Marilyn Ingram Executive Director	Rivercrest Place Assisted Living
Georgina Ivers Executive Director	Crescent Place Assisted Living

Tracey Javid Owner	Pleasant Meadow Assisted Living
Betsy Johnson President/Executive Director	Kentucky Association of Healthcare Facilities/Kentucky Center for Assisted Living (KAHCF/KCAL)
Matthew Jones Executive Director	The Legacy at English Station
Joe Jurgensen	Crescent Place Assisted Living Fairview Place Senior Living
Douglas King Treasurer	Osborn Enterprises, Manages Mayfair Village Retirement Center
George Robert King Board of Directory Chairman	Laurel Senior Living Communities
Kristie Kronk Chief Operating Officer	Arcadia Communities
Lawrence Kuhl Board of Directors and Resident	Laurel Senior Living Communities
Cliff Lake Executive Director	Brookdale Senior Living
Maria Lee Co-Founder	The Paragon of Madisonville, Inc.
Mark Lee Attorney Registered Legislative Agent Registered Executive Lobbyist President of Paragon Vice President, Development and Government Affairs	The Paragon of Madisonville, Inc. Paragon Operations Group, LLC Paragon Development Consultants, LLC Heartsong Management, Inc.
Susan Matherly Post-Acute System Director	McDowell Place of Danville
Mona Lisa McCubbins Administrator of Assisted Living	Franciscan Health Care Center

Sean McElroy	Family Member of Assisted Living Resident
Theresa McFarlin Executive Director	Chandler Senior Living
Kara Meredith Executive Director	The Springs at Stony Brook
Jonathan Miller Assistant Administrator	Laurel Senior Living Communities
G. Parker Moore Executive Director	Westport Place Health Campus
Renee Moore Executive Director	The Willows at Citation
Jason Morgan	Highgrove Senior Living
Kristi Noah Executive Director	Forrest Springs Health Campus
Amy Payne Executive Director	Fern Terrace of Owensboro
Rebecca Pfalzgraf Executive Director	Kentucky Senior Living Association (KSLA)
Vicki Phillips VP Assisted and Independent Living Services	Sayre Christian Village
Gwen Reverman Executive Director	Legacy Living Florence
Bailee Roberson Executive Director	BeeHive Homes of Grayson County
Cristi Rucker Community Relations	Belmont Village
Brandie Windsor-Shanklin Executive Director	Sunrise Senior Living
Eric Sherrard Owner	BeeHive Assisted Living Home Goshen

Rob Simpson	Fern Terrace of Owensboro
Nichole Smith, LNHA	St. Charles Community
Mary Crowley-Schmidt Assistant Director	Bluegrass Area Agency on Aging & Independent Living
Alex Strein Executive Director	The Paragon of Madisonville
Tim Veno President and CEO	LeadingAge Kentucky
Andy Wade Chief Operating Officer	Traditions at Beaumont
Mackenzie Wallace Director of Public Policy	Alzheimer's Association of Greater Kentucky and Southern Indiana
Clinton Warf Executive Director	Charter Senor Living of Paducah
Denise Wells Executive Director	Nursing Home Ombudsman Agency of the Bluegrass
Allie Wilson Executive Director	Fairview Place Senior Living
Janet D. White Residence Director	Kenton Pointe Assisted Living
Robert W. White Consultant	The Quail Group
Kathey Young Administrator	Laurel Senior Living Communities

III. The following people from the promulgating administrative body responded to the comments:
<u>Name and Title</u>

Adam Mather, Inspector General

Kara L. Daniel, Deputy Inspector General

Stephanie Brammer-Barnes, Contractor

IV. Summary of Comments and Responses

(1) Subject: Tiered Licensure Structure for Assisted Living Communities

(a) Comment: Rebecca Pfalzgraf, KSLA, Betsy Johnson, KAHCF/KCAL, and Tim Veno, LeadingAge Kentucky, submitted the following written comments. In addition, Lisa Biddle-Puffer, KAHCF/KCAL and Mr. Veno presented verbal comments during the public hearing held on January 23, 2023, that are similar to the following: “This letter conveys the request for a Public Hearing, during which, each of the undersigned will testify.

It also conveys the formal comments regarding 902 KAR 20:480 from Coalition Partners, consisting of the Kentucky Association of Health Care Facilities (KAHCF)/Kentucky Center for Assisted Living (KCAL), the Kentucky Senior Living Association (KSLA), and LeadingAge Kentucky. The coalition represents nursing facility, personal care, and assisted living providers throughout the Commonwealth of Kentucky. Personal care homes and assisted living providers, and the residents that they serve, will be directly and negatively impacted by the proposed regulation. We respectfully submit the following comments for your consideration.

Comment #1:
The proposed regulation conflicts with the express wording and intent of SB 11 (2022), as overwhelmingly enacted by the General Assembly. The regulation creates three licensure categories that will significantly reduce residents’ ability to safely age in place, in their chosen homes, for which they privately pay 100% of the costs. SB 11 was intended to allow residents to continue to live within the same apartment as their care needs increase. The proposed regulation would defeat that purpose.

Per KRS 194A.710 ‘Licensure Requirement – Categories’: ‘The following categories are established for assisted living community licensure:

(a) An assisted living community license for any assisted living community without a secured dementia care unit; and

(b) An assisted living community with dementia care license for an assisted living community that provides assisted living services and dementia care services in a secured dementia care unit.’

However, 902 KAR 20:480 states, in Section 2 - Licensure Categories:

(1) The licensure categories established by this administrative regulation include the following:

(a) A social model assisted living community (ALC) license for any facility that provides assisted living services, excluding basic health and health-related services;

(b) An assisted living community with basic health care (ALC-BH) license for any facility that:
1. Provides assisted living services, including basic health and health-related services directly to its residents; and
2. Does not have a secured dementia care unit; and
(c) An ALC with dementia care (ALC-DC) license for any facility that provides assisted living services and dementia care services in a secured dementia unit.

Current law (which provides for the social model of assisted living and the basic health services model of personal care) already stipulates the implementation of care described by this regulation. The purpose of SB 11 was to blend the two private-pay levels (assisted living and personal care) into one continuum of care. SB 11 allows providers to choose how much care to deliver and to permit seamless aging in place within the parameters of basic health care, all within the same resident apartment.

Unfortunately, the way that the proposed regulation is written, a once healthy and active resident, whose needs have increased over the years, would either have to bring in outside caregivers to meet his or her basic health needs (at an additional cost) or move from their 'ALC' (social only) licensed facility to an 'ALC-BH' (basic health) facility. In either case, the resident suffers by having to absorb the costs of bringing in outside caregivers or by experiencing the trauma of having to leave their home, friends, and familiar surroundings to move somewhere different to receive the basic health services that they need. This was not the intent of SB 11.

This would hold true in short-term situations as well. For example, a resident who has had eye surgery and needs help instilling eye drops for a few days (a service prohibited in a social model assisted living facility) would have to bring in an outside agency or family member to assist with this or temporarily move to another space that can offer that basic health service. Again, the resident bears the burden of either option. Please note, SB 11 passed with bi-partisan support in both the House and Senate and was signed by Governor Beshear with the intent to allow elders to age in place – the proposed regulation, as currently written, prohibits elders from doing just that."

(b) Response: In accordance with the 2022 passage of SB 11, the cabinet filed 902 KAR 20:480 to replace the current structure of certification for social model assisted living communities (ALC) with a new framework that will allow ALCs to seek licensure to continue providing social model services, optional basic health and health-related services, or maintain secure dementia care units in which case the delivery of basic health services will be mandatory.

The overall goal of allowing ALC residents to age in place to the extent that they require basic health and health-related services is a shared goal of the cabinet and Kentucky's three long-term care associations. However, in response to the long-term care associations' assertion that 902 KAR 20:480 conflicts with the express

wording and intent of SB 11 by creating three licensure categories, the cabinet disagrees.

The cabinet is authorized to regulate health facilities and establish licensure classifications pursuant to statute. KRS 216B.042(1)(c) not only grants statutory authority regarding licensure classification and safety standards, it makes it the responsibility of the cabinet to:

> Establish licensure standards and procedures "to ensure safe, adequate, and efficient . . . health facilities . . ."; and
> Establish ". . . classification of health facilities and health services according to type, size, range of services, and level of care. . ."

Given that SB 11 added ALCs to the definition of "health facility" in KRS 216B.015(13), the cabinet has authority under KRS 216B.042(1)(c) to establish appropriate licensure and classification standards for ALCs just as the cabinet has long had the authority through administrative regulation to create licensure levels to fit the services provided. There are at least 40 different categories of health facilities that the cabinet licenses, and many of those classifications are created by regulation and are not prescribed in the statutes.

Although the existing statutory language enacted by SB 11 prescribes two categories, it does not limit the cabinet's authority to create additional categories. The regulation creates the two categories that were prescribed, but also creates the social model category to allow providers that choose not to offer basic health services to be licensed in a category that is consistent with the more limited services they provide. As stated above, it is within the cabinet's authority and responsibility to establish classification of health facilities according to "type, size, range of services, and level of care" as prescribed by KRS 216B.042(1)(c).
Last spring, long-term care industry representative and facility owner Mark Lee told members of the Health, Welfare, and Family Services (HWFS) committee that ALCs would be allowed to retain their social model status rather than transition to a basic health care model. Additionally, the bill's sponsor, Sen. Ralph Alvarado, testified before committee as the bill moved through the House that any ALC that wished to remain a social model would be able to do so and would not be required to add services. The cabinet's Department for Aging and Independent Living staff also report that they have heard from several ALC providers who have expressed their interest in remaining a social model facility. Adding the third category will benefit those providers who wish to remain a social model by reducing the amount of regulatory requirements they will need to follow, and it will help reduce consumer confusion and ensure appropriate marketing.

The three-tiered licensure structure will not interfere with a resident's ability to safely age in place to the extent that basic health services are needed or in situations in which a resident experiences a "temporary condition" as defined by KRS 194A.700(26). If an ALC intends to provide services to a mix of residents on the same campus who need social model assisted living services as well as residents

who need basic health and health-related services, the ALC must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time.

The cabinet will not amend the regulation in response to the long-term care associations' comments and would further like to address concerns the cabinet has heard from family members, including Sean McElroy who spoke during the public hearing on January 23, 2023, regarding recent rate increases. Mr. McElroy testified that the ALC where his mother resides has already begun charging residents increased fees citing the delivery of health services under SB 11 as justification for the increases. It is important to remind providers that converting to a health care model is premature at this time because there is no mechanism in place for ALCs to seek licensure from the OIG to provide basic health and health-related services until 902 KAR 20:480 is fully implemented.

(a) Comment: Robert White, The Quail Group, submitted the following comments. In addition, Mr. Berg presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "I submit these public comments in opposition to 902 KAR 20:480.

I am currently a consultant in the long-term care and senior living environment. I have been involved in long-term care and senior living since 1975. I retired as Executive Director of the Kentucky Senior Living Association (KSLA) in July, 2022. I was instrumental in gaining support for SB-11, having met with Adam Mather, Inspector General, Eric Friedlander, Secretary of CHFS, Victoria Elridge, Commissioner of the Department of Aging and Independent Living (DAIL) and Dr. Keith R. Knapp, Senior Advisor on Adult Programs, Office of the Secretary, CHFS early in 2019 to gain their input on a new assisted living statute. At that time, they were very supportive in our quest to modernize assisted living in Kentucky. I am currently a Kentucky Executive Agency Lobbyist and Legislative Agent. I was responsible for creating the Coalition Partners comprised of Kentucky Senior Living Association (KSLA), Kentucky Association of Health Care Facilities (KAHCF), Kentucky Center for Assisted Living (KCAL), and Leading Age Kentucky. The Coalition Partners worked collaboratively over two and a half years to create a statute to assure our elderly citizens of the Commonwealth the opportunity to age in place as their basic health needs increase. The residents will be able to stay in their own apartment rather than having to seek a higher level of care. Senate Bill 11 was passed during the 2022 regular session 30-2 by the Senate, and 94-0 by the House.

The 56 page regulation that was filed by CHFS appears to have been compiled by the Cabinet without even looking at the law that was created by SB-11. It is inconceivable that there are nearly two dozen problems with the filed regulation. The most glaring change from the statute to the regulation is the fact that the Cabinet is proposing three licenses for assisted living, whereas the statute only calls for two license categories. Others will testify concerning the other discrepancies in the regulation.

I feel that this regulation is flawed and should be revised by the Cabinet to confirm with the law as set out in SB-11."

(b) Response: In response to the commenter's assertion that, "The 56 page regulation that was filed by CHFS appears to have been compiled by the Cabinet without even looking at the law that was created by SB-11", the cabinet disagrees. The regulation implements SB 11 and is entirely consistent with its language and intended purpose to allow seniors to age in place when possible, but in a safe environment with quality care that will fit their needs. It should also be noted that Inspector General Adam Mather spoke last fall at the annual conferences of both LeadingAge KY and KAHCF/KCAL at their request. Mr. Mather used a detailed PowerPoint presentation to explain the requirements of SB 11 to association members, a copy of which may be downloaded from KAHCF/KCAL's website at: https://kahcfkcal.org/common/Uploaded%20files/2022%20Annual%20Meeting/2022%20Annual%20Meeting%20Handouts/Session%2012%20Handouts.pdf The cabinet has closely reviewed the requirements in SB 11 and drafted a regulation to implement its requirements.

In the long-term care associations' testimony before HWFS committee members last spring, association representatives said that they reviewed the rules and regulations of other states as they drafted SB 11 but they were heavily influenced by Minnesota's state laws governing ALCs. Likewise, the cabinet also researched other states' laws and modeled much of 902 KAR 20:480 on Minnesota's rules, adding key standards to the proposed regulation that were not included in SB 11.

Please see the previous response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for the three-tiered licensure structure. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. The cabinet will not amend the regulation in response to this comment.

(a) In addition to the comments Rebecca Pfalzgraf, KSLA, submitted earlier with the other two long-term care associations, she submitted the following additional written comments which are similar to the comments she presented at the public hearing held on January 23, 2023: "My name is Rebecca Pfalzgraf and I'm the Executive Director for the Kentucky Senior Living Association. In this role, I have the privilege of providing support for 129 senior living providers across the Commonwealth. These providers own and/or operate apartment-style, private pay communities which include assisted living communities, personal care homes, independent living communities and memory care communities.

In 2019, and for the first time ever, the Kentucky Senior Living Association formed a coalition partnership with two other Kentucky senior living associations whose purpose was to modernize assisted living, to allow residents to safely age in place,

in the home of their choosing and for which they privately pay. Argentum, the Kentucky Senior Living Association's national affiliate, wholeheartedly supported this initiative and provided grants totaling $50,000 to assist us in funding this endeavor. With that grant money, we hired a consultant to lead the project.

Our consultant is an assisted living community owner/operator, and an attorney, and has a long and successful history in the senior living industry in Kentucky. As part of his due diligence, our consultant conducted a thorough study of the best statutory and regulatory approaches used across the United States. That research, along with the dedicated, thoughtful, and collaborative efforts of the coalition partners, and members of our current and past board of directors, resulted in SB 11, a clearly written and detailed bill, which was overwhelmingly passed during the 2022 regular session. I provide this background so that you know that an enormous amount of research and thoughtful consideration went into SB 11 by industry professionals who have decades of real-life and practical experience in assisted living, personal care, memory care and private pay senior living in Kentucky. These are the industry experts.

Unfortunately, there are several areas of significant concern with 902 KAR 20:480 proposed rule 'assisted living communities.' This regulation, if allowed to go into effect as filed, will have a direct and negative impact on senior living residents in Kentucky.

My first and most pressing concern is the issue of licensure categories. The statute clearly states that there will be two. The first licensure category, 'ALC' would pertain to communities without secured dementia care units and would effectively merge existing Assisted Living Communities with Personal Care Homes to create a broader continuum of care. Under the 'ALC' license, providers would have the option to remain a social model if desired or offer basic health services so long as they meet the requirements to do so. The second licensure category, 'ALC-DC,' is for communities with a secured dementia care unit.

Under the statute's two-licensure model, residents who don't require a secured dementia care unit or skilled care, can safely age in place. Services they need can be delivered to them in their homes, regardless of location, and without forcing them to endure the trauma of a move. However, the proposed licensure model in the filed regulation eliminates this option because it bifurcates the 'ALC' license into two separate licenses, a model that is virtually no different from current assisted living and personal care. The result eliminates safe aging in place and defeats the express wording and purpose of SB 11. And the party who suffers will be the resident."

(b) Response: Please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for the three-tiered licensure structure. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure

classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Catherine Deist, Counsel to Charter Senior Living, submitted the following comments: “I represent Charter Senior Living, LLC (‘Charter’), a senior living community management company that currently manages over forty senior living communities in twelve states, including six facilities in Kentucky. Charter is committed to providing quality care, and we make every effort to ensure that our company policies and standards meet or exceed the strictest state standards.

Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480, Assisted Living Communities.

The proposed regulations will create two categories of assisted living community (ALC) licenses: (1) social model assisted living community (‘ALC-social’); and (2) assisted living community with basic health care (‘ALC-BH’). Currently, the ALC license allows providers to serve residents in both categories, so that an ALC may safely care for its residents as they age in place. Additionally, the proposed rules include many cumbersome and unnecessary staffing requirements, which directly conflict with existing regulations. Ultimately, the changes resulting from the proposed regulations will not only negatively impact Charter, but also the residents we serve.

The proposed two category ALC system (ALC-social and ALC-BH) will make it difficult for residents to age in place. For example, it is common for a resident to move into our community needing very little assistance that gradually increases over time. Under the current ALC model (which includes both social and basic health care), our community can serve the resident through these gradual increases in level of care. However, under the proposed two category ALC model, a resident in an ALC-social building who experiences even a slight change in level of care will have two options: (1) move to an ALC-BH building, which is traumatic to a resident who has made his or her home at our community; or (2) hire a full-time private duty aide, which is an option only if the resident can find a private duty aide, and only if the resident can afford the exorbitant costs of a private duty aide, and only if the community permits the resident to stay at the community (a private duty aide does not alleviate the risk and liability for an ALC-social building that is not licensed as an ALC-BH). This proposed two category system is unfair to a resident who must either endure the trauma of moving or endure the financial impact of hiring a full-time private duty aide.”

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet’s rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident’s ability to safely age in place to the extent that basic health services are needed. The three-tiered structure is consistent with the language and intent of SB 11 and within

the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Sheila Carter, Heartsong Memory Care, submitted the following Comments. In addition, Ms. Carter presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: “Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, ‘assisted living communities.’ The changes in this proposed rule would not only impact my Personal Care Memory Care community, also the residents and families we serve.

Heartsong Memory Care is located in Louisville/Jefferson County. We specialize in the care of individuals with Alzheimer’s disease and other forms of dementia and are held in high regard among families and other senior service providers. We are committed to providing high quality care and continually strive to do the best for the people we serve. Part of that commitment includes building relationships with legislators and being involved in advocacy activities to promote safe, effective statues and regulations related to those we serve.

Kentucky Senior Living Association (KSLA) is the only association serving only freestanding, apartment-style, private pay housing for senior adults in Kentucky, but KSLA took the lead in forming Coalition Partners in 2019 with the two other KY associations serving assisted living residents (a historical feat given the inherent ‘competition’ among the members for residents). Their goal is to modernize assisted living in Kentucky and to assure assisted living residents they can safely age in place, in the home of their choosing, for which they pay privately. The worked collaboratively to help write and file SB 11 which received bipartisan support and was overwhelmingly enacted during the 2022 General Assembly.

Proposed regulation 902 KAR 20:480 overreaches the SB 11 statute in a number of ways. 1) The filed regulation creates three (3) licensure categories that significantly diminished our residents’ ability to safely age in place. One of the primary purposes of SB-11 was to allow Assisted Living communities to adjust care to meet the changing needs of residents—without the resident having to change apartments. The proposed regulation requires that there be only one license per building so a provider would not be able to offer both social model services and basic health services in different parts of the building. Residents and their families suffer. SB-11 successfully blended the continuum of care, allowing providers to choose how much care is delivered and to permit seamless aging in place within the same resident apartment.”

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet’s rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident’s

ability to safely age in place to the extent that basic health services are needed. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Susan Matherly, Ephraim McDowell Health, submitted the following comments: “I have worked in senior living for over 26 years, 23 of those years being in assisted living and personal care. I currently serve as the President of the board of directors for Kentucky Senior Living Association (KSLA) and have been involved with the association for many years. I was involved first-hand in the early discussions several years ago of re-thinking and re-imagining how assisted living and personal care could be blended together to create a combined level of care which would be easier for consumers to understand. It was imagined that it would be a level of care which would allow residents to more easily age in place, without having to move to a different apartment within a community in order to able to receive more basic health services that may be needed by a resident.

Proposed regulation 902 KAR 20:480 violates KRS 13A.120, section 2(h) and (i). Certain provisions within the proposed regulation are not authorized by SB 11, which was passed by the Kentucky General Assembly during the 2022 regular session.

The proposed regulation completely contradicts the intent of SB11 and restricts the licensure categories that diminish residents ability to safely age in place. As written, the regulation is more restrictive and creates three licensure categories therefore stripping the resident's ability to safely age in place. It takes away the choice of providers to deliver basic health care to a resident within the same apartment. A resident needing more health care services would be forced to move to another apartment, temporarily or permanently, within the same building or bring in outside caregivers to render the needed healthcare services. This is unfair to the resident who chooses to live in the assisted living environment, and is a transition that the resident should not have to endure.”

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet’s rationale for proposing three licensure levels, including why the tiered licensure structure does not violate the drafting requirements of KRS Chapter 13A and does not interfere with a resident’s ability to safely age in place to the extent that basic health services are needed.

If an ALC intends to provide services to a mix of residents on the same campus who need social model assisted living services as well as residents who need basic health services, the ALC must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The cabinet will not amend the regulation in response to this

comment.

(a) Comment: Ted Burfict, Belmont Village, submitted the following comments: “Belmont Village is located in Louisville, Kentucky. We are committed to providing high quality care and continually strive to do the best for the people we serve. U. S. News & World Report ‘Best in Senior Living’ survey, where residents and family members rated their respective communities in the criteria of best in Independent Living, Assisted Living and Memory Care included our community in the final rankings, reflecting our company’s commitment to the highest standards of quality care, programming, and amenities. The real satisfaction comes from knowing that our residents and families are truly enjoying programs that they receive on a daily basis to the community themselves, which feel like home.

Proposed regulation 902 KAR 20:480 ‘Licensure requirement- categories.’ Specifically, we are concerned with the following:

The filed regulation attempts to legislate by regulation in direct conflict with the express wording and intent of SB 11 as overwhelmingly enacted by the General Assembly. It creates three licensure categories that significantly diminish residents’ ability to safely age in place.

For example, one of our residents, Bill moved into our community over four years ago. Bill had no significant health concerns at that time, and was quite healthy in all areas except for one issue with one of his foot. Bill had a treatment to his foot that required treatment and dressing changes initially three times a week. Home health had to come in to perform this treatment and dressing changes. These treatment and dressing was outside of our scope to perform per our license. Bill loved living here and he had a great relationship with the staff. He did not know the home health folks as he knew us. They had no relationship with him. His treatment was increased to twice a day. This was upsetting to him that we could not perform the treatments and dressing rather than the home health folks. The cost for services was increasing for Bill, he could not sustain the cost and he ended up having to transfer out. This is not aging in place if we’re not allowed to provide these type of services to our seniors without having to transfer them out.

We are passionate about the care we provide to our residents and if the Cabinet for Health and Family Services moves forward with the proposed regulation as drafted, we are concerned about the impact this would have on our ability to continue to operate and provide quality care to our residents.”

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet’s rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident’s ability to safely age in place to the extent that basic health services are needed. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of

health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Brian Durbin, Arcadia Communities, submitted the following written comments. Mr. Durbin's verbal testimony during the public hearing held on January 23, 2023, is similar to his written comments. Additionally, Jennifer Brown, Pat Cranmer, and Candie Gray, Arcadia Communities, submitted written comments that are similar to Mr. Durbin's, which begin: "I've had the honor and privilege to serve seniors in Kentucky for the past 25 years including my current role as President of Arcadia Communities, a Kentucky-based senior living company who proudly serves our residents in Assisted Living Communities in Elizabethtown, Bowling Green, Paducah, and Benton. We have built our company on the core values of honesty, respect, transparency, and compassion and are very proud of the work our teams do each day to enhance the lives of those we serve. With that said, I'm very concerned that the drafted regulations will provide a real hardship for providers in Kentucky and ultimately have a negative impact on those we serve. Clearly the past few years have been very difficult for senior living providers given the impact of the pandemic, labor challenges, rising costs and inflation pressures, increased insurance costs, etc. I'm very concerned that the impact of the Proposed regulation 902 KAR 20:480 will add an additional layer of challenges that many providers will simply not be able to overcome. My concerns include:

Three Licensure Categories: The filed regulation attempts to legislate by regulation in direct conflict with the express wording and intent of SB 11 as overwhelmingly enacted by the General Assembly. It creates three licensure categories that significantly diminish residents' ability to safely age in place. If the regulation is allowed to go into effect as-is, the establishment of three licensure categories significantly reduces the residents' ability to safely age in place, in their AL home, for which they privately pay 100% of the costs. One of the primary purposes of SB-11 was to allow residents' care to change to meet their needs, all within the same apartment. This regulation would defeat that. With three levels of licensure, residents who live in an ALC licensed facility (social-only) cannot age in place if their needs increase to a point where they require basic health services. They must either bear the cost of bringing in outside contract agencies to provide those needed health services or suffer the trauma of moving to another community (ALC-BH licensed community) that does offer basic health services. Either way, the resident suffers.

Also, if an ALC (social-only) community elects to begin offering basic health services, it will be required to apply for (and potentially pay for) an ALC-BH license. However, SB 11 statute does not require this re-licensure process. The community should only be required to meet the increased staffing and equipment requirements to offer basic health services. The regulation requires that there be only one license per building. Accordingly, a provider could not have both social model and basic health services in different parts of the same building. Additionally, current law

(social model AL and basic health services model Personal Care) already does what the licensure part of this regulation would implement. Another primary goal of SB-11 was to blend those two private pay levels (PC and AL) into one continuum of care, allowing providers to choose how much care is delivered and to permit seamless aging in place within the parameters of basic health care, all within the same resident apartment. The requirements must still be met by providers who offer basic health services and permits residents to age in place, which is strongly desired by our residents and their families."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. KRS 216B.042(1)(c).

In response to the comment regarding the licensure of buildings, 902 KAR 20:480, Section 5(4) states that the cabinet will issue a single license for each building operated by the licensee *or* a single license for two or more buildings on a campus if operated by the same licensee.

Therefore, if an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Charlotte Bowling, Roy Bowling, Sharon Garland, Carol Gregory, George Robert King, Lawrence Kuhl, Jonathan Miller, and Kathey Young of Laurel Senior Living Communities submitted the following comments: "Please accept this letter of comment on the recently filed proposed legislation, 902 KAR 20:480 proposed rule 'assisted living communities.' The changes in this proposed rule would not only impact my assisted living facility, Village Heights, but also the residents we serve.

Village Heights is located in London Kentucky. For the past 17 years our facility has been committed to providing high quality care and we continually strive to do the best for the community and residents we serve. Village Heights houses 34 residents in a homelike environment and we maintain a high census and demand for our services. Village Heights residents remain very active in our community and are very proud of the community and home that they have helped create. Recently Village Heights residents and staff members participated in the community Christmas Lights Decorating challenge creating much excitement for our campus. They loved the additional visitors this project generated and were thrilled with the

accolades their decorations received. Village Heights truly is a home for all of our residents providing a unique sense of community and family.

Proposed regulation 902 KAR 20:480 presents the following challenges and concerns for caring for our residents:

Under the proposed regulation there are three licensure categories for Assisted Living. It is the goal for the majority of our residents to age in place in their homes in Assisted Living. By having three licensure categories instead of two it will be very difficult to allow residents to achieve this goal. For example residents may need basic health services such as medication administration of eye drops following cataract surgery, or two person assistance occasionally. These needs could case residents to have to relocate from facilities identified as a Social Model facility. In the Statute there are only two categories for licensure eliminating the need for residents to be forced to move from their home for non-dementia related basic health services. These residents pay privately for their apartments and services. Forcing them to relocate or move often places increased financial burden on governmental programs such as Medicare and Medicaid."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The cabinet will not amend the regulation in response to this comment. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c).

(a) Comment: Eric Sherrard, BeeHive Assisted Living, submitted the following comments: "My name is Eric Sherrard and I am the owner of the BeeHive Assisted Living home in Goshen, KY. I have owned this home for over 10 years now and over the past few years, our assisted living home has received the top rated Caring Star award from Caring.com (as based on customer reviews) and is the only home in Kentucky to receive this award. We are a small home that prides ourselves on the high level of personalized care we offer our residents. Throughout this time, I have also seen many regulations and changes from our state that focuses on the overall care of our senior population to ensure each of us is providing the best care possible. Many of the regulations that have been implemented over this period have been beneficial to our home and residents. However, I am writing this to you in regard to the recently filed proposed regulation 902 KAR 20:480 proposed rule, 'assisted living communities.'

Upon review, this regulation that was submitted is in direct conflict with the direct wording and intent of SB11 which was overwhelming approved by the General Assembly this past July 2022. One of the main reasons the group of Assisted Living

communities pushed for this SB11 and got such support was that it condenses the licensure categories in assisted living from three to two. This was created and approved to help our residents safely age in place. The new proposed regulation keeps it at 3 licensure categories."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Mark Hegele, BeeHive Assisted Living, submitted the following comments: "My name is Mark Hegele, and I am the Kentucky Area Director for BeeHive Assisted Living Homes. As such, I represent over 100 residents in our BeeHives throughout the state, and I am writing to you to express my opposition to the proposed new regulations (902 KAR20:480) governing assisted living in Kentucky.

Our primary concerns are:

1. The implementation of 3 licensed levels of care as proposed could prohibit residents from aging in place, especially if a particular AL home or campus can only hold a license for one level of care."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. If an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Gwen Reverman, Legacy Living Florence, submitted the following comments: "The facility will only be able to hold one license. This will extremely affect the cost of the care the residents will pay due to the increase in the licensed staffing required. Again, this revolves around mandating these items making it less

assisted living like and more skilled nursing home like."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels.

As stated previously, 902 KAR 20:480, Section 5(4) states that the cabinet will issue a single license for each building operated by the licensee *or* a single license for two or more buildings on a campus if operated by the same licensee.

Therefore, if an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. However, if an ALC chooses to remain a social model and not provide additional services, it may do so and will not have to hire licensed staff. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Cristi Rucker, Belmont Village, submitted the following comments: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' The changes in this proposed rule would not only impact my Personal Care Community but also the residents we serve.

Belmont Village Senior Living is located in Louisville, KY. We are committed to providing high quality care and continually strive to do the best for the people we serve. Belmont Village has been a licensed Personal Care Community in KY for 24 years and serves 120 residents. We have a specialized memory support program that has won national awards called Circle of Friends. We offer enriching programming for seniors in an Assisted Living setting and we also offer a Secured Memory Care Unit.

Proposed regulation 902 KAR 20:480 violates KRS 194A.710 'Licensure requirement - categories.' Specifically, we are concerned with the following: The filed regulation attempts to legislate by regulation in direct conflict with the express wording and intent of SB 11 as overwhelmingly enacted by the General Assembly. It creates three licensure categories that significantly diminish residents' ability to safely age in place.

In my career, I have worked in all of the levels of care available in KY. I have worked in communities as well as a Senior Living Placement Specialist. The most traumatic thing an individual can do is to go through the initial move. It can become so frustrating for families that as soon as their loved one is adjusted and settling in to the community, a small issue arises that requires a need for a private duty care giver or a move because the regulations do not allow the community to provide a simple service.

For example, a resident has a fall and is undergoing therapy. In the morning when they are first waking up, their joints are a little stiff and need the help of two people to get up and going. Under our current guidelines, that is not allowed. So, in order for the resident to stay in the community with their friends they have made and the staff that they have grown to know and trust, they have to hire an outside agency to come in for 4 hours every morning (because this is the minimum amount of time that most agencies require). This cost about $30+/hour. The cost is for the resident to bear and adds an additional $3600/month.

Another example would be a resident currently lives in a assisted living community. They routinely have eye drops that they give themselves. They suffer an injury to their arm where they cannot use it for a period of time, therefore they cannot self-administer their eye drops. The Assisted Living is not allowed to administer this medication for them, so they have to either hire an outside agency to come in to administer this or a family member has to coordinate to be there daily to do so.

Unfortunately, with three levels of licensure, these residents' options will not improve. In an ALC (social-only) licensed building, they will still have to bring in contract providers to assist her. The cost or trauma involved will be theirs to bear.

But, under the statute's two-licensure model (one that includes social and basic health under a single ALC license), these residents will have the freedom to stay in their current home and receive the services they need. All without having to move or pay extra, because we could provide those services."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. If an ALC intends to provide services to a mix of residents on the same campus that includes social model residents and residents who need basic health services, the ALC may do so if they obtain an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time and allow them to age in place so long as only basic health services are needed. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Janet White, Kenton Pointe Assisted Living, submitted the following comments: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' The changes in this proposed rule would not only negatively impact my assisted living facility, but also the residents and families we serve.

Kenton Pointe Assisted Living is located in Maysville, KY. We are committed to providing high quality care and continually strive to do the best for the residents and families that we serve. We are a small AL with 32 apartments and the only facility in our 5-county area. We have also been voted Best of the Best, which is important in

our small community.

Proposed regulation 902 KAR 20:480 with regards to the licensure categories is in direct contradiction to the original purpose of SB11. Requiring three licensure categories does not give the residents the opportunity to age in place in the one apartment that they have chosen to make their home. As resident needs change, the original SB11 allowed us to meet those needs by increased staffing or equipment, not having to file for and pay for an additional licensure. Our residents chose to move to Kenton Pointe and pay all of their expenses out of pocket. I can give you so many examples of people who have chosen to live with us, have increased their level of care and avoided the skilled nursing facility! One couple moved in with us when we opened our facility in 2013. Once the husband passed away, the wife stayed with us until she passed away last year because we were able to increase her level of care and allow her to stay in her home for 9 years. Her daughter lives in Florida and that was a huge relief for her to know that she was well cared for and in the place where her parents had chosen to live their lives out. Your proposed regulations take away our resident's choices. I would have had to ask this resident to leave our facility, which would have been a hardship to the resident and their family with no benefit to anyone."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. Neither SB 11 nor this regulation changes the delineation between assisted living and skilled nursing levels of care. So long as a resident's needs do not exceed basic health services and dementia care within the definitions of SB 11 and this regulation, the resident would be able to remain in an appropriately licensed ALC. The cabinet will not amend the regulation in response to this comment.

(a) Comment: James Hepner, Dogwood Estates, submitted the following comments: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' As the Owner and Director of Dogwood Estates LLC., an Assisted Living Community with 38 residents located in Beaver Dam, KY, I am very concerned about the impact that the proposed regulation will have; specifically for small 'Mom and Pops' run Assisted Living Communities like the one I own here in rural Ohio County. The changes in this proposed rule would not only impact my family business, my current residents, and just as importantly, the future residents of Ohio County for over 20 years and I plan on continuing to provide a high level of service for the next 20 years. After comparing SB 11 to the proposed regulations, I have major concerns that our whole service industry will be altered because the proposed regulations do not mirror the intent of SB 11 in my view. I am asking that the regulations that have been proposed be sent back to the beginning and restructured to better meet SB 11's true intent. Someone has decided to circumvent the good intentions of SB 11 by pushing a different agenda with the proposed regulations.

One clear and obvious example of a deficiency in the proposed regulation is the difference between SB 11's two types of licensure categories and the proposed regulation's (902 KAR 20:480) three levels of licensure. SB 11 calls for two categories of Assisted Living; without dementia care and with a secured dementia care unit. The proposed regulation calls for three levels of licensure; Social Model, Basic Health Care Model, and the secured Dementia Care model. By separating the licensure of Social Model and Basic Health Care Model, you limit the residents' ability to age in place, the core reason from creating SB 11 in the first place. A resident that has a urinary tract infection that needs a little more 'basic health care needs' for a week or so but then recovers to the standard of the Social Model may have to be removed from the community or have to seek a more expensive and unnecessary avenue of recovery. There are many, many examples of the failures of this proposed regulation that I'm sure you will see in other letters from ALC's all across the state."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. If an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Andy Wade, Traditions at Beaumont, submitted the following comments: "Proposed regulation 902 KAR 20:480 attempts to legislate by regulation in direct conflict with the express wording and intent of SB 11 as overwhelmingly enacted by the General Assembly.

If the regulation is allowed to go into effect as-is, the establishment of three licensure categories significantly reduces the residents' ability to safely age in place, in their home, for which they privately pay 100% of the costs.

Countless studies have proven that relocation at older age has been related to decline of physical and cognitive functions. When allowed to age in place, seniors may continue enjoying the comforts they've gotten used to in a familiar environment. One of the primary purposes of SB-11 was to allow residents' care to change to meet their needs, all within the same apartment. 902 KAR 20:480 would defeat that.

With three levels of licensure, residents who live in an ALC licensed facility (social-only) cannot age in place if their needs increase to a point where they require basic health services. They must either bear the cost of bringing in outside contract agencies to provide those needed health services or suffer the trauma of moving to another community (ALC-BH licensed community) that does offer basic health services. Either way, the resident suffers.

At Traditions at Beaumont, we are passionate about the care we provide to our residents and if the Cabinet for Health and Family Services moves forward with the proposed regulation as drafted, we are concerned about the impact this would have on our ability to continue to operate and provide quality care to our residents."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. If an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The cabinet will not amend the regulation in response to this comment.

(a) Hannah Bruenderman, Long-Term Care Pharmacy Services Provider submitted the following comments: "Residents overwhelmingly and understandably prefer to age in place. SB 11 proposed a simple solution to improve Kentucky's assisted living communities' ability to meet their residents' inherent desire to age in the place of their choosing – their home. The proposed regulation, 902 KAR 20:480, if filed as-is, will have the exact opposite effect.

Assisted living communities are the residents' homes – the accommodations are carefully chosen and privately paid for, not funded through state or federal programs. Much of 902 KAR 20:480 reads like regulations pertaining to providers who participate in the Medicaid and Medicare programs.

The proposed regulation 902 KAR 20:480 violates KRS 194A.710 'Licensure requirement - categories.' The filed regulation attempts to legislate by regulation in direct conflict with the express wording and intent of SB 11 as overwhelmingly enacted by the General Assembly. 902 KAR 20:480 creates three licensure categories that significantly diminish residents' ability to safely age in place - the purpose of SB 11 and the overwhelming desire of our residents. Under a three-licensure model, residents will still need to move from one licensure category to another, even for relatively minor changes in healthcare needs. Under the statute's two-licensure model (one that includes social and basic health under a single ALC license), residents will have the freedom to stay in their assisted living home and receive the services they need to safely do so. 902 KAR 20:480 misses the point."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Theresa McFarlin, Chandler Senior Living, submitted the following comments: "Chandler Park Assisted Living and Chandler Memory Care are located in Bowling Green, KY. We are the premier assisted living provider in this area, committed to delivering excellence in senior living care and affordable options in this market.

Some areas of concern in the proposed regulation are as follows:

(3) licensure categories – The overall concern is that this regulation takes away what should be the common goal of all regulatory bodies, and that is the right for our seniors to age in place. Making a move from the home they've lived in for 60 years into an assisted living community is a life altering even in itself. No resident wants to move multiple times based upon what health service they may need at the time. Our assisted livings are designed to be an extension of their home, not institutionalized facilities."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. If an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Michael Berg, Magnolia Springs Senior Living, submitted the following Comments. In addition, Mr. Berg presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.'

The proposed regulations, while intended to increase the quality of care provided to residents, would create unnecessary financial burden for residents, reducing, not increasing, the services available to seniors in Kentucky.

Magnolia Springs serves residents in Louisville (Lyndon/St. Matthews), East Louisville, Lexington, and Florence Our company was founded in 2009 as a non-

profit with the simple mission of creating a meaningful environment where residents could receive the services they need to continue celebrating life as they age. In our 14-year history, we have continuously looked at the needs of our aging population and adapted, as we are able, to best serve them.

As the years have gone on, the needs of our seniors have changed. We have found ourselves limited in social model assisted living to serve our residents, particularly those afflicted with various forms of dementia. Thus, why several individuals in our organization began advocating through Kentucky Senior Living Association (KSLA) for adaptations to the legislation.

For the past 3 years, I have had the privilege of being a part of the Coalition Partners, a partnership comprised of the 3 mayor senior living associations in Kentucky. Together, we wrote a piece of well-balanced legislation that was overwhelmingly passed, with only 2 opposing, in the 2022 legislative session. This legislation was person-centered, ensuring we have environments that best serve the individuals that choose, via private pay, to live in our communities.

Unfortunately, thereafter, we as professionals, who do have our residents' best interests in mind, were not allowed to participate in writing the regulations. As it stands, the proposed regulations are a deviation from the legislation as passed and would hurt the residents we seek to serve. First, proposed regulation 902 KAR 20:480 attempts to create 3 licensure categories, rather than 2 as the passed legislation states (Section 2). 3 licensure categories would again cause KY to be behind the times and create consumer confusion. The goal of the legislation was to reduce consumer confusion by combining AL and PC, thus when a family visits our communities, they are not left wondering the difference between these two very similar styles of senior care. 3 categories would additionally inhibit our seniors from aging in place, forcing them to move from their home, which they pay 100% privately for."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Carla Austin, Barrington of Ft. Thomas, submitted the following written comments: "a. The purpose of SB 11 was to blend the two private-pay levels (AL and PCH) into one continuum of care. The proposed regulations do not support this. b. SB 11 allows providers to choose how much care to deliver and to permit aging in place within the parameters of basic health care, to remain within the same resident apartment. The proposed regulations do not support this. c. The proposed regulation requiring a resident to move from their AL social licensed facility to an ACL-BH facility creates physical, mental, emotional and financial burdens to the resident and families. This was not the intent of SB 11 to allow elders to seamlessly

age in place with the same resident apartment."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. If an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Alex Strein, The Paragon of Madisonville, submitted the following comments: "The licensing structure set forth in the filed regulation would prohibit safe aging in place. This, again, was a primary purpose of Senate Bill 11. Once again, the regulation is in direct conflict with the related statute, which as I understand it violates KRS 13A.120."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The three-tiered structure is consistent with the language and intent of SB 11 and is within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c).
The cabinet will not amend the regulation in response to this comment.

(a) Raymond Dickison, Jr., Wesley Manor Retirement Community, submitted the following comments: "The Cabinet's proposed level of licensure will continue to cause confusion with consumers and create unnecessary, bureaucratic processes that will not add value to the public protection or enforcement work of the Cabinet.

Lastly, if these draft regulations are not eliminated or significantly revised the affordability of these services will not be practical for our existing and future customer base. Less consumers will result in fewer providers. With potentially less assisted living and personal care providers in the Commonwealth, seniors will have less options, caregivers will have more struggles and the shrinking volume of skilled nursing providers will not be able to handle the needs of this population which are now safely being provided with the levels and scope of practice outlined in the bill that was passed by our legislature – at no expense to the Commonwealth.

We think allowing a clear path as outlined in Senate Bill 11 for our elders to receive basic health services in the home that they have chosen is important. The proposed regulations should be consistent with the legislatures and Governor's intentions as

the bill was passed. Any proposed unnecessary over-regulation or over-intention should not be allowed."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Adam Bailey, Cedar Ridge Health Campus, Beth Blair, The Willows at Fritz Farm, Eric Bryant, Cooper Trail Senior Living, Rachel Dadisman, The Willows at Harrodsburg, Brittany Faucher, Shelby Farms Senior Living, Lindsey Foster, Walker's Trail Senior Living, Sam Frazier, The Willows, Marty Hawkins, Glen Ridge Health Campus, Matthew Jones, The Legacy at English Station, Mona Lisa McCubbins, Franciscan Health Care Center, Kara Meredith, The Springs at Stony Brook, G. Parker Moore, Westport Place Health Campus, Renee Moore, The Willows at Citation, and Kristi Noah, Forest Springs Health Campus, submitted the following comments: "Maybe the most concerning aspect of the proposed regulation is it modifies the legislative intent of SB 11. Specifically, the intention of the regulation was to allow communities to choose what services they provide and to have the ability to change with their client's needs. The two licensure categories goes against the law as written and again, only affects Kentuckians seeking this level of care."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for proposing three licensure levels, including why the tiered licensure structure does not interfere with a resident's ability to safely age in place to the extent that basic health services are needed. The regulation allows ALCs to choose the level of services they wish to provide and obtain a license consistent with those services, whether that is the social model, basic health services, or dementia care. If an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time. The cabinet will not amend the regulation in response to this comment.

(2) Subject: Staffing

(a) Comment: Rebecca Pfalzgraf, KSLA, Betsy Johnson, KAHCF/KCAL, and Tim Veno, LeadingAge Kentucky, submitted the following comments: "The proposed regulation's requirement that a registered nurse be available when staff are performing delegated tasks overreaches the requirement of the statute. SB 11 is silent as to this issue and appropriately defers to the Nurse Practice Act, the existing law which already governs these issues. The proposed regulation, in Section 14 – Staff Requirements, states:

(4) Availability of nurse.
(a) An ALC-BH and ALC-DC shall have a registered nurse available for consultation by staff performing delegated nursing tasks.
(b) The registered nurse shall be readily available in person, by telephone, or by other means to the staff at times the staff is providing delegated services.

If this provision of the regulation is allowed to go into effect, any assisted living community that offers basic health services will be required to have a registered nurse 'readily available in person, by telephone, or by other means to the staff at times the staff is providing delegated services.' Because the enacted statute defers to the requirements of the Nurse Practice Act, we believe this additional requirement is not authorized by SB 11."

(b) Response: In response to the Kentucky's long-term care associations' comments about deferring to the Nurse Practice Act, the cabinet held a Teams meeting with the Kentucky Board of Nursing (KBN) on January 26, 2023, and again on February 17th. Based on KBN's recommendations during the meetings and subsequent follow-up discussion, the cabinet agreed to amend Section 14(4) as follows:

> (4) Availability of nurse. **[~~(a)~~]** An ALC-BH and ALC-DC shall have a **[~~registered~~]** nurse **readily** available **[~~for consultation by staff performing delegated nursing tasks. (b) The registered nurse shall be readily available~~]** in person, by telephone, or by other means **of live, two-way communication** to **unlicensed [~~the~~]** staff at times the staff is providing delegated **nursing tasks[~~services~~]**.

Please note that the proposed staffing requirement is less stringent as the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may be readily available at times unlicensed staff is providing delegated nursing tasks. This will help ensure that any unpredictable resident outcome may be immediately addressed by appropriately licensed personnel. KBN has reviewed the regulation and has not raised any concerns regarding inconsistency with the Nurse Practice Act.

(a) Comment: Tim Veno, LeadingAge Kentucky, provided the following comments during the public hearing on January 23, 2023: "The big issue, of course, is nurse delegation of tasks. The Kentucky Board of Nursing under Kentucky law has the responsibility to regulate medication administration. Medication administration is clearly a nurse practice, function, up to the Board of Nursing to regulate. The Board of Nursing has allowed nurse delegation of tasks, including administration of medications.

Here with these regulations we are not only duplicating their authority or usurping their authority, we are exceeding that authority. We would prefer, as we have made

comments, written comments and oral comments, that the Kentucky Board of Nursing be the sole agency to prescribe how nurse task functions are done.

Today in personal care there is no requirement for a nurse to be on-site. However, nurse delegation of tasks occur every day without any of the issues that have been indicated to us by the Cabinet that may occur. It has not occurred. Our goal, again, was to bring assisted living identical to personal care. Personal care is Kentucky's basic health category. And what we were attempting to do was to make assisted living identical to current personal care authority."

(b) Response: In response to the commenter's assertion that 902 KAR 20:480 duplicates, usurps, or exceeds KBN's authority with respect to the delegation of nursing tasks, please refer to the above response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky. The cabinet has met twice with KBN and KBN has reviewed the regulation and not raised any concerns regarding inconsistency with the Nurse Practice Act.

In response to comments that the long-term care associations' goal was to "bring assisted living identical to personal care", there is an important distinction between the services they can provide. Please note that the definition in KRS 194A.700(8) of "basic health and health-related services" for ALCs is similar but not identical to the description of "basic health and health related services" in the PCH regulation, 902 KAR 20:036, Section 4(1). Although the ALC statute includes "administration of medications" under the definition of "basic health and health-related service", Section 4(1) of the PCH regulation requires only the "supervision of self-administration of medications"

Beyond the requirement for "supervision of self-administration", the PCH regulation contemplates additional health services such as administration of medication as shown by the fact it requires controlled substances to be administered only by a nurse in accordance with 902 KAR 20:036, Section 4(1)(g)3.d.

Although the PCH regulation is silent on who can administer non-controlled medications, 902 KAR 20:036, Section 4(1)(j)1.a. requires PCHs that store and administer non-controlled substances in an emergency medication kit (EMK) to have licensed personnel as established by the Kentucky Board of Pharmacy's (KBP) regulation 201 KAR 2:370, Section 2(4)(i). Both the OIG and KBP regulations therefore recognize that staffing in a PCH should include a nurse if medication administration is taking place or otherwise delegated.

The cabinet further acknowledges that the conditions under which PCH staff may administer medications is potentially confusing. Therefore, the cabinet intends to collaborate in the future with KBN and stakeholders, including providers, on the addition of clarifying language consistent with nursing laws and practice as it relates to the delegation of nursing tasks in the PCH setting.

(a) Comment: Sheila Carter, Heartsong Memory Care, submitted the following Comments. In addition, Ms. Carter presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: “The filed regulation requires a registered nurse to be readily available for consultation by staff performing delegated nursing tasks…in person, by telephone, or by other means to the staff at times they are providing delegated services. This blatantly overreaches the requirement of the statute. SB-11 did not address nurse requirements because that is regulated by the Kentucky Nurse Practice Act. There is already a severe shortage of nurses in Kentucky, especially Registered Nurses. Adding this overreaching requirement potentially adds to the impossible staffing challenges for facilities and exacerbate this already-critical shortage in other levels of care. The statue allows facilities to manage this creatively, while complying with the Nurse Practice Act while striving to control costs which are passed on to consumers in this private-pay arena.”

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding nurse availability in an ALC-BH or ALC-DC, including the proposed change as agreed upon with KBN.

(a) Comment: In addition to the comments Rebecca Pfalzgraf, KSLA, submitted earlier with the other two long-term care associations, she submitted the following additional comments: “I’m also concerned about the regulation’s requirement of a registered nurse. The requirement of a registered nurse reaches beyond what is required in the statute which appropriately defers to the Nurse Practice Act, existing law that governs this issue. Further, this requirement reaches beyond current personal care requirements. Clearly, the past few years have been very difficult for senior living providers given the impact of the pandemic, labor challenges, and rising costs. There is a shortage of nurses for hire in Kentucky. If one can be found, this portion of the proposed regulation will add an additional and significant expense for providers to overcome, the cost of which would most certainly have to be passed on to residents. Residents’ funds will be exhausted more quickly, and many will no longer be able to afford to live in a private-pay community.”

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced “registered nurse” with “nurse” so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC. KBN has reviewed the regulation and has not raised any concerns regarding inconsistency with the Nurse Practice Act.

(a) Comment: Brian Durbin, Jennifer Brown, Pat Cranmer, and Candie Gray, Arcadia Communities, submitted the following written comments. Mr. Durbin’s verbal testimony during the public hearing held on January 23, 2023, is similar to his written comments. Additionally, Kristie Cronk, Arcadia Communities, expressed similar comments during her verbal testimony during the hearing: “If the regulation is allowed to go into effect as-is, any assisted living community that offers basic health services will be required to have a registered nurse ‘readily available in

person, by telephone, or by other means to the staff at times the staff is providing delegated services.' This will undoubtedly lead to significant increases in provider costs and ultimately to steep increases in resident rent. As mentioned previously, assisted living communities across our State are experiencing an unprecedented increase in the cost of doing business as well as real life challenges in recruiting health care professionals. This has led to rapidly increasing resident rents, providers exiting the business and, in some cases, communities closing and/or filing for bankruptcy. With the rapidly increasing numbers of seniors in need of services, we need to look for opportunities to remove provider barriers and decrease costs, not the opposite."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding nurse availability in an ALC-BH or ALC-DC, including the proposed change as agreed upon with KBN.

(a) Comment: Susan Abercrombie, Sterling Meadows Assisted Living, submitted the following comments: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' The changes in this proposed rule would not only impact my assisted living Sterling Meadows but also the residents we serve.

Sterling Meadows is in Mount Sterling KY. We are committed to providing high quality care and continually strive to do the best for the people we serve. Our residents often struggle now with the cost of AL, this will only make it worse for them.

Proposed regulation 902 KAR 20:480 If the regulation is allowed to go into effect as-is, any assisted living community that offers basic health services will be required to have a registered nurse 'readily available in person, by telephone, or by other means to the staff at times the staff is providing delegated services.' This could lead to increases in provider costs and resident rent. I have personally worked In Assisted Living as an ALF Administrator in Alabama for 16 years and the process is strict for assisting Residents with medication and this process has worked without having Nursing involved.

We are here to help create a better life for our Residents to age in Place. These Regulations will be so much more financial strain on our Communities that we have to pass on to our Residents. Some struggle now with the cost, this will only make it worse and more and more will not be able to come into Assisted Living due to this."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding nurse availability in an ALC-BH or ALC-DC, including the proposed change as agreed upon with KBN.

(a) Comment: Nichole Smith, St. Charles Community, submitted the following comments: "Throughout [the] document a registered nurse is needed. We do not

have a registered nurse on staff and such requirement would be determinantal to our residents and operation. We operate with LPNS as we do not have the need for an RN. Such requirements would have significant operational and financial implications for our 16 bed facility. We ask that the requirement of the RN be deleted."

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

(a) Comment: Adam Bailey, Cedar Ridge Health Campus, Beth Blair, The Willows at Fritz Farm, Eric Bryant, Cooper Trail Senior Living, Rachel Dadisman, The Willows at Harrodsburg, Brittany Faucher, Shelby Farms Senior Living, Lindsey Foster, Walker's Trail Senior Living, Sam Frazier, The Willows, Marty Hawkins, Glen Ridge Health Campus, Matthew Jones, The Legacy at English Station, Mona Lisa McCubbins, Franciscan Health Care Center, Kara Meredith, The Springs at Stony Brook, G. Parker Moore, Westport Place Health Campus, Renee Moore, The Willows at Citation, and Kristi Noah, Forest Springs Health Campus, submitted the following comments: "There are also situations in the proposed regulation requiring an RN to oversee or observe other staff performing their duties—another significant and unnecessary cost without demonstrated benefit that will get added to the facility expenses and passed onto the end consumer."

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

(a) Comment: Catherine Deist, Counsel to Charter Senior Living, submitted the following comments: "Prior to Covid, senior living communities across all categories had a difficult time finding qualified registered nurses (RNs) and qualified licensed practical nurses (LPNs). Following Covid, RNs and LPNs have become increasingly harder to recruit, and we often rely on staffing companies to fulfill our needs, which are very expensive. Proposed regulation 902 KAR 20:480 increases staffing requirements and staff qualifications, which conflicts with the current statutory requirements of KRS 194A §§ 700-729 and KRS Chapter 314, Registered Nurses – Practical Nurses, which promulgates 201 KAR Chapter 20, Board of Nursing. In other words, the new regulations conflict with the statutes and regulations already in place by the Kentucky Board of Nursing. The Kentucky Board of Nursing – not the Cabinet for Health and Family Services – is the appropriate administrative body to make these decisions.

First, Section 14, Staff Requirements, mandates that an RN must be available at all times if a staff member is providing delegated nursing tasks and delegated services. This requirement reaches beyond the scope of the current laws under KRS 194A §§ 700-729 and 201 KAR Chapter 20:400, Delegation of Nursing Tasks."

(b) Response: The proposed regulation does not conflict with the Nurse Practice Act. Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding nurse availability in an ALC-BH or ALC-DC, including the proposed change as agreed upon with KBN. The cabinet has met with KBN twice and KBN has reviewed the regulation and has not raised any concerns regarding inconsistency with the Nurse Practice Act.

(a) Comment: Gwen Reverman, Legacy Living Florence, submitted the following comments: “Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, ‘assisted living communities.’ The changes in this proposed rule would not only impact my Legacy Living Florence but also the residents we serve.

Legacy Living Florence is located in Florence, Kentucky. We are committed to providing high quality care and continually strive to do the best for the people we serve. Legacy Living Florence is a community that provides care with a servant’s heart to all of our residents and families. Our community is special because of the values we set forth. A comment from one of our residents, Janie Kirkpatrick ‘You all do so much for us, you all work together as a team, it’s not unusual to see all of you helping out in all departments. Where I was at before you would never see that.’ Our residents and their family member fill out forms monthly called ‘YAH Did Good’ on our team members recognizing all the moments they go above and beyond for them.

Proposed regulation 902 KAR 20:480 If this regulation goes into effect, it will prohibit the ability of our residents to age in place. First Concern: The residents would have to increase what they pay a month to have enhanced services. Thus, causing more financial burden on them, causing them to run out of money faster, which then makes them go to a skilled nursing under Medicaid faster.

Second Concern: The requirement of a Registered Nurse. This will increase the cost of care to the residents due to the increased cost to pay a Registered Nurse. The regulation is still stating assisted living, therefore, why the need of an RN? The Assisted Living is not a skilled unit.”

(b) Response: The proposed regulation does not interfere with a resident’s ability to safely age in place to the extent that basic health services are needed.

In response to this comment and upon agreement with KBN, the cabinet replaced “registered nurse” with “nurse” so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

(a) Comment: Mark Hegele, BeeHive Assisted Living, submitted the following comments: “The proposed requirement for a registered nurse to be on staff for the ALC-BH and ALC-DC levels of care overreaches the current successful operational methods and the requirements for the recently approved statute, SB-11.”

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced “registered nurse” with “nurse” so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

(a) Hannah Bruenderman, Long-Term Care Pharmacy Services Provider submitted the following comments: “The filed regulation introduces the requirement of a registered nurse, which overreaches the requirement of the statute. With already historic nursing shortages affecting skilled nursing facilities and hospitals, the challenge this requirement introduces to assisted living communities should be clear and obvious.

Is now the appropriate time to introduce additional nursing staffing strain into Kentucky’s assisted living industry and further exacerbate the same issue in Kentucky nursing homes and hospitals? Just over a year ago, the Governor declared a state of emergency due to the nursing shortage. This requirement is nearly impossible to meet given the staffing crisis adjacent industries are already experiencing.

If this requirement is implemented, what will happen to assisted living communities, residents’ homes, when they can’t meet this part of the regulation?

How does the inclusion of this requirement help the nursing staffing crisis in general?

There simply aren’t enough nurses to fill these positions and adding this regulation in today’s climate will have far-reaching effects beyond just assisted living communities.”

(b) Response: Only ALCs that opt to provide basic health and health-related services, including medication management, and ALCs with a secure dementia unit must have a nurse on staff. A social model ALC is not required to have a nurse. Please also note that the cabinet relaxed the requirement and replaced “registered nurse” with “nurse” so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

(a) Comment: Jennifer Gish, Gaither Suites at West Park, submitted the following comments: “After reviewing there are many issues with the proposed regulation. I feel the main issue is the changes will negatively impact, most importantly, the senior population across Kentucky. The rule will also increase the current staffing crisis in Assisted Living and Personal Care Homes across the state.

Gaither Suites at West Park is in Paducah Kentucky. We are committed to providing high quality care and continually strive to do the best for the people we serve. We have 14 Assisted Living apartments and 26 personal care apartments, a total of 44 residents. I have been the Executive Director for 15 years and we have a wonderful reputation for providing excellent care. Since I have been Executive Director, we have had years of deficiency free surveys. If the committee has not reviewed senior PC homes surveys by OIG or been in a currently operating Personal Care Home,

then you should start by doing that first. Check the complaints and the lawsuits compared to other healthcare models.

In 2018 I received the KSLA Leadership award. With the increasing stress from the pandemic, in 2021 I started a non-profit to help all the seniors that have no options in our broken senior health care system. The reason I started the non-profit was due to the several calls over the years of seniors I could not help. I have talked to several colleagues, and they faced the same challenge. I always try to find resources for everyone I cannot help by moving to our community. The non-profit has helped over 800 seniors in the last year, most of which could not afford Assisted Living or did not meet criteria for nursing home. Proposed regulation 902 KAR 20:480, will increase the gap and less seniors will have options, because 'The regulation requires staffing beyond the statute or current Personal Care regulations.' If this regulation, as written, passes we will have to increase rates in our community because we will have to increase our nursing staff. Where we currently train our med passers-by in house, as other states do, it will require licensed KMA's which currently we cannot find because the classes for such are almost nonexistent in this state. It is not just having KMA's, but we will be required to have LPN's 24/7 where before we have one, forty hours a week, because even a licensed KMA will not be allowed to pass certain medication. That will have a huge impact on our payroll and in return our rates will increase. More of the increasing senior population will not have options.

Proposed regulation 902 KAR 20:480 violates KRS 13A.120, section 2(h) and (i). Certain provisions within the proposed regulation are not authorized by SB 11, which was passed by the Kentucky General Assembly during the 2022 regular session. Additionally, certain provisions of the proposed regulation modify the legislative intent of SB 11."

(b) Response: The regulation is consistent with the language and intent of SB 11 and is within the authority and responsibility of the cabinet to establish standards to ensure safe and adequate health facilities. See KRS 216B.042(1)(c).

Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding changes to the requirement for nurse availability, which does not have to be in person during the time in which unlicensed staff perform delegated nursing tasks.

In response to the comments regarding staffing in personal care homes (PCH), it is important to note that KRS 194A.700(8)'s definition of "basic health and health-related services" for ALCs is similar but not identical to the description of "basic health and health related services" in the PCH regulation, 902 KAR 20:036, Section 4(1). The notable difference is that the ALC statute includes "administration of medications" under the definition of "basic health and health-related service" while Section 4(1) of the PCH regulation requires only the "supervision of self-administration of medications".

Beyond the requirement for “supervision of self-administration”, the PCH regulation contemplates additional health services such as medication administration as shown by the requirement that it requires controlled substances to be administered only by a nurse in accordance with 902 KAR 20:036, Section 4(1)(g)3.d.

Although the PCH regulation is silent on who can administer non-controlled medications, 902 KAR 20:036, Section 4(1)(j)1.a. requires PCHs that store and administer non-controlled substances in an emergency medication kit (EMK) to have licensed personnel as established by the Kentucky Board of Pharmacy’s (KBP) regulation 201 KAR 2:370, Section 2(4)(i). Therefore, both the OIG and KBP regulations recognize that staffing in a PCH should include a nurse if medication administration is taking place.

In response to the comment about medication aides, please refer to the cabinet’s response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

(a) Comment: Susan Matherly, Ephraim McDowell Health, submitted the following comments: “The proposed rule also requires staffing beyond the statute or current Personal Care regulations. It requires a Registered Nurse to be available to staff when delegating tasks. This goes beyond the requirement of the statute. The delegation of tasks are already overseen and regulated by KBN through the Nurse Practice Act. Therefore this should not be addressed in the proposed language. Moreover, it requires that the delegation be limited to someone who has successfully completed a Kentucky medication aide training program (ie. a KMA). This is overreaching and is requiring more than what is required for our current personal care facilities. KMA training programs are NOT widely available across the state, so communities would not have access to allow their staff to be trained. In addition, person's with the KMA training are already in huge demand for staffing SNF's and are not readily available for assisted living communities or personal care facilities to hire. There is already an extreme shortage in KMA's similar to that of license nurses - LPNs or RNs. Suffice it to say, that this is yet another reason that this proposed rule would limit the basic health care services that could be given to residents in assisted living communities because of the lack of available staff based on the staffing requirement laid forth in the proposed language.”

(b) Response: In response to the comment regarding registered nurses and upon agreement with KBN, the cabinet replaced “registered nurse” with “nurse” so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to comments comparing ALCs and personal care homes, please see the above response regarding the differences in the medication services.

In response to the comment about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

(a) Comment: Theresa McFarlin, Chandler Senior Living, submitted the following comments: "Staffing requirements - requirement of a Registered Nurse versus Licensed Practical Nurse. It's not a new concern, the entire country is in a nursing shortage. If this proposed regulation is passed the increase cost of a RN alone will be enough to cause smaller AL's to close. There is absolutely no reason that LPNs could not perform the required functions for communities choosing the HS model. Small companies simply cannot absorb these cost, which in turn, will be forced upon the resident in form of increased rent and ancillary fees."

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

(a) Comment: Raymond Dickison, Jr., Wesley Manor Retirement Community, submitted the following comments: "Of most concern for me relates to the proposed requirements of Registered Nurse (RN) and Kentucky Medicaid Aide (KMA). In the current and proposed levels of licensure, there are absolutely no duties that require the presence or defined scope of a RN. Moreover, there is a significant shortage of RNs in Kentucky and this proposed regulation will worsen this condition and impact all levels of healthcare. As it relates to the KMA requirement, we currently do not have the capacity of training programs to adequately train enough KMAs and sustain what will be necessary to meet this requirement."

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comment about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

(a) Angela Goodlett, McDowell Place of Danville, submitted the following comments. Mandy Emmons, McDowell Place of Danville submitted similar comments: "McDowell Place of Danville is an independent, assisted living, and personal care community in the heart of central Kentucky. We strive to provide our community with a neighborhood that is inviting to the senior population to age in place. No matter what stage they may be experiencing in their senior years, they can feel comfortable that they will be able to stay in one place during these transitions of life.

I have been fortunate to grow and work with the assisted living population for 14

years. Within that time I have experienced changes that have been beneficial to the care we were providing. I would like to continue providing our community with a place they can call their home in their final years without being uprooted when they are needing more care.

I have also been fortunate to be a member of one of the coalition partners, (KSLA) The Kentucky Senior Living Association, for those 14 years, who have represented the assisted living and personal care communities throughout the Commonwealth of Kentucky. I feel that the personal care homes, assisted livings, and the residents we serve will be greatly and negatively impacted by the proposed regulations. I respectfully submit the following comments for your consideration.

'The proposed regulations mandate the presence of a registered nurse during the delegation of tasks that exceed the mandates of SB 11. The statute does not address this matter, deferring instead to the Nurse Practice Act and existing laws that already regulate such issues.'

The proposed regulation, In Section 14 - Staff Requirements/states:
(4) Availability of nurses.
(a) An ALC-BH and ALC-DC shall have a registered nurse available for consultation by staff performing delegated nursing tasks.
(b) The registered nurse shall be readily available In person, by telephone, or by other means to the staff at times the staff is providing delegated services.

Should this regulation be implemented, all assisted living communities offering basic health services must have a registered nurse accessible to staff in person, by telephone, or by other means during the delegation of services. This requirement exceeds the mandates of SB 11, as the statute defers to the Nurse Practice Act and does not authorize it.

Within Kentucky, seniors must pay privately for a residence within an Assisted Living facility. Facilities currently have the option of using an LPN instead of an RN for basic health services. The nursing shortage has impacted healthcare facilities, resulting in their reliance on travel agencies for staffing. LPNs and RNs have found that working through these agencies can increase their earning potential. This situation is creating both winners and losers within the healthcare industry. Assisted living communities, which are forced to rely on these agencies to staff their facilities with LPNs and care attendants, are facing higher operating expenses. Suppose they are required to provide care with an RN. In that case, their operating costs will increase even further, leading to higher costs for seniors in their golden years, which will decrease the possibility of seniors being able to afford a place where they can age in place with the appropriate care."

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

(a) Comment: Marilyn Ingram, Rivercrest Place Assisted Living, submitted the following written comments: “I appreciate the opportunity to provide comments on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, ‘assisted living communities.’ I am very concerned that the changes in this proposed rule would not only impact our assisted living communities and the residents we serve but thousands of Kentuckians who will no longer be able to afford private pay assisted living in Kentucky. Kentucky does not have a Medicaid program to assist with the cost of Assisted Living and many residents are already struggling to pay the current costs of assisted living.

Our industry is already dealing with staffing challenges and the proposed regulations will require additional staffing in the form of Registered Nurses and medication techs. Prior to becoming an Executive Director in Assisted Living about a year ago, I spent 45 years working in nursing facility and personal care facilities in far western Kentucky. We constantly struggled to hire registered nurses and medication techs were almost impossible to hire as the local technical college was no longer offering the program. My previous company attempted to work with the college to offer a medication tech program for their facilities and the college was not able to do this. My question is not only how are we going to afford nurses and medication techs but where are we going to find them?

The approximate costs of adding the additional staff would be $150,000 per year. This cost will be passed on to our current and future residents through increase in room and board, medication assistance and Level of Care fees. Almost daily, I have a resident coming to me asking what is going to happen when they run out of money or exhaust their long-term care policy. They are worried they will outlive their money and these increased costs will only speed up this process. The idea behind SB 11 was to allow our residents to age in place however many will not be able to do this if their funds are depleted.”

(b) Response: In response to this comment and upon agreement with KBN, the cabinet replaced “registered nurse” with “nurse” so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comment about medication aides, please refer to the cabinet’s response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

In response to the comment regarding Medicaid funding, ALCs initially established themselves in Kentucky as a private pay non-health care model for residents who are mostly independent except for needing some assistance with everyday tasks. Issues involving payment are beyond the OIG’s scope of operations.

(a) Comment: Allie Wilson, Fairview Place Senior Living, submitted the following

comments: “Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480, proposed rule ‘assisted living communities.’ The changes in this proposed rule would not only impact my assisted living operations but also the residents we serve. My assisted living is located in Carrollton, Kentucky in Carroll County. This is an area of the state that does not have a lot of money to pay for private pay assisted living services. Our rates are some of the lowest in the state, yet we still struggle to find people in our area who can afford our rates. Our fear is that there are several items in the proposed regulations that will add significant expenses to our operations, namely the staff we would have to hire in order to perform certain services such as assistance with medications. I am very familiar with personal care homes and know that they perform the same services without the staff requirements that SB 11 is calling for. That makes no sense to me and, I find it very discriminatory. The state is finding it OK to tack on additional charges to the people that have money yet don’t imply the same charges to those who don’t have money. If I must incur more expenses, the only way to keep the operation going is to pass on the increases to our clients. We strive to keep our rates as low as possible but expenses like these would give us no choice. I am also unaware on issues in personal care homes related to medications and the staff they have. With proper training, unlicensed staff can perform the basic services that are needed. In addition, there is a severe shortage of CMTs in Kentucky. What few there are getting hired by the skilled nursing homes and only if they can keep them from getting hired by the hospitals. We don’t stand much of a chance of finding any, more or less, hiring any. This is an ill-advised portion of the regulations and will only hurt those Kentuckians who need assisted living services. If we had Medicaid for assisted living things would be different but, we don’t.

I have also read Senate Bill 11 and see that certain things don’t jive with it and the proposed regulations. My understanding was that a facility would have the ability to choose the services they want to provide, meet the criteria for those services and not have to apply for a new license to cover the entire facility. That does not make sense to me. I don’t know why the proposed regulations would differ from the actual bill.”

(b) Response: As stated previously, the definition in KRS 194A.700(8) of “basic health and health-related services” for ALCs is similar but not identical to the description of “basic health and health related services” in the PCH regulation, 902 KAR 20:036, Section 4(1). The notable distinction between the two is that the ALC statute includes “administration of medications” under the definition of “basic health and health-related service” while Section 4(1) of the PCH regulation requires only the “supervision of self-administration of medications”

In response to the comment about medication aides, please refer to the cabinet’s response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

In response to the comment regarding Medicaid funding, ALCs initially established themselves in Kentucky as a private pay non-health care model for residents who are mostly independent except for needing some assistance with everyday tasks. Issues involving payment are beyond the OIG's scope of operations.

(a) Comments: Alex Strein, The Paragon of Madisonville, submitted the following comments: "The regulation is poorly written. There are sections that conflict with the primary statute to which it relates, thereby violating KRS 13A.120 and making the regulation unenforceable. Additionally, there are parts of the regulation that conflict with each other. For instance, section 7(2)(k)2 of the filed regulation conflicts with section 14(3) regarding staffing requirements.

The regulation would harm the residents of my building and the thousands of other Kentuckians who live in assisted living communities. The regulation places many unnecessary and inappropriate burdens on assisted living communities that are not required or authorized by statute and are not mandated for even higher levels of care. One example is the requirement in section 15 that a nurse may only delegate medication administration tasks to a staff person who has successfully completed the Kentucky medication aide training program. There are no such training programs in the western half of Kentucky where my assisted living community is located, and there are only two in the entire Commonwealth. As a result, we could not hire medication aides at any hourly rate. They simply are not currently available. So, we could hire nurses to administer medications, which would harm residents by causing significant increases in their private pay-rent. It is likely some assisted living communities would have to decide to not offer basic health services just in order to stay in business, which defeats a vital purpose of Senate Bill 11."

(b) Response: In response to the commenters' assertion that the proposed regulation violates KRS 13A.120, the cabinet disagrees. KRS 216B.042(1) authorizes the cabinet to promulgate regulations necessary for the proper administration of the licensure function, which includes establishing licensure standards to ensure safe, adequate, and efficient health facilities. Given that SB 11 added ALCs to the definition of "health facility" in KRS 216B.015(13), the cabinet has authority under KRS 216B.042(1) to establish appropriate licensure standards for ALCs, just as it has done so for all facilities regulated by the Office of Inspector General.

In response to the comment that Section 7(2)(k)2 conflicts with the staffing requirements of Section 14(3), it is important to note that there is no subparagraph 2 under Section 7(2)(k) in the proposed regulation.

Section 14(3) of the regulation refers to KRS 194A.717(2) which requires only one awake staff member to be on site at each licensed entity at all times. The law overlooks an important safety standard for ALCs that have more than one building on campus. Licensees should ensure sufficient staffing in each building at all times, including during nighttime hours to respond promptly and effectively to individual resident emergencies. Moreover, KRS 194A.717(2) is less stringent than the PCH

regulation's staffing requirement in 902 KAR 20:036, Section 3(8)(j) that requires "no less than one (1) staff member shall be awake and on duty on each floor in the facility at all times."

The cabinet will retain the proposed requirement in 902 KAR 20:480, Section 14(3)(b) for at least one staff person to be awake and on-site at all times at each licensed entity *or* in each building on the same campus if two or more buildings are operated by the licensee. This will help ensure sufficient staffing to respond promptly and effectively to individual resident emergencies.

In response to the comments about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky under the section on "Medication management."

(3) Subject: Medication Management

(a) Comment: Mary Crowley-Schmidt, Bluegrass Area Agency on Aging and Independent Living, submitted the following comments: "AL residents need to have trained qualified staff handling medications and coordinating services."

(b) Response: The cabinet agrees that all unlicensed staff who administer medications under the delegation of a nurse should be properly trained and competency evaluated. Please see the response in this section to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding medication administration.

(a) Comment: Sherry Culp, State Long-term Care Ombudsman, presented the following comments during the public hearing on January 23, 2023: "I'm the Kentucky State Long-Term Care Ombudsman. I joined the program as a volunteer in 1996. And I've been the state ombudsman for the last few years. I have got over 25 years of experience in advocating for people who live in licensed long-term care.

Our state ombudsman office is housed at the Nursing Home Ombudsman Agency of the Bluegrass. There are 15 local district ombudsman programs that work with me, and they are housed in area development districts and nonprofit agencies across Kentucky, working alongside with me to help serve residents in family care homes, personal care homes, nursing homes. We have begun serving residents in assisted living communities.

We are a federally required resident advocate, as defined by the Older Americans Act. We visit every licensed long-term care facility in Kentucky at least quarterly. And we respond to complaints that residents have about their care and services. We work to resolve those complaints by participating in care plans, negotiating with facility staff, educating providers, and mediating for resolutions. We meet individually with residents and their families and providers and clinicians to provide information in consultation, most often about topics like resident rights, abuse and neglect, benefits, regulations, things like that.

Others have mentioned registered nurse and KMA requirements, and I'm going to say that having at least these minimally required professionals is essential. In my years of experience of advocating for residents of personal care homes, and in nursing facilities, that it is just always at the forefront that qualified staff is just absolutely essential.

Not having qualified staff is something that is behind many, many of the complaints that we work to resolve and many times when residents are harmed. Medication management complaints in the short period of time that we have been serving assisted living facilities has been one of the first complaints that we have received, residents and families confused and concerned about how their medication is being managed and administered."

(b) Response: Please see the following response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the delegation of medication administration to unlicensed staff.

(a) Comment: Rebecca Pfalzgraf, KSLA, Betsy Johnson, KAHCF/KCAL, and Tim Veno, LeadingAge Kentucky, submitted the following comments. In addition, Lisa Biddle-Puffer, KAHCF/KCAL, presented similar testimony during the hearing on January 23, 2023: "The proposed regulation states that nurses are limited from delegating medication administration to anyone other than a staff person who has 'successfully completed the Kentucky medication aide training program.' In doing so, the regulation attempts to impose a standard that is within the sole authority of the Kentucky Board of Nursing (KBN), exceeding the cabinet's authority.

The standard proposed by the cabinet significantly exceeds what the KBN requires and what is currently permitted in licensed personal care facilities.

The proposed regulation, in Section 15 – Medication Management, states:

> (6) Administration of medication. A licensed health care professional may:
> (a) Administer medications as authorized under the professional's scope of practice; or
> (b) Delegate medication administration tasks in accordance with subsection (7) of this section.
> (7) Delegation of medication administration. Unlicensed personnel may only administer oral or topical medication if delegated to them by a licensed health care professional. If medication is delegated to unlicensed personnel, the ALC-BH or ALC-DC shall ensure that the registered nurse or licensed health care professional has:
> (a) Delegated medication administration to a staff person who has:
> 1. Successfully completed the Kentucky medication aide training program; and
> 2. Demonstrated the ability to competently follow the procedures;

The KBN does not have the requirement as outlined in the proposed regulation. See 201 KAR 20:400 (Delegation of Nursing Tasks). Communities that cannot staff a Kentucky medication aide (KMA) will not be able to pass medications to residents unless it is done by a nurse thereby increasing resident and provider costs. There are only two places in Kentucky that offer KMA training, and there are significant shortages of KMAs – not to mention the shortages of nurses in Kentucky."

(b) Response: In response to the long-term care associations' comments regarding the delegation of medication administration to unlicensed personnel as well as concerns regarding the availability of training for certified medication aides, the cabinet contacted KBN and discussed these issues during a Teams meeting on January 26, 2023, and again on February 17th.

KBN reported that a workgroup is currently reviewing issues related to the delegation of nursing tasks, including medication administration. KBN also indicated that they are aware of limited opportunities to sufficiently meet the demand for training unlicensed personnel on medication administration. However, both KBN and the cabinet agree that unlicensed personnel should be properly educated and competency evaluated prior to administering medications to elderly residents.

Based on KBN's recommendation, the cabinet will amend Section 15(7)(a) as follows by replacing the requirement for completion of the Kentucky medication aide training program with a requirement for unlicensed personnel who administer medications to be certified as a medication aide or have successfully completed medication aide training accepted by KBN. This will expand the number of training programs that will meet the regulation's requirement:

(7) Delegation of medication administration.
(a) Unlicensed personnel **who meet the requirements of subparagraph 1. of this paragraph** may only administer oral or topical medication**, or preloaded injectable insulin** if delegated to them by a **nurse or appropriate** licensed health **[~~care~~]** professional. If medication **administration** is delegated to unlicensed personnel, the ALC-BH or ALC-DC shall ensure that the **[~~registered~~]** nurse or licensed health **[~~care~~]** professional has:
1. **[~~(a)~~]** Delegated medication administration to a staff person who**:**
a. Is a certified medication aide; or
b. Has **[~~: 1.~~]** successfully completed **a:**
i. **[~~the Kentucky~~]** Medication aide training program **accepted by the Kentucky Board of Nursing (KBN)**; and
ii. Skills competency evaluation;
2. [~~Demonstrated the ability to competently follow the procedures;~~
~~(b) Instructed the unlicensed personnel in the proper methods to administer oral or topical medications;~~
~~(c)~~]) Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and
3. **[~~(d)~~]** Communicated with the unlicensed personnel about the individual

needs of the resident.

The above change will help ensure that unlicensed personnel are competent to administer medications and not restricted only to training offered by the Kentucky Community and Technical College System. In addition, this change expands upon what medication aides will be able to do in long-term care settings by allowing certified medication aides to administer preloaded injectable insulin in addition to oral or topical medications.

Upon adoption of this change in 902 KAR 20:480, the cabinet will amend other long-term care facility regulations under 902 KAR Chapter 20 to align.

(a) Comment: In addition to the comments Rebecca Pfalzgraf, KSLA, submitted earlier with the other two long-term care associations, she submitted the following additional comments which are similar to the comments she presented at the public hearing held on January 23, 2023: “The requirement of a Kentucky Medication Aide in assisted living is another concern. There is an insufficient number of KMA training programs in Kentucky, making those with that specific certification nearly impossible to find. This problematic requirement falls under the sole jurisdiction of the Kentucky Board of Nursing. It exceeds what KBN requires and what is currently required in personal care.”

(b) Comment: In response to the comment about medication aides, please refer to the above response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky.

(a) Comment: Jason Morgan, Highgrove at Tates Creek, submitted the following the comments: “Thank you for accepting this letter of comment on the proposed 902 KAR 20:480 regulations. The proposed regulations have irrecuperable and consequential implications to my senior living communities, to our residents, and elder care in the Commonwealth. I am requesting the proposed regulations be withdrawn in its entirety.

Continental Senior Communities stand with our healthcare partners and public servants and is committed to the spirit of Senate Bill 11; to allow our seniors to age in place and free of fear of being evicted from their home due to regulatory rule. Senate Bill 11 was passed with the intent to align Kentucky’s care of seniors with the rest of the our country and to modernize senior care. Unfortunately, proposed regulations in 902 KAR 20:480 does not modernize or standardize senior care. If the regulations are adopted, the result will undeniably harm and displace our seniors.

Proposed regulation 902 KAR 20:480 is an attempt to legislate through regulation. Senate Bill 11, was a comprehensive bill, passed overwhelmingly with bipartisan support from our legislators and signed into law by our governor. Yet, the Cabinet through appointment and regulatory pen is writing law that extends far beyond the intent and spirit of the bipartisan passage and subsequent signing of Senate Bill 11.

I take strong exception to the proposed staffing regulations in 902 KAR 20:480. Particularly the mandate of Registered Nurse (RN) and Medication Aides (KMAs). The proposed rule ignores what Senate Bill 11 didn't, the Nurse Practice Act. The proposed rule will add to the financial burden senior living communities sustain each year. It will lead to the unfortunate displacement of many seniors to an already understaffed, underfunded, and government subsidized facilities."

(b) Response: In response to comments regarding the Nurse Practice Act and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC. KBN has reviewed the regulation and met with the cabinet and has not raised any concerns regarding inconsistency with the Nurse Practice Act.

In response to the comment about medication aides, please refer to the above response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky.

(a) Comment: Rebecca Pfalzgraf, KSLA, Betsy Johnson, KAHCF/KCAL, and Tim Veno, LeadingAge Kentucky, submitted the following comments: "Section 15 of the proposed regulation reaches beyond current personal care regulations regarding medication management. This section contains significantly more requirements to be met regarding medication management than are currently in place for personal care homes, which was not the intent of SB 11.

KRS 194A.704 states, '(1) A licensed personal care home in substantial compliance with KRS 194A.703 shall be licensed as an assisted living community as of July 14, 2022. The cabinet shall issue an assisted living community license to the facility to replace its personal care license. If the personal care home has a secured dementia care unit, the replacement license shall be an assisted living community with dementia care license.'

If an assisted living community license will replace current personal care home licenses, the regulations regarding medication management have no reason to change. Those regulations have successfully been in place and carried out for many years. Section 15 is not authorized by the plain language in SB 11."

(b) Response: Representatives from the long-term care associations told HWFS committee members last spring that they were heavily influenced by Minnesota's state laws governing ALCs when they drafted SB 11. This is evidenced by the fact that SB 11 created a definition of "assisted living services" (which includes "medication management" in its list of services) and a separate definition of "medication management" that is similar to Minnesota's definitions, see Section 144G.08, Subd. 9 and Subd. 39: https://www.revisor.mn.gov/statutes/cite/144G.08.

SB 11 does not include any requirements related to medication management other than the above definitions and a requirement in KRS 194A.708(1)(d) for ALCs-DC

to develop and implement policies and procedures that address medication management pursuant to orders from a resident's health care practitioner. It is typical for a statute to establish a framework of requirements and for an associated regulation to implement those requirements in more detail. The cabinet added Section 15, Medication management, to the proposed ALC regulation which is similar to Minnesota's rules for medication management under Section 144G.71: https://www.revisor.mn.gov/statutes/2021/cite/144G.71.

In addition, Section 15(21) and (22) mirror the language of the PCH regulation in 902 KAR 20:036, Section 4(1)(g) and (j), which was a recommendation submitted to the cabinet by the long-term care associations in the marked-up copy of the cabinet's ALC regulation discussed prior to filing 902 KAR 20:480.

The cabinet will not amend the regulation in response to the comments.

(a) Comment: In addition to the comments Rebecca Pfalzgraf, KSLA, submitted earlier with the other two long-term care associations, she submitted the following additional comments which are similar to the comments she presented at the public hearing held on January 23, 2023: "The medication management section of the proposed regulation reaches beyond the personal care requirements on the same topic. If an assisted living community license will replace a current personal care home license, the regulations regarding medication management have no reason to change. Those regulations have been successfully in place and carried out for many, many years in the current personal care model."

(b) Response: Please refer to the above response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky.

(a) Comment: Brian Durbin, Jennifer Brown, Pat Cranmer, and Candie Gray, Arcadia Communities, submitted the following comments. Mr. Durbin's verbal testimony during the public hearing held on January 23, 2023, is similar to his written comments. Additionally, Kristie Cronk, Arcadia Communities, expressed similar comments during her verbal testimony during the hearing: "The filed regulation attempts to impose a standard that is within the sole jurisdiction of the Kentucky Board of Nursing, exceeding the cabinet's authority. Additionally, the problematic standard significantly exceeds what KBN requires and what is currently permitted in licensed Personal Care facilities. If the regulation is allowed to go into effect as-is, only Registered Nurses or Kentucky Medication Aides will be able to pass meds in assisted living communities that offer basic health services. There are only two places in Kentucky that offer Kentucky Medication Aid training, and there are significant shortages in the workforce of KMAs. Communities that cannot staff a KMA will be unable to pass meds unless it is done by a nurse which will again increase provider costs and resident rent. It is my opinion, that many providers would choose to not offer Basic Health Services due to the lack of availability of Registered Nurses and Kentucky Medication Aides which significantly reduces options for aging seniors in Kentucky. It also seems very clear to me that the filed

regulation overreaches beyond current Personal Care regulations regarding medication management and contains significantly more requirements to be met than in the Personal Care regulations that have successfully been in place for many years. The intent of SB 11 was to consolidate PC and AL Licensing and remove confusion regarding options for seniors housing in Kentucky not to overburden providers with significant changes in staffing requirements and overregulate processes that have been working well independently of each other."

(b) Response: In response to comments regarding the Nurse Practice Act and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comments regarding PCHs, the definition in KRS 194A.700(8) of "basic health and health-related services" for ALCs is similar but not identical to the description of "basic health and health related services" in the PCH regulation, 902 KAR 20:036, Section 4(1). The notable difference is that the ALC statute includes "administration of medications" under the definition of "basic health and health-related service" while Section 4(1) of the PCH regulation requires only the "supervision of self-administration of medications."

In response to the comment about medication aides, please refer to the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky. As indicated in the response, the cabinet has agreed to make additional changes to the regulation as it relates to increasing training opportunities for certified medication aides.

(a) Comment: Catherine Deist, Counsel to Charter Senior Living, submitted the following comments. In addition, Clinton Warf, Charter Senior Living, presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "Section 15, Medication Management, mandates that only an RN or Kentucky Medication Aide ('KMA') may administer medication. The Kentucky Board of Nursing makes no such requirement in 201 KAR 20:400, Delegation of Nursing Tasks. This proposed Section 15 is especially cumbersome because there is a significant shortage in the workforce for KMAs; there are only two places in Kentucky that offer KMA training, and the training is long and expensive. Thus, communities that are unable to hire enough KMAs will be unable to administer medications unless they employ additional RN support, which will increase provider costs, provider liability, and ultimately, resident costs. If the Legislature intends for these ALC licenses to replace the personal care home ('PCH') license – as appears to be the case – medication management is already extensively addressed in 902 KAR 20:036, Section 4, Provision of Services."

(b) Response: In response to comments regarding 201 KAR 20:400 and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comment about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue.

(a) Comment: Charlotte Bowling, Roy Bowling, Sharon Garland, Carol Gregory, George Robert King, Lawrence Kuhl, Jonathan Miller, and Kathey Young of Laurel Senior Living Communities submitted the following comments: "The proposed regulation create requirements for Nurses and Medication Aides that are overreaches of the statutes as well as confusing language regarding staffing requirements. There are already nursing practice laws in place that govern nursing issues. The staff requirements listed in the proposed regulations would increase the costs greatly of providing care to the residents. This may result in a percentage of the private pay residents being unable to afford assisted living and again being forced to move placing a financial burden on governmental programs such as Medicare and Medicaid."

(b) Response: In response to comments regarding the Nurse Practice Act and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comment about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue.

(a) Comment: Janet White, Kenton Pointe Assisted Living, submitted the following comments: "An additional concern is with medication management. If the regulation is allowed as-is, only Rn's and Kentucky Medication Aides will be able to pass meds in assisted living communities that offer basic health services. Staffing shortages are significant today and this would make it even more critical since the KMA trainings are only offered in two places, none close to our rural area. That would require a nurse to pass meds, which would increase the cost of staffing and make assisted living unaffordable for those who need it.

We take the responsibility of care and trust that our residents and their families place in us very seriously. We offer an independence that they cannot find anywhere else and the opportunity to stay where they are as they age and need additional services. Most importantly, this care is not a burden to the state or federal government because they burden the ENTIRE cost from savings they have accumulated for this time in their life. If the Cabinet for Health and Family Services moves forward with the proposed regulation as drafted, we are concerned about the impact this would have on our ability to continue to operate and provide quality care to our residents."

(b) Response: In response to comments regarding the registered nurses and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an

ALC-BH or ALC-DC.

In response to the comment about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

(a) Comment: Brandie Windsor-Shanklin, Sunrise Senior Living, submitted the following comments: "I would like to raise concern that the changes in this proposed rule would not only impact our current personal care homes and assisted living communities and the residents we serve but thousands of Kentuckians that otherwise would be forced into a Medicaid nursing home bed.

For more than 25 years, I have had the pleasure of caring for aging Kentuckians with a goal of providing a safe, home like environment allowing those individuals to successfully age in place. With the new regulations, the most immediate change would be the staffing constraints imposed upon facilities. Already the workforce is limited, and we are in a nursing shortage. With the new regulations, facilities would have to employee KY CMTs to pass medication. This is not feasible, and it is an undue monetary burden that will then be visited upon the private pay residents we support. This may in fact create a situation that a resident would have to become a Medicaid recipient in a nursing home rather than stay in their apartment style community in which they are happy and successful. Current PCH regulations do not require such staffing.

During a meeting with KCAL, Inspector Mather discussed a CMT noticing a bruise and being able to assess the need to continue with coumadin therapy, check the INR or call the physician. Unfortunately, CMT's are not trained in the assessment process. Discussions such as these may lead to in adequate assessment by an unlicensed individual."

(b) Response: In response to the comments regarding staffing in PCHs and as stated previously, it is important to note that KRS 194A.700(8)'s definition of "basic health and health-related services" for ALCs is similar but not identical to the description of "basic health and health related services" in the PCH regulation, 902 KAR 20:036, Section 4(1). The notable difference is that the ALC statute includes "administration of medications" under the definition of "basic health and health-related service" while Section 4(1) of the PCH regulation requires only the "supervision of self-administration of medications"

Beyond the requirement for "supervision of self-administration", the PCH regulation contemplates additional health services such as medication administration because it requires controlled substances to be administered only by a nurse in accordance with 902 KAR 20:036, Section 4(1)(g)3.d.

Although the PCH regulation is silent on who can administer non-controlled

medications, 902 KAR 20:036, Section 4(1)(j)1.a. requires PCHs that store and administer non-controlled substances in an emergency medication kit (EMK) to have licensed personnel as established by the Kentucky Board of Pharmacy's (KBP) regulation 201 KAR 2:370, Section 2(4)(i). Therefore, both the OIG and KBP regulations recognize that staffing in a PCH should include a nurse if medication administration is taking place.

In response to the comment about medication aides, please refer to the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue.

(a) Comment: Sheila Carter, Heartsong Memory Care, submitted the following Comments. In addition, Ms. Carter presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "The filed regulation attempts to impose a standard regarding medication administration that is within the jurisdiction of the Kentucky Board of Nursing and exceeds the cabinet's authority. Additionally, the standard exceeds what is currently permitted in licensed Personal Care homes in Kentucky."

(b) Response: Please see the responses to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters who have submitted similar comments regarding certified medication aides and the personal care home regulation.

(a) Comment: Gwen Reverman, Legacy Living Florence, submitted the following comments: "Medication Management of a RN, LPN or KMA will give limited options for staffing. Kentucky only has two places for KMA to test. This will increase the residents out of pocket costs. Again, it is still assisted living, yet this regulation is consistent with skilled nursing. Medication management in assisted living has been very successful as currently stated."

(b) Response: Please see the responses to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters who have submitted similar comments regarding certified medication aides.

(a) Comment: Michael Berg, Magnolia Springs Senior Living, submitted the following Comments. In addition, Mr. Berg presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "The proposed regulation repeatedly requires a registered nurse to provide services to residents (Section 14). As I have experienced in Ohio, where Magnolia Springs also has a community, requiring higher trained staff to perform services that can otherwise be performed by a LPN or certified nurse aid, only hurts residents by increasing their service fees. In states that require highly trained individuals to perform simple services, costs are becoming too high for residents to pay. Such requirements prevent certain individuals of lower levels of income and savings to be able to receive services at all. In a business where 85% of our controllable costs are related to labor, make no mistake, requiring RNs would significantly increase expenses, an amount that would need to be passed on to residents. This would be

in addition to the significant increases providers have already had to give to residents due to economic impacts caused by Covid-19. Some communities have already been forced to give residents 10%+ rent increases coming into 2023 just to be able to reasonably continue to operate the homes of our residents. We are looking to find ways to cut expenses to keep assisted living affordable, yet the added pressures (this regulation being one of them), has an adverse effect on that goal. We need to find solutions to the rise cost of healthcare, not add to those costs.

To think that senior living communities can stomach such expense is erroneous, since even prior to the pandemic, communities have faced shrinking margins. The pandemic only exacerbated the issue. The point is not that 'communities will make less money' if a RN is required. The point is that, in some areas, particularly smaller towns with less wealth, senior living communities will not be able to sustain enough margin to operate, thus effectively shutting down these communities and leaving seniors with no place to serve their needs. Or, if the communities do not shut down, they will only be able to be afforded by those in the top wealth tier. We should seek to provide solutions for those of all economic tiers."

(b) Response: In response to comments regarding the registered nurses and upon agreement with KBN, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC. Also, if an ALC chooses not to provide basic health services, it can continue to operate as a social model and it would not be required to hire licensed staff.

(a) Comment: Michael Berg, Magnolia Springs Senior Living, submitted the following Comments. In addition, Mr. Berg presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "My third area of concern relates to requirements for medication aides (Section 15:6,7). The healthcare industry for years has faced a staffing crisis, a crisis only getting worse as the Boomers move into our communities. During the pandemic, individuals left the healthcare field, creating a larger staffing gap. For the past 2 years, communities have fought to staff at appropriate levels to serve the needs of our seniors. Further restricting who we can staff in our communities will cause us to not be able to provide services to the seniors that need them. In KY, medication aide programs are limited. Unless there is a drastic change to the availability of such programs, it is an impossibility for all AL communities in KY to be able to utilize them for staffing. Instead, of the proposed regulations, KY communities should be allowed to follow what services the Nursing Board allows in terms of oversight by a RN, but not directly require a RN to perform such services.

Overall, the proposed regulation is bad news for the future of assisted living in Kentucky. The legislation passed creates a healthy balance of care services that can be provided at manageable costs for the providers. But the proposed regulation would cause community expenses to skyrocket, meaning only more cost to our seniors, who are already struggling to pay for assisted living services.

Our goal should be to protect our seniors through good legislation and regulation, not fail (through regulation) to make such services affordable to them. If expenses continue to rise, there will be limited care options available for seniors at a time when we needed to be creating more options for them."

(b) Response: Please see the responses to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters who have submitted similar comments regarding certified medication aides.

(a) Comment: Theresa McFarlin, Chandler Senior Living, submitted the following comments: "Delegation of Nursing Task – again another function that is within the scope of a LPN. To accommodate this regulation, communities will need to hire 3-5 CMA's to ensure proper staffing patterns. With the limited availability of CMA's and limited providers that offer certification, this will present communities with a new level of staffing challenges. And again, the cost inevitably will be forced upon the resident in form of increased rent and/or ancillaries and it will limit future occupancy rates. This proposed regulation is hard to understand because it's not even a requirement for hospital or snf's."

(b) Response: In response to comments regarding the licensed practical nurses, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comment about medication aides, please refer to the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue.

In response to the comments regarding hospitals and nursing facilities, certified medication aides are not authorized to administer medications in Kentucky-licensed hospitals, see 902 KAR 20:016, Section 4(2)(i): https://apps.legislature.ky.gov/law/kar/titles/902/020/016/

In Kentucky's nursing facility settings, all medications must be administered either by licensed medical or nursing personnel or by personnel who have completed a state approved training program from approved training providers.

(a) Comment: Comment: Adam Bailey, Cedar Ridge Health Campus, Beth Blair, The Willows at Fritz Farm, Eric Bryant, Cooper Trail Senior Living, Rachel Dadisman, The Willows at Harrodsburg, Brittany Faucher, Shelby Farms Senior Living, Lindsey Foster, Walker's Trail Senior Living, Sam Frazier, The Willows, Marty Hawkins, Glen Ridge Health Campus, Matthew Jones, The Legacy at English Station, Mona Lisa McCubbins, Franciscan Health Care Center, Kara Meredith, The Springs at Stony Brook, G. Parker Moore, Westport Place Health Campus, Renee Moore, The Willows at Citation, and Kristi Noah, Forest Springs Health Campus, submitted the following comments: "Currently, Kentucky is one of four states where Medicaid is not provided for assisted living. If someone needs the services of an assisted living

provider yet can't afford to write a personal check each month, there is no appropriate place in Kentucky for that person. If these regulations go through, as written, they will put significant additional expenses onto the assisted living communities. For example, per the regs, it would require a community to have a Certified Medication Tech (CMT) 24 hours a day, seven days a week, 365 days a year. That cost of approximately $175,000 will get passed onto the current residents and future residents. That regulation is unnecessary and very costly. Personal care homes have performed these services for decades with little adverse events.

In addition, finding CMTs (and other health care workers) in Kentucky is extremely difficult. If a community could not admit and keep people, simply because they can't find CMTs to hire, it goes against the purpose of this bill, i.e., allowing Kentuckians to age in place as long as possible."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters who have submitted similar comments regarding certified medication aides and the personal care home regulation.

In response to the comment regarding Medicaid funding, ALCs initially established themselves in Kentucky as a private pay non-health care model for residents who are mostly independent except for needing some assistance with everyday tasks. Issues involving payment are beyond the OIG's scope of operations.

(a) Comment: Georgina Ivers, Crescent Place Assisted Living, submitted the following comments: "I would like to comment on the proposed assisted living regulation regarding Senate Bill 11. I have several issues with the proposed regulation, but my main concern are the staffing requirements. It seems as if these proposed regulations were written in a vacuum with little to no insight on the current reality of hiring and staffing in Kentucky. I understand the viewpoint that higher educated staff is better for everyone, but continuing with that logic, why do we stop as KMA's and RN's? If higher educated staff is the best route to go forward, and we don't have to worry about reality, then let's require MD's to be at every facility. That would be the best practice if we don't have to worry about the supply of MD's, the cost to hire MD's and costs that will inevitably get passed down to all assisted living residents of Kentucky. Unfortunately, we have to deal with the reality of the employment pool in Kentucky, particularly in more rural locations, such as mine. For one second, let's forget about the cost to hire a KMA and only focus on finding and hiring a handful of them to care for my residents around the clock on a 7 day a week basis, as these regulations would require. I have worked in Kentucky long term care for several decades and know the scarcity of KMA's. I have worked in large nursing homes, that had the money to pay for KMA's, but we could never find them. They pay was not the issue, it was finding them. Back in the 1990's and beginning of 2000, we could find KMA's, or CMT's (as they were known then), but over the past decade or so, they are in drastic short supply.

So, to require this level of employment is unreasonable and my fear is that if my

facility, or any other assisted living facility, can't hire the staff required to care for their residents, then their residents are going to have to move out. And, if this is an issue that numerous assisted livings are going to experience, then there will be numerous residents without a home. This is not a farfetched scenario but instead is simply reality. It does not make sense to me that there will be so many assisted livings and personal care homes that are caring for their residents today with the staff they have but if these regs go through, they will be required to hire staff that does not exist, or is in very short supply, to perform the exact same care. That does make sense to me. I feel like these regulations would make Kentucky take a step backwards vs forwards. Assisted Living will be harder to obtain, and for the many who are currently in it, there is a good chance they will lose their housing if their facility can't find the required staff to hire. This staffing and hiring situation is serious and it does not seem as if the State has done anything to help the situation. Just the fact that KMA's now have to go through CNA school first does not help. It used to not be that way and we had a lot more KMA's when they didn't. This is a problem that has been in the making for almost 20 years and won't be solved by September. It's impossible."

(b) Response: In response to the comment about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

(a) Angela Goodlett, McDowell Place of Danville, submitted the following comments. Mandy Emmons, McDowell Place of Danville submitted similar comments: "In addition, the proposed regulation also restricts nurse delegation of medication administration to staff who have completed the Kentucky medication aide training program, exceeding the cabinet's authority. This attempt to impose a standard falls under the sole jurisdiction of the Kentucky Board of Nursing (KBN).

The cabinet's proposed standard exceeds both the KBN requirements and what is currently allowed in licensed personal care facilities.

The proposed regulation, in Section 15 - Medication Management, states

(6) Administration of medication. A licensed healthcare professional may:
(a) Administer medications as authorized under the professional's scope of practice; or
(b) Delegate medication administration tasks in accordance with subsection (7) of this section.
(7) Delegation of medication administration, Unlicensed personnel may only administer oral or topical medication if delegated to them by a licensed healthcare professional. If medication is delegated to unlicensed personnel, the ALC-BH or ALC-DC shall ensure that the registered nurse or licensed healthcare professional has:
(a) Delegated medication administration to a staff person who has:

1. Successfully completed the Kentucky medication aide training program; and
2. Demonstrated the ability to follow the procedures competently.

The KBN does not impose the requirement specified in the proposed regulation (as per 201 KAR 20:400). Lack of staffing for a Kentucky medication aide (KMA) will result in increased costs for both residents and providers, as medication administration can only be done by a registered nurse. This is exacerbated by the limited availability of KMA training programs and the shortage of KMAs and nurses in Kentucky."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters who have submitted similar comments regarding certified medication aides. The cabinet's response regarding certified medication aides was developed in collaboration with KBN. KBN has reviewed the regulation and has not raised any concerns regarding inconsistency with the Nurse Practice Act or interference with KBN's authority.

(a) Comment: Mark Hegele, BeeHive Assisted Living, submitted the following comments: "Perhaps our biggest concern is the proposed requirement for Kentucky Medication Aides only to be able to pass meds to residents. There currently are not enough such med techs available throughout the state, and only 2 institutions statewide can train and certify more such personnel. While standardizing and controlling the administration of medications in AL is probably a good idea, this requirement is impractical and virtually impossible to enforce at this point in time. In addition, the proposed regs are ambiguous as to whether or not this requirement would apply to all 3 proposed levels of AL or just to the two levels which provide some level of medical care."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters who have submitted similar comments regarding certified medication aides.

In response to the comment that the regulation is ambiguous, ALCs that wish to retain their social model status will continue to be prohibited from providing health services including medication administration. Social model ALCs may only offer assistance with self-administration of medication. Facilities with an ALC-BH or ALC-DC license will be authorized under their scope of licensure to provide medication administration if appropriately staffed to do so.

(a) Comment: Bobby Greene, Sayre Christian Village submitted the following comments: "Proposed regulation 902 KAR 20:480 violates KRS 13A.120, section 2(h) and (i). Certain provisions within the proposed regulation are not authorized by SB 11, which was passed by the Kentucky General Assembly during the 2022 regular session. Additionally, certain provisions of the proposed regulation modify the legislative intent of SB 11. Specifically, we are concerned with the following:

My fear is that there are several items in the proposed regulations that will add significant expenses to our operation, namely the staff we would have to hire in order to perform certain services such as assistance with medications. I am very familiar with personal care homes and know that they perform the same services without the staff requirements that SB 11 is calling for. That makes no sense to me and, I find it very discriminatory. The state is finding it OK to tack on additional charges to the people that have money yet don't imply the same changes to those that don't have money. If I must incur more expenses, the only way to keep the operation going is to pass on the increases to our clients. We strive to keep our rates as low as possible but expenses like these would give us no choice. I am also unaware on issues in personal care homes related to medications and the staff they have. With proper training, unlicensed staff can perform the basic services that are needed. In addition, there is a severe shortage of CMTs in Kentucky. What few there are getting hired by the skilled nursing homes and only if they can keep them from getting hired by hospitals We don't stand much of a chance of finding any hiring any. This is an ill-advised portion of the regulations and will only hurt those Kentuckians who need assisted living services. If we had Medicaid for assisted living things would be different but, we don't. I have also read Senate Bill 11 and see that certain things don't jive with it and the proposed regulations. My understanding was that a facility would have the ability to choose the services they want to provide, meet the criteria for those services and not have to apply for a new license to cover the entire facility. That does not make sense to me. I don't know why the proposed regulation would differ from the actual bill."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters who have submitted similar comments regarding certified medication aides, the personal care home regulation, and Medicaid funding. The regulation is consistent with the language and intent of SB 11 and is within the authority and responsibility of the cabinet to establish standards to ensure safe, adequate health facilities and establish licensure classification of health facilities according to type, range of services, and level of care. See KRS 216B.042(1)(c). It is typical for a bill to establish the framework for new requirements and for a regulation to implement the bill by establishing more detailed requirements and procedures. An ALC may choose what types of services to provide and apply for the applicable license. If an ALC intends to provide services to a mix of residents on the same campus, including social model residents and residents who need basic health services, the ALC may do so but must apply for an ALC-BH license.

(a) Comment: Carla Austin, Barrington of Ft. Thomas, submitted the following written comments: "a. Regarding the proposed registered nurse availability when staff are performing delegated tasks, this proposed regulation should appropriately yield to the Nurse Practice Act which the statute defers to. This additional requirement is not authorized by SB 11.
b. The delegating of medication administration to only a staff person who has successfully completed the Kentucky medication aide (KMA) training program

significantly exceeds what the Kentucky Board of Nursing requires and what is currently permitted in licensed personal care homes.
c. The delegation of medication administration to a KMA in itself is challenging from a standpoint there is a significant shortage of KMAs in Kentucky. This is an ill-advised and risky portion of the regulations.
d. The delegation of medication administration by the community if a KMA cannot be staffed would therefore need to be done by a nurse thereby increasing financial cost to the resident and provider. There is also a current shortage of nurses in Kentucky.
e. This medication management regulation reaches beyond current personal care regulations and contains significantly more requirements in place for personal care homes. This is not the intent of SB 11.
f. Since the intent of SB 11 is for the cabinet to issue an ALC license to the facility to replace its PC license the regulations regarding medication management have no reason to change."

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky and other commenters in this section who have submitted similar comments regarding nurse availability, certified medication aides, and comparisons to the personal care home regulation.

(4) Subject: Functional Needs Assessment

(a) Comment: Rebecca Pfalzgraf, KSLA, Betsy Johnson, KAHCF/KCAL, and Tim Veno, LeadingAge Kentucky, submitted the following comments. In addition, Lisa Biddle-Puffer, KAHCF/KCAL, presented similar comments at the public hearing on January 23, 2023: "The proposed regulation directly conflicts with the express wording and intent of SB 11 by requiring all assisted living communities to use a standardized functional needs assessment (FNA) form.

The statute is straightforward in its language and intent, which is to permit each provider the flexibility to develop its own FNA so long as it addresses the required elements set forth in the statute. Per KRS 194A:705:

> (6): An assisted living community shall complete and provide to the resident:
> (a) Upon move-in, a copy of a functional needs assessment pertaining to the resident's ability to perform activities of daily living and instrumental activities of daily living and any other topics the assisted living community determines to be necessary; and
> (b) After move-in, a copy of an updated functional needs assessment pertaining to the resident's ability to perform activities of daily living and instrumental activities of daily living, the service plan designed to meet identified needs, and any other topics the assisted living community determines to be necessary."

(b) Response: In accordance with the drafting requirements of KRS 13A.224(4), the cabinet's proposed Functional Needs Assessment (FNA) will help ensure that a

standardized form is used by Kentucky's ALC providers to ensure uniformity and effectively meet the requirements of KRS 194A.705 for gauging a resident's ability to perform activities of daily living and instrumental activities of daily living.

On February 7, 2023, the cabinet met with Tim Veno, LeadingAge Kentucky, Betsy Johnson, KAHCF/KCAL, and a small group of providers for their feedback on the FNA. Upon consideration of the comments, the cabinet has agreed to make the following changes:

Page 2, under "Exclusions", amend Question 7 and Question 9 as follows:

7. Does the individual/resident have a history of frequent falls **with major injuries** that would put them in *constant* danger?

9. If incontinent (bowel or bladder), is the **facility able to provide assistance to the** individual/resident **to manage incontinence [~~incapable of self-managing with minimal assistance~~]**?

Page 2, under "Exclusions", after "may be considered for admission in an", add "**ALC-BH**".

Page 3, under "Dietary", add a box to document food allergies.

Page 4, under "Medication", replace "Needs medication management" with "Needs medication administration".

Page 4, under "TO BE COMPLETED BY STAFF PERSON COMPLETING THE FNA", after "your", delete "professional".

Page 4, under the signature of the staff person completing the FNA, add the following statement: **The FNA shall be completed by a staff person who meets the qualifications of 902 KAR 20:480, Section 7(1)(c)2.**

The cabinet acknowledges that KRS 194A.705 characterizes the FNA as having "any other topics the assisted living community determines to be necessary." ALCs may use a separate, supplemental document with topics specific to their programs in addition to a standardized FNA to further help determine appropriateness of placement in their facilities. It should be noted that over the years, many ALCs have requested that the cabinet adopt a functional needs assessment form and that after this regulation was drafted and discussed by Inspector General Adam Mather at a conference hosted by LeadingAge, many providers expressed their appreciation to the cabinet for creating the form. The use of the standardized form relieves providers of the burden and expense of developing their own or paying an outside entity to assist them in developing their own, yet let them retain the flexibility to create an additional form personalized for their program if they choose.

(a) Comment: Gwen Reverman, Legacy Living Florence, submitted the following comments: “Requiring everyone to utilize a standard FNA. Every community has a standard level of care costs with points. With this standard form, there are no points associated with the lines. Thus, making it very difficult for communities to evaluate for their level of care. Which in turn will increase the cost of the care the resident receives.”

(b) Response: Please refer to the above response to Kentucky’s three long-term care associations.

(a) Comment: Eric Sherrard, BeeHive Assisted Living, submitted the following comments: “Another area of concern with the new filed regulation is that it requires all ALC’s to use the same standardized Functional Needs Assessment form. Currently, there is no standardized form and it was kept that way in SB11 for a reason. The statute permits each AL provider the flexibility to develop its own FNA as long as it addresses the required elements set forth in the statute.”

(b) Response: Please refer to the cabinet’s response to Kentucky’s three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Catherine Deist, Counsel to Charter Senior Living, submitted the following comments: “Proposed Section 19 mandates that communities utilize a standardized functional needs assessment form, which is beyond the statutory requirements of KRS 194A.705. Currently, KRS 194A.705(6) mandates a functional needs assessment in substance, which communities can accomplish through their own mechanism. For instance, Charter uses a resident management software that securely houses all of our resident assessments and resident information. Proposed Section 19 will require each community to copy assessments onto the functional needs assessment form, which serves no purpose other than to increase Staff workload, which costs will be passed onto residents.”

(b) Response: Please refer to the cabinet’s response to Kentucky’s three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Theresa McFarlin, Chandler Senior Living, submitted the following comments: “First of all, there is no ‘standard’ FNA. The proposed FNA is vague in certain areas, as well as limiting and controversial in other areas. It fails to address ‘mobile nonambulatory’ residents, stating rather to ‘disqualify’. There are many mobile non-ambulatory residents that are well within the scope of assisted living care. Other areas of assessment such as fall, mobility, and cueing are met with ‘do not consider for admission.’ FYI, people fall. People fall at home, people fall in public venues, at the grocery store, at work, at church. That’s absolutely not an exclusion for admission. Which leads me to this, if residents didn’t need our assistance with various aspects of daily living, they would stay in their homes and we would have no business and nothing for the state to regulate.”

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section. Additionally, the FNA sufficiently addresses mobile nonambulatory residents. Please refer to the definition of "ambulatory" on page one of the FNA under "Resident Criteria" as KRS 194A.700(2) defines "ambulatory" as "able to walk, transfer, or move from place to place with or without hands-on assistance of another person, and with or without an assistive device, including but not limited to a walker or wheelchair." If a resident meets that statutory definition, they are not ineligible to live in an ALC. The functional needs assessment form is consistent with SB 11 and the level of services required by residents of an ALC. SB 11 did not alter the delineation between skilled nursing care and lower levels of care.

(a) Comment: Sheila Carter, Heartsong Memory Care, submitted the following Comments In addition, Ms. Carter presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "The filed regulation requires all assisted living communities to use a standardized Functional Needs Assessment. This attempts to legislate by regulation in direct conflict with the express wording and intent of SB 11."

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Adam Bailey, Cedar Ridge Health Campus, Beth Blair, The Willows at Fritz Farm, Eric Bryant, Cooper Trail Senior Living, Rachel Dadisman, The Willows at Harrodsburg, Brittany Faucher, Shelby Farms Senior Living, Lindsey Foster, Walker's Trail Senior Living, Sam Frazier, The Willows, Marty Hawkins, Glen Ridge Health Campus, Matthew Jones, The Legacy at English Station, Mona Lisa McCubbins, Franciscan Health Care Center, Kara Meredith, The Springs at Stony Brook, G. Parker Moore, Westport Place Health Campus, Renee Moore, The Willows at Citation, and Kristi Noah, Forest Springs Health Campus, submitted the following comments: "There is no need to move to a standard, state-developed functional needs assessment. As one of 20 Trilogy Health Service campus in Kentucky, we have a very well developed functional needs assessment that can meet any requirements the State feels is necessary."

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Vicki Phillips, Sayre Christian Village, submitted the following comments: "The 'exclusions' questions 1-9, these questions in no way are supported by statute (law) and should not be included in the FNA but should be addressed in care plan/service plan to mitigate risk. These exclusions should not solely prevent admission provided they follow statute.

This FNA would do just the opposite, based on this assessment with the exclusions. Sayre Christian Village would have to find higher level of care for many residents

who are currently residing in our AL building with optional services very successfully. We need to consider the impact the implementation of these forms/regulations will have on the current population currently residing within our ALC/PC facilities before just blindly approving a form with no evidence-based outcomes and effectiveness. We need to think about how families of these individuals will manage if they need to care for their parents, aunts/uncles, brothers/sisters or just friends because the individual has no family."

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Georgina Ivers, Crescent Place Assisted Living, submitted the following comments: "I also don't see the need for a state-made FNA. I wish the state would have come up with standardized dementia training for assisted livings, but they wouldn't and made every facility come up with their own. And now I wish they would have every facility come up with their own FNA but instead they want to standardize it."

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Jason Morgan, Highgrove at Tates Creek, submitted the following the comments: "Proposed regulation 902 KAR 20:480 attempt to operate via the regulatory pen with the mandate of standardized Functional Needs Assessment Form (FNA). This requirement not only defies the will of the legislator and subsequently governor by ignoring state law. Senate Bill 11 stated with no uncertain terms, each provider shall be permitted to develop its own FNA so long as the required elements in the statute are addressed. Legislation from the regulatory pen defies the well of our lawmakers and will result unnecessary displacement of our seniors to government subsidized communities."

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Patrick Beaven, The Homeplace of Henderson, submitted the following written comments: "It is unreasonable to mandate a standardized form as a prerequisite for admission for people into both assisted living and assisted living with dementia care. For example, question number six within the Exclusions section of the FNA asks about individuals becoming agitated or unwilling to receive instruction; this is overly subjective for a yes/no response to either qualify or disqualify someone for residency. The answer for most individuals suffering from Alzheimer's or other forms of dementia is almost undoubtably subject to change – based on who is asking, how it is asked, when it is asked, etc.

It is also unreasonable to mandate a standardized form as a prerequisite for admission into heterogenous communities. For example, we are the first facility in

Kentucky to invest in Foresite technology within our apartments. Foresite provides state-of-the-art monitoring to help us proactively manage and anticipate out residents' care needs. Foresite continuously monitors over 30 different factors, including heart rate, respiratory rate, bed restlessness, gait, motion and activity, and many more. This continuous monitoring helps us identify and address individual risks for certain types of illness and injury. With those insights, we can make changes in care and/or the environment to reduce risk of fall or other incidents. Should a fall or other adverse event occur, the Foresite technology also provides tangible information to yield a better understanding of what led up to the incident. We can then determine the best possible course of action to decrease the likelihood of it happening again. That said, question number seven within the Exclusions section of the FNA asks about individuals having a recent history of frequent falls; this is overly subjective for a yes/no response to either qualify or disqualify someone for residency. The answer in one community may result in the individual being in constant danger. However, partnering with a community that understands many incidents don't just "happen,", but in fact are often the result of changes – such as the way someone is walking or how they're sleeping – and has invested in technologies such as Foresite, may be that same individual's best option for reducing the risk of danger."

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section.

(a) Comment: Carla Austin, Barrington of Ft. Thomas, submitted the following written comments: "a. There is a direct conflict with the intent of SB 11 requiring all ALC to use a standard FNA form.
b. The statute permits each provider to develop its own FNA so long as it addresses the required elements set forth in the statute.
c. I am not in objection to the state providing a standard FNA form to be used by those ALC if they choose, but I object to regulating such a standardized form.
d. Each ALC has specific subject matters they would like to address in assessing the potential resident as well as ways to calculating levels of care and the cost attached to those particular care levels. This standardized form does not permit the provider to measure a resident's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to develop a service plan to meet individual identified needs."

(b) Response: Please refer to the cabinet's response to Kentucky's three long-term care associations at the beginning of the Functional Needs Assessment section.

(5) Subject: Drafting Requirements under KRS Chapter 13A

(a) Comment: Rebecca Pfalzgraf, KSLA, Betsy Johnson, KAHCF/KCAL, and Tim Veno, LeadingAge Kentucky, submitted the following comments: "In general and as discussed in the issues of concern listed above, the proposed regulation violates KRS 13A.120(2)(e)(f)(h)(i) & (4) because it contains duplicative or contradictory

language to that contained in the SB 11 language.

> KRS 13A.120 (2) states: 'An administrative body shall not promulgate administrative regulations:
> (e) When a statute prescribes the same or similar procedure for the matter regulated.
> (f) When a statute sets forth a comprehensive scheme of regulation of the particular matter.
> (h) On any matter that is beyond the statutory authorization of the administrative body to promulgate administrative regulations or that is not clearly authorized by statute.
> (i) That modify or vitiate a statute or its intent.' (Emphasis added).

KRS 13A.120 (4) further states: 'Any administrative regulation in violation of this section or the spirit thereof is null, void, and unenforceable.' (Emphasis added).

The proposed regulation violates the provisions of KRS Chapter 13A for the reasons stated above. Additional examples of these violations include:

> Section 7(2)(k)2: While SB 11 continued current law requiring staffing to meet scheduled resident needs, this section requires staffing to meet scheduled and 'reasonably foreseeable unscheduled needs' of residents. Further, the filed regulation section cited above conflicts with another section of the same regulation [section 14(3)(a)] which requires 'staffing to meet the twenty-four (24) hour scheduled needs of each resident …'
>
> Section 14(3)(b) requires that 'at least one staff person shall be awake and onsite at all times at each licensed entity or building on the same campus for two or more buildings operated by the same licensee' yet, section 8 of SB11 requires that 'one awake staff member shall be on site at each licensed entity at all times.'

The contradictory language attempts to modify the intent of the statute, which makes the regulation 'null, void and unenforceable.' In addition, the duplicative language is unnecessary and creates confusion for providers by causing the proposed regulation to be excessively long and difficult to understand."

(b) Response: In response to Kentucky's three long-term care associations' assertion that 902 KAR 20:480 violates the drafting requirements of KRS Chapter 13A, the cabinet disagrees. Please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky under the section entitled "Tiered Licensure Structure for Assisted Living Communities."

Regulations are standards put forth by administrative agencies that govern how laws will be implemented and enforced. Although SB 11 establishes much of the framework for the operation of ALCs, the cabinet is authorized by KRS Chapter

216B to establish licensure standards for health facilities [which include ALCs according to the definition in KRS 194A.015(13)] to help ensure the safety and well-being of all patients and residents. The regulation is consistent with the language and intent of SB 11 and is within the authority and responsibility of the cabinet. See KRS 216B.042(1)(c).

In the long-term care associations' testimony before HWFS committee members last spring, association representatives said that they reviewed the rules and regulations of other states as they drafted SB 11 but they were heavily influenced by Minnesota's state laws governing ALCs. Likewise, the cabinet also researched other states' laws and modeled much of 902 KAR 20:480 on Minnesota's rules, adding key standards to the proposed regulation that were not included in SB 11.

In response to the comment that Section 7(2)(k)2 conflicts with Section 14(3)(a), please note that there is no subparagraph 2 under Section 7(2)(k). Presumably, the associations meant to cross-reference Section 7(2)(j)2. This is the section that requires ALCs to "ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's functional needs assessments and service plans on a twenty-four (24) hour per day basis." This requirement aligns with the same requirement in the Minnesota statute, Section 144G.41, Subd. 1(11)(ii): https://www.revisor.mn.gov/statutes/cite/144G.41.

Regarding the commenters' assertion that the above requirement conflicts with Section 14(3)(a), the key phrase is "reasonably foreseeable". The expectation is not to staff for every possible scenario. But, if a resident's care needs have increased and they are requesting assistance more often than previously, then a reasonably foreseeable unscheduled need may be to staff for the ability to conduct more frequent safety checks on the resident. It is within the cabinet's authority under KRS 216B.042(1) to establish a safety standard such as that proposed by Section 7(2)(j)2, especially given that neither the law nor the regulation establish staff-to-resident ratios.

In response to the comments regarding Section 14(3)(b), this section of the regulation cross-references KRS 194A.717(2) which requires only one awake staff member to be on site at each licensed entity at all times. However, the law overlooks an important safety standard for ALCs that have more than one building on campus. Licensees should ensure sufficient staffing in each building at all times, including during nighttime hours to respond promptly and effectively to individual resident emergencies. Moreover, KRS 194A.717(2) is less stringent than the PCH regulation's staffing requirement in 902 KAR 20:036, Section 3(8)(j) that requires "no less than one (1) staff member shall be awake and on duty on each floor in the facility at all times."

Given that KRS 194A.704 requires apartment-style PCHs to convert their licensure to ALC licensure, the cabinet believes that PCHs should continue to comply with the

same staffing levels as they do currently rather than be held to the weaker standard established by KRS 194A.717(2), which does not guarantee resident safety.

The cabinet will retain the proposed requirement in 902 KAR 20:480, Section 14(3)(b) for at least one staff person to be awake and on-site at all times at each licensed entity *or* in each building on the same campus if two or more buildings are operated by the licensee.

(a) Comment: Mark Hegele, BeeHive Assisted Living, submitted the following comments: “And from a legal and technical standpoint, these proposed regulations overstep the requirements and intentions of SB-11, which was overwhelmingly approved by the Kentucky legislature last summer. In reality, these proposed changes are confusing, excessively long, and attempt to legislate by regulation things that were not included in the statutes of SB-11.

Our daily mission at BeeHive Homes is to provide the best care possible for our precious residents, while limiting the amount we have to charge for such care to the lowest practical level. These proposed regulations would endanger our ability to do that and therefore we must respectfully request that these proposals be withdrawn until these issues can be properly addressed.”

(b) Response: Please see the above explanation to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding why the regulation does not “overstep” the requirements of SB 11. The regulation is consistent with the language and intent of SB 11 and is within the authority and responsibility of the cabinet to establish standards to ensure safety and establish licensure classification of health facilities. See KRS 216B.042(1)(c). The cabinet will not amend the regulation in response to this comment.

(a) Comment: Jason Morgan, Highgrove at Tates Creek, submitted the following the comments: “Additionally, language requiring staffing to meet ‘reasonable foreseeable unscheduled needs’ is ambiguous and will result in financial hardship of both the provider and to the seniors living in the community. Ambiguousness of regulations ultimately lead to an unbridged divide between surveyors, providers, residents, and their families. With our residents and families suffering the greatest consequence from the divide. The staffing mandate will result to seniors facing the financial hardship of private care and be forced to move to a government subsidized nursing home.”

(b) Response: Please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky for an explanation regarding this issue. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Sheila Carter, Heartsong Memory Care, submitted the following comments. In addition, Ms. Carter presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: “The

filed regulation violates KRS 13A.120 (2)(e)(f)(i) and (4) because it contains language that is duplicative and contradictory to language in the SB 11 statute. The duplicative language is unnecessary and creates confusion for providers by causing the filed regulation to be excessively long and difficult to understand. More importantly, the contradictory language attempts to modify the intent of the statute, which makes it 'null, void and unenforceable'. At Heartsong Memory Care we are passionate about the care we provide to our residents. Our Director of Operations and I have both served on the KSLA Board of Directors and participated directly in creation of SB 11 in order to assure that Assisted Living Memory Care providers in the state provide the safest care in the most reasonable manner for their residents. If the Cabinet for Health and Family Services moves forward with the proposed regulation as drafted, we are concerned about the impact this would have on the ability of assisted living providers across the state to operate and provide quality care to their residents."

(b) Response: In response to the commenters' assertion that 902 KAR 20:480 violates the drafting requirements of KRS Chapter 13A, the cabinet disagrees. Please refer to the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky. The cabinet will not amendment the regulation in response to this comment.

(6) Subject: Dietary Services

(a) Comment: Nichole Smith, St. Charles Community, submitted the following comments: "P. 19 12 (j) Food shall be cut, chopped or ground to meet the individuals needs.
The way this is written even if you do not offer a therapeutic diet we have to ground food if needed. Can this be revised to read if therapeutic diets are offered. We do not provide therapeutic diets nor do we have the ability to ground foods.
14 substitutes must be recorded.
Recording of every substitution is cumbersome and feels like a SNF. The regulations are burdensome for an Assisted Living."

(b) Response: In response to the comments, the cabinet agrees to amend the regulation so that social model ALCs will continue to be subject to the current requirements for dietary services as established by KRS 194A.705(1)(b) which requires only that three meals and snacks be made available each day.

According to comments submitted by Kentucky's three long-term care associations who brought SB 11 forward, the associations sought to "blend the two private-pay levels (assisted living and personal care) into one continuum of care." Therefore, to ensure that apartment-style PCHs required by KRS 194A.704(1) to convert to ALCs adhere to the same dietary service standards as they do currently as well as require the same standards for ALCs-BH, the cabinet's inclusion of a section on dietary services in 902 KAR 20:480 mirrors the same requirements established in the PCH regulation, 902 KAR 20:036, Section 4(3)(c).

Additionally, although the PCH regulation requires that “modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician”, the definition of “assisted living services” in KRS 194A.700(7)(f) refers to “modified diets ordered by a licensed health professional.” Therefore, the cabinet will amend the ALC regulation to replace “physician” with “licensed health professional”.

(a) Comment: Bailee Roberson, BeeHive Homes of Grayson County, submitted the following comments. In addition, Ms. Roberson presented verbal comments during the public hearing held on January 23, 2023 that are similar in nature to the following: “Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, “assisted living communities.” The changes in this proposed rule would not only impact BeeHive Homes of Grayson County, but also the residents we care for and love.

BeeHive Homes of Grayson County is located in Leitchfield, KY. We are committed to providing high quality care and continually strive to do our best for the people we serve. I have been the Executive Director at BeeHive homes for about 4 years now, and I have worked here for almost 5 years in total. We are a small community (only 16-17 beds), and we are located in a rural area (our city has a population of around 6,400). Even though we are small, we serve many families in our community—numbers likely in the hundreds for families and residents served since our opening in 2011—and we have a wonderful reputation in our community and in surrounding counties that we serve. Almost anywhere you go in this town, when BeeHive Homes is brought up in conversation, someone pipes up to say that they had an aunt or uncle, grandmother or grandfather, father or mother, sister or brother, a friend or loved one that was well loved at The BeeHive. In a community this small, and with the high volume of residents served here, a good reputation being maintained for almost 12 years is quite the feat. But—that is what is so special about a tiny, little place like us. We have wonderful resident-to-caregiver ratio, the ability to truly practice personalized care in all aspects, and extremely personal relationships with all residents and families we serve. I feel blessed that I get to know specific details about each resident and his or her care, and that I get to personally know each one of the families we serve—it is something that I know not all facilities get to do. Again, that is what is so special about a place like us…it is more than a facility; it is a home.

Proposed regulation 902 KAR 20:480 causes some areas of concern for a small home like ours. The section for Dietary Services for ALCs states that we would now be required to record snacks being offered/refused, the times that residents refuse food during meals, and that a substitute has been offered. While we do already offer substitutes if residents do not want an item, and we offer snacks and even incorporate them into our activity program, recording this will be a large added duty to our one cooking staff member per day. Many facilities that are small do not have one person per department to spare the time for such documentation. Additionally, it does not seem that we could hire and train anyone without some other training or

experience to do the job. Our cooks/Kitchen Manager would need to be consulting with special dietitians/ nutritionists, and I am sure that it would also begin to become costly to make all needed changes. Furthermore, hiring extra personnel would be an extreme strain on cost for facilities like ours that are already struggling to make ends meet in the current economy, and we would not have the kitchen staff to meet such changes in the regulations."

(b) Response: In response to the comments, the cabinet agrees to amend the regulation so that social model ALCs will continue to be subject to the current requirements for dietary services as established by KRS 194A.705(1)(b) which requires only that three meals and snacks be made available each day.

According to comments submitted by Kentucky's three long-term care associations who brought SB 11 forward, the associations sought to "blend the two private-pay levels (assisted living and personal care) into one continuum of care." Therefore, to ensure that apartment-style PCHs required by KRS 194A.704(1) to convert to ALCs adhere to the same dietary service standards as they do currently as well as require the same standards for ALCs-BH, the cabinet's inclusion of a section on dietary services in 902 KAR 20:480 mirrors the same requirements established in the PCH regulation, 902 KAR 20:036, Section 4(3)(c).

Additionally, although the PCH regulation requires that "modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician", the definition of "assisted living services" in KRS 194A.700(7)(f) refers to "modified diets ordered by a licensed health professional." Therefore, the cabinet will amend the ALC regulation to replace "physician" with "licensed health professional".

(7) Subject: Funding for the Kentucky State Long-Term Care Ombudsman Program

(a) Comment: Sherry Culp, Kentucky State Long-Term Care Ombudsman Program, submitted the following written comments and shared similar comments during the public hearing on January 23, 2023. Mary Crowley-Schmidt, Bluegrass Area Agency on Aging and Independent Living, submitted similar comments: "The licensing and annual fee does not include funding for the long-term care ombudsman program. The Kentucky State Long-Term Care Ombudsman Program (KY SLTCOP) requests that the fee include $20 per unit for the long-term care ombudsman program. This amount is not the full cost to provide services, but will support assisted living residents' rights to access to ombudsman services."

(b) Response: KRS 194A.707(9) permits the cabinet the promulgate administrative regulations to establish a fee for assisted living communities but stipulates that the fee cannot exceed the costs of the program to the cabinet. The statute further requires the cabinet to provide a breakdown of the fees assessed and costs incurred for conducting only licensure reviews upon request of any interested person. In addition, KRS 216B.042(1)(a) requires the cabinet to establish

reasonable application fees for health facility licenses. Accordingly, the fee schedule proposed in 902 KAR 20:480, which is the same fee schedule currently established under 910 KAR 1:240, is restricted to covering the cost of the licensure function. The Office of Inspector General is therefore not able to transfer a portion of the monies collected from fees to the KY SLTCOP.

(a) Eric Evans, AARP, submitted the following comments: “We urge you to ensure that Assisted Living Centers address the increasing health, medical, and social needs of residents and maximize each resident’s dignity, independence, autonomy, and privacy. To that end, we urge Kentucky to provide adequate funding to the Kentucky Long-Term Care Ombudsmen to ensure all Assisted Living Center residents have full access to Kentucky Long-Term Care Ombudsman services.”

(b) Response: The Office of Inspector General does not have available funding to transfer to the KY SLTCOP to support the activities of that office.

(8) Subject: Survey Inspection Findings Available to the Public

(a) Comment: Sherry Culp, Kentucky State Long-Term Care Ombudsman Program, submitted the following comments. Mary Crowley-Schmidt, Bluegrass Area Agency on Aging and Independent Living, submitted similar comments and Denise Wells, Nursing Home Ombudsman Agency of the Bluegrass shared similar comments during the public hearing on January 23, 2023: “Access to information is paramount to making informed healthcare decisions. The KY SLTCOP recommends that these regulations include a requirement that each ALC, ALC-BH, and ALC-DC make readily available to residents, family members, and legal representatives, the results of the most recent survey of the facility. In addition, the KY SLTCOP recommends that OIG makes these surveys accessible to the public on their long-term care inspection website.”

(b) Response: Because ALCs are subject to the residents’ rights statute, KRS 216.515, each “resident and the responsible party or his responsible family member or his guardian has the right to have access to all inspection reports on the facility.” In addition, the Office of Inspector General will post ALC survey findings and plans of correction at the following link with the inspection finding for other long-term care facilities: https://gensearch.ky.gov/Search.aspx?TK=335.

No further amendment of the regulation is necessary in response to the above comment.

(9) Subject: Resident Grievance Process

(a) Comment: Sherry Culp, Kentucky State Long-Term Care Ombudsman Program, submitted the following comments. Mary Crowley-Schmidt, Bluegrass Area Agency on Aging and Independent Living, submitted similar comments and Denise Wells, Nursing Home Ombudsman Agency of the Bluegrass shared similar comments

during the public hearing on January 23, 2023: “Page 16 Line 15 – The KY SLTCOP recommends clarifying that the notice shall have 1. Contact information for the State long-term care ombudsman.”

(b) Response: The cabinet agrees with this comment and will amend 902 KAR 20:480, Section 7(5)(b)1. by adding “state” before “long-term care ombudsman.”

(10) Subject: Background Checks

(a) Comment: Sherry Culp, Kentucky State Long-Term Care Ombudsman Program, submitted the following written comments and shared similar comments during the public hearing on January 23, 2023. Mary Crowley-Schmidt, Bluegrass Area Agency on Aging and Independent Living, submitted similar comments: “Page 25 Line 15 – The KY SLTCOP recommends that background checks be required of all facility staff, regardless of whether they provide direct care. Employees that do not provide direct care still have access to vulnerable adults, their possessions, and their personal information.”

(b) Response: The cabinet agrees that ALC employees with access to residents, their possessions, or their personal information are subject to the required background checks and will add clarifying language to Section 14(1) of the regulation.

(11) Subject: Closure of the Facility

(a) Comment: Sherry Culp, Kentucky State Long-Term Care Ombudsman Program, submitted the following written comments and shared similar comments during the public hearing on January 23, 2023. Mary Crowley-Schmidt, Bluegrass Area Agency on Aging and Independent Living, submitted similar comments: “If an ALC, ALC-BH, ALC-DC closes voluntarily or involuntarily, the KY SLTCOP recommends that a facility must form a closure team to assist residents with notifying their family and friends, finding a new ALC or appropriate housing, and moving their belongings. The closure team should inform the Office of Inspector General and Long-Term Care Ombudsman program of their progress in relocating residents.”

(b) Response: If an ALC closes, the cabinet expects the facility to comply with the move-out notice and other requirements of KRS 194A.705(5) which requires written notice and assistance to residents in finding appropriate living arrangements.

In addition, 902 KAR 20:480, Section 3(3)(g) requires all ALCs to provide written notice to residents at least 60 days prior to voluntarily relinquishing a license as well as notification to the cabinet. ALCs with secure dementia units are subject to the notification and other steps for voluntary relinquishment established by KRS 194A.7063.

(12) Subject: Emergency Disaster Plans

(a) Comment: Sherry Culp, Kentucky State Long-Term Care Ombudsman Program, submitted the following comments: “How will OIG confirm that an ALC’s evacuation plan will be feasible? Should the facility have enough staff to evacuate those who need help 24/7?”

(b) Response: The emergency disaster plan must describe an ALC's comprehensive approach to meeting the health, safety, and security needs of their residents and staff during an emergency or disaster situation. The plan must address the requirements of 902 KAR 20:480, Section 7(4)(c) and Section 12. The emergency disaster plan must also ensure the facility has considered a multitude of events rather than just one type of potential emergency that may occur in their area.

Section 7(2)(j)3. requires that ALCs develop and implement a staffing plan for determining staffing levels that ensure the facility can respond promptly and effectively to individual resident emergencies and to emergency, safety, and disaster situations, including for residents who require assistance in evacuating. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Eric Evans, AARP, submitted the following comments: “Regulations need better health and safety protections for residents. AARP Kentucky should revise the regulations to ensure that Assisted Living Centers have well-developed, feasible, and practiced emergency plans for residents. There should be adequate number of well-trained staff to carry out such plans. Emergency plans should be prepared and reviewed annually by the local emergency management agency as well as the Department. Emergency plans must include procedures for safely evacuating residents and continuing needed care. There should also be plans for safely transporting medical records, emergency medicines, and other supplies.

Kentucky should require Assisted Living Centers prepare a consumer-friendly summary of their emergency plan and provide it to current and prospective nursing home residents and their families and caregivers. It should be posted on the premises and also available to members of the public upon request.”

(b) Response: Please see the above response regarding emergency disaster plans. Section 12(2) of the proposed ALC regulation requires facilities to provide emergency and disaster training to all staff at initial orientation and annually thereafter as well as make emergency and disaster training available to residents. Staff who have not yet received the training are prohibited from working unless training staff also work on site.

Because the ALC’s emergency disaster plan must be posted prominently in accordance with the proposed requirement of 902 KAR 20:480, Section 12(1)(b), a user friendly version of the plan is available to residents, their families, and the general public.

It is worth noting that the above comments mention “prospective nursing home

residents", which appears to be a clerical error. However, it is an important reminder that a key distinction between ALCs and nursing facilities is that while ALC residents require assistance with everyday tasks, they must be ambulatory pursuant to KRS 194A.711 unless they have a temporary condition, and may be in need of basic health and health-related services or dementia care services. Nursing facility residents, in contrast, have more complex and demanding health needs that mean independence is not possible.

(13) Subject: Personal Care Home Conversion to Assisted Living

(a) Comment: Sharon Davis, Mayfair Village Retirement Community, submitted the following comments. Douglas King, Osborn Enterprise, submitted similar comments: "It is my opinion that licensed Personal Care was discriminated against when Assisted Living arose in 2000. We are, I feel, very much like the proverbial 'baby in the bathwater'. Once Assisted Living became law, I could not market Mayfair's Personal care as delivering assisted living services. I had an old ad in the yellow pages directory under assisted living category on a 12 month contract and I received a call and was threatened with consequences if I didn't remove it immediately. Therefore, from 2000 until today (twenty three years) I have built a successful brand identity using the name Personal Care without using the words assisted living. Now once again Personal Care operators are being discriminated against by being forced to give up our brand identity with a name change to ALC/BH! I find that acronym distasteful. Mayfair's brand is one of excellence and basic health sound contrary to that. I feel at least the state could choose a better acronym for Personal Care facilities ALC/PC preferably or ALC/HS. After all, we are the only business model for over 32 years that has delivered these health services to Kentucky seniors. I understand that the AL acronym is used around the country; however the problem lies within the Kentucky AL model adopted in 2000. Personal Care in Kentucky is not broken, not the problem. The problem was the AL business model that was not designed correctly to adequately care for Kentucky seniors in the first place. A business model that I perceived at the time was created to avoid oversight as much as possible from the state rather than a well thought out plan to extend care to seniors.

Mayfair Village Personal Care has established an exemplary survey record with OIG, having no deficiencies in the past 15 years. We operate with certified staffing which includes two LPN, two CNA, two CMA, and our Administrator with a KY Medications Aide certification, as well as 6 RA, a large staff for a small Personal Care operation. We have a pharmaceutical contract and the pharmacist works closely with our staff and is available if needed by telephone. Mayfair Village has a third party therapy group located on site for any physical therapy and any skilled care is provided by a Home Health Agency with registered nurses. We also have doctors on call who visit the facility and are available if needed by telephone. The average length of employment in Personal care staffing is over 10 years. We feel that our record of excellence speaks for itself with OIG. It is our concern that we will now have to revise all our print marketing and our website to reflect an acronym

which is confusing to the public and will appear as a downgrade of our services as we are firmly branded as Personal Care, 'a higher level of services'. Having been told that this change was to level the playing field so to speak, I see this as hurting Personal Care operators who are stand alone and have no presence out of state or in state association within their brand as Assisted Living operations. It is with this in mind that we request that OIG formulate some plan based on survey records to grandfather Personal care operators such as Mayfair Village, using current staffing only, and with some acronym that gives a nod to our previous name branding in use for over 32 years with excellent service to our senior population."

(b) Response: As stated previously, Kentucky's three long-term care associations drafted SB 11 and brought the measure forward. SB 11 created a new statute, KRS 194A.704, that requires apartment-style PCHs in substantial compliance with KRS 194A.703 to convert to the applicable ALC licensure category. SB 11 requires this change; the regulation only implements it. Accordingly, the proposed ALC regulation aligns with the statute. The cabinet will not amend the regulation in response to this comment.

(a) Comment: Cliff Lake, Brookdale Senior Living, submitted the following comments: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' The changes in this proposed rule would not only impact my assisted living community, but also the residents we serve.

Brookdale Stonestreet is in Louisville, KY. We are committed to providing high quality care and continually strive to do the best for the people we serve.
I am specifically concerned with the following:

My facility is currently licensed/certified for Personal Care and Assisted Living.

1. If this regulation is left as is, I wonder why we bothered to make any changes to our current system. I currently have to move residents within my community as needs change. I had hoped with the change that this would not be the case.
2. I am also concerned that I will either have to be an ALC-social or an ALC-BH. Currently I can evaluate a resident and recommend that they move into either PC or AL. We charge more for our personal care services as their needs are typically higher. Under the proposed regulation, I would have to become an ALC-BH – because of my current population and this would increase my charges for the residents I currently serve in my Assisted Living section.

I appreciate the challenges there are in developing regulations for a new level of care. I know from working in both the SNF and AL sectors, that I have appreciated the fact that AL allowed more freedom to work with our residents and families. I hope that doesn't change."

(b) Response: If a PCH converts to ALC licensure in accordance with KRS 194A.704, the facility may continue to provide services to a mix of residents in need of social model assisted living services and residents in need of basic health and health-related services. The PCH must apply for an ALC-BH license to avoid any disruption in care. The service plan as defined by KRS 194A.700(24) will establish which services are provided to each resident, thereby allowing for a mix of residents that receive services specific to their care needs.

Moreover, a facility's rates should correspond to the services the resident receives, not increase automatically because a PCH converts to ALC-BH licensure. The cabinet will not amend the regulation in response to this comment.

(14) Subject: Medical Exam

(a) Comment: Kathy Bevil, Dogwood Retreat, submitted the following comments: "We are incredibly thankful to you for taking the time to read this letter in regards to the proposed regulation, 902 KAR 20:480 and what it could mean for Assisted Living Communities in Kentucky. If this rule passes, the changes in said proposed rule would not only impact my Assisted Living Community but, more importantly, our residents themselves. This will impose a very expensive obligation to all ALCs in Kentucky. What's more is that my Assisted Living Community is located in a very rural area of western Kentucky. Many of these types of communities are often overlooked because of the popularity and size of ALCs that are located in urban areas.

Dogwood Retreat Inc. is located in Hartford, KY. We are committed to providing high quality care and continually strive to do the very best for the people we love and serve. I, along with my husband, daughter, and son-in-law began our corporation in October of 1998; long before assisted living was even regulated by the state. Our community houses 12, and we feel that that somewhat small number makes all of the difference in the world. We are able to provide very personalized care in this small setting, which is extremely important when it comes to our residents and their comfortability and contentment. For over 24 years, Dogwood Retreat has prided itself on its 'homey' atmosphere. The last thing we want our residents/resident's families to feel is as if they are being institutionalized. Throughout the years I have been familiar with all policies and rules, and this proposed regulation seems to be the very first step in turning Kentucky Assisted Living communities into something that we have never envisioned for our facility. We most definitely choose to keep our certification as a Social Model Assisted Living Community but the additional rules and workload that come with this regulation will be quite overwhelming for such a small, close-knit community such as ourselves.

While reading in detail about the proposed regulation, one thing certainly jumped out at me. I was studying a blank sample copy of what the new and updated Functional Needs Assessment form will look like. It will read as follows: 'In

accordance with KRS 216.765(1), a prospective resident must have a medical examination prior to admission to an ALC, ALC-BH, or ALC-DC. The medical examination is separate from this FNA and must include a: medical history; physical examination; and diagnosis.'

Previously, residents were not required to have a medical examination before they could be admitted to Dogwood Retreat. This seemingly small change will impact our community greatly. As I stated above, we are located in rural western Kentucky. Our county has a very 'small-town' and neighborly presence, which is incredible, but can also mean that the lines between business and pleasure can become extremely blurred. Many of the physicians in this area own or co-own Nursing and Rehabilitation Facilities, so it only makes sense that these doctors will recommend Skilled Facilities rather than Assisted Living. It happens more often than you think; doctors pushing their own bureaucratic agendas. It is a very concerning thought that many potential residents can be so easily deterred from our services, as a large amount of people trust and rely on their doctors more than anyone else in life.

We are very passionate and invested in the work we do here at Dogwood Retreat, and our community has been providing residents with quality care for a quarter of a century. If this regulation comes to pass, we worry about the toll this will take on our ability to continue providing the maximum and specific care that our residents deserve. It has not always been easy throughout the years facilitating our community, especially being located in a rural and small town. But, we have done absolutely everything in our power to give nothing but impeccable care to our residents and we have remained strong in the midst of challenges and setbacks along the way. We will continue to do so now. However, this proposed regulation will only make it harder for our citizens; as it could possibly mean that citizens may lose their choice to be a part of an Assisted Living Community. Our concerns and thoughts are very real, so we thank you for taking the time to learn a little about Dogwood Retreat and how much this community means our entire county."

(b) Response: In response to the comments regarding the requirement for a medical examination, SB 11 amended KRS 216.765 to require "a medical examination that includes a medical history, physical examination, and diagnosis" prior to admission to a personal-care home or assisted living community. This requirement was added by SB 11 and the regulation implements that requirement. The cabinet will not amend the regulation in response to this comment.

(15) Subject: Proposed Standards

(a) Comment: Mary Nell Bouvier, Bee Hive Homes of Grayson County, submitted the following comments: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' The changes in this proposed rule would not only impact our Assisted Living Community and our residents but will impose expensive regulatory burdens on other small Assisted Living communities located in underserved rural areas and

small towns in our state. Some small ‘mom and pop owned’ ALFs may even be forced to close. Rural areas and small towns are often overlooked by large companies because household incomes may not match those in urban areas, workers are hard to find, profit margins in the industry are slim and operating expenses continue to increase.

Bee Hive Homes of Grayson County is located in Leitchfield, KY. We are committed to providing high quality care and continually strive to do the best for the people we serve. We are a 16 room community able to personalize care in a small home setting. Our residents and families feel like they are part of a family. We have served Grayson, Breckinridge and surrounding counties for over 11 years. My husband and I own this Bee Hive franchise and have been actively involved in its development and operation. We have become part of the local community. Our personal goal in opening our Bee Hive was to own and operate a community that we would feel good about having our own parents or relatives living in, and we have met this goal.

For over 20 years I was a licensed Nursing Home Administrator so I am familiar with the typical rules and regulations governing long term care. Proposed regulation 902 KAR 20:480 appears to begin to turn Kentucky Assisted Living communities into more highly regulated long term care facilities that accept government payments. We plan to keep our certification as a Social Model Assisted Living Community but the additional regulatory burden will be overwhelming.

When I read the proposed regulations for Dietary Services for AL Social Model, I note menus must now be posted one week in advance, and kept on file for 30 days, supplements cannot be given without a doctor’s order (guess families cannot bring in Ensure), if a resident refuses food a substitute must be offered (we do) but it must be recorded, snacks must be offered through the day and at bed time and also recorded. Proposed regulations for Medical Records for AL Social Model require for each resident a Medical Exam, Medical History, list of Allergies, all records of communication pertinent to resident services, documentation of significant changes in resident status, and resident records must be retained for six years after resident discharge in a secure location. Residents of an AL Social Model must now have a Service Plan in addition to a Functional Needs Assessment. Additionally, under this proposed regulation Staffing Plans for AL Social Model are to be evaluated twice a year for appropriateness and to ensure staffing levels are sufficient to meet scheduled and reasonably foreseeable unscheduled needs of each resident as required by Functional Needs Assessments and Service Plans. A Quality Management Program is proposed to be added to the AL Social Model. This program sounds remarkably like the Quality Assurance Committee that is mandated for Skilled Nursing Facilities. Documentation for this Quality Management Program shall be maintained for at least 2 years and available to the Office of the Inspector General at time of survey, investigation, or renewal. The above are just a sampling of my concerns with this proposed regulation. We do not have the management staff available to meet these increased regulations.”

(b) Response: Although the commenter's issues have been addressed in other sections, the cabinet would like to repeat its response to the comments regarding dietary services. In response to the comments, the cabinet agrees to amend the regulation so that social model ALCs will continue to be subject to the current requirements for dietary services as established by KRS 194A.705(1)(b) which requires only that three meals and snacks be made available each day.

According to comments submitted by Kentucky's three long-term care associations who brought SB 11 forward, the associations sought to "blend the two private-pay levels (assisted living and personal care) into one continuum of care." Therefore, to ensure that apartment-style PCHs required by KRS 194A.704(1) to convert to ALCs adhere to the same dietary service standards as they do currently as well as require the same standards for ALCs-BH, the cabinet's inclusion of a section on dietary services in 902 KAR 20:480 mirrors the same requirements established in the PCH regulation, 902 KAR 20:036, Section 4(3)(c).

Additionally, although the PCH regulation requires that "modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician", the definition of "assisted living services" in KRS 194A.700(7)(f) refers to "modified diets ordered by a licensed health professional." Therefore, the cabinet will amend the ALC regulation to replace "physician" with "licensed health professional".

In response to the comment regarding medical examinations, SB 11 amended KRS 216.765 to require "a medical examination that includes a medical history, physical examination, and diagnosis" prior to admission to a personal-care home or assisted living community. Therefore, the proposed ALC regulation aligns with state law.

In response to the commenter's objection about requiring the resident's record to include "all records of communications *pertinent* to the resident's services", ALCs should document only relevant information that is exchanged about the resident's care needs such as a change in services.

In response to the comments regarding the requirement for resident records to include "documentation of significant changes in the resident's status and actions taken in response to the needs of the resident", it is important to note that many ALCs pushed for the passage of SB 11 to allow residents to age in place as their care needs change over time from social model assisted living services to basic health and health-related services, including dementia services and end-of-life services in accordance with SB 11's definition of "temporary assistance." The requirement for documentation of significant changes in the resident's status is a reasonable standard that helps facilities determine whether the resident is still eligible for continued stay in the ALC or whether the resident's condition has progressed to the extent that his or her care needs are beyond the scope of what ALCs are authorized by law to provide.

In response to the comment about records retention, requiring resident records to be maintained for six (6) years is consistent with the same requirement for other levels of care regulated by the OIG.

In response to comments regarding the service plan, SB 11 added a definition of "service plan" to KRS 194A.700(24). SB 11 also added language to KRS 194A.705(6)(b) that characterizes service plans as being designed to meet a resident's identified needs. Additionally, SB 11 added service plans to KRS 194A.717(1) by requiring ALCs to establish their own staffing levels based on each resident's lease agreement, functional needs assessment, and service plan. The proposed regulation therefore aligns with SB 11's requirement for ALCs to maintain a service plan for each resident.

As stated previously, Kentucky's long-term care association representatives told HWFS committee members last spring that they reviewed the rules and regulations of other states as they drafted SB 11 but they were heavily influenced by Minnesota's state laws governing ALCs. Likewise, the cabinet also researched other states' laws and modeled much of 902 KAR 20:480 on Minnesota's rules, adding key standards that were enacted by Minnesota's laws for ALCs but not included in SB 11. Therefore, the requirement for developing and implementing a staffing plan for determining staffing levels, including an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility is a reasonable standard. It requires that an ALC look at the make up of its residents and staff every six months since the mix of residents and their needs will change over time. The ALC should consider whether its staffing still fits the needs of the residents or if changes are warranted. The requirement is consistent with some other states' and mirrors the Minnesota rule in Section 144G.41, Subd. 1(11) in the following link: https://www.revisor.mn.gov/statutes/cite/144G.41

The proposed regulation's requirement for quality management is a reasonable standard similar to Minnesota's rules under Section 144G.42, Subd. 2: https://www.revisor.mn.gov/statutes/cite/144G/full#stat.144G.42. Moreover, formalizing internal quality management activities will help ALCs identify any corrective actions and system changes as necessary to ensure any insufficient services are corrected and regulatory compliance is maintained as well as ensure that evaluation of resident services, complaints, and other issues is ongoing.

The staffing plan and quality improvement plan are also required by KRS 216B.160(5) for all health facilities licensed under KRS Chapter 216B, which now includes ALCs because SB 11 added ALCs to the definition of "health facility" in KRS 216B.015(13). See Section 40 of SB 11: CHAPTER 20 (SB 11, Alvarado and others) (ky.gov)

The cabinet will not amend the regulation in response to the comments.

(a) Comment: Bailee Roberson, BeeHive Homes of Grayson County, submitted the following comments. In addition, Ms. Roberson presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: “In addition to not having the staff to carry out all required duties in the kitchen, we would not have the management staff to meet increased duties listed in the regulations. Prior to move in, the regulations require us to get a medical exam from the new resident, a medication list, their medical history, a list of allergies, and all records of communication pertinent to resident services (not sure what the limit of ‘ALL records’ may entail). We must then document significant changes in resident status (no longer just updating an FNA), retain resident records for six years after discharge in a secure location (when we currently are not required to keep them at all), and that we must now do a Service Plan for each resident while continuing to do Function Needs Assessments. Moreover, in the proposed regulations, management must evaluate staffing twice a year for appropriateness and to ensure staffing levels are sufficient to meet scheduled and reasonably foreseeable unscheduled needs of each resident as required by functional needs assessments and service plans—with that, who or what determines what a proper level of staffing is? Is there clear guidance for what qualifies as ‘appropriate’ listed anywhere in the regulations? What will be the deciding factor during a certification review to say whether our staffing is truly sufficient or not? A Quality Management Program is also proposed to be added to ALC, and it sounds rather similar to the Quality Assurance Committee that is mandated for SNFs. Management then has to maintain documentation from the Quality Management Program for at least two years, and it has to be available to the Officer Inspector General at the time of survey, investigation, or renewal. We only have about 2 to 3 management staff members at any given time in a facility of our size, and the added work in the increased regulations is not obtainable. Again, the cost of hiring the extra staff that would be required would be impossible for us.

Some of the things I am concerned about and have listed would be detrimental to small facilities in the state of Kentucky. Rent would be increased for residents so much in these small communities (if we were able to make these changes) that it would become impossible to remain a private pay entity and option for our older population. There are around 80-100 older people housed in BeeHives in Kentucky alone…not including other ‘mom and pop’ assisted livings like us. 80-100 older people would gradually become homeless with the passing of these proposed regulations. Many nursing homes and hospitals are already overrun and understaffed—where do they go?”

(b) Response: Please see the above response to Mary Nell Bouvier, also with BeeHive Homes of Kentucky, as both sets of comments are similar.

(a) Comment: Adam Bailey, Cedar Ridge Health Campus, Beth Blair, The Willows at Fritz Farm, Eric Bryant, Cooper Trail Senior Living, Rachel Dadisman, The Willows at Harrodsburg, Brittany Faucher, Shelby Farms Senior Living, Lindsey Foster, Walker’s Trail Senior Living, Sam Frazier, The Willows, Marty Hawkins, Glen Ridge

Health Campus, Matthew Jones, The Legacy at English Station, Mona Lisa McCubbins, Franciscan Health Care Center, Kara Meredith, The Springs at Stony Brook, G. Parker Moore, Westport Place Health Campus, Renee Moore, The Willows at Citation, and Kristi Noah, Forest Springs Health Campus, submitted the following comments: “The proposed dietary requirements are a concern. Personal care homes are a social model with residents who sign a lease agreement, just as if they were living in an apartment. Anyone can choose to move into a community. The model works very well. A resident should not have the burden of having to get a health and physical by a provider before moving in. Current apartment style personal care homes should have the choice to remain a PCH or to get an assisted living license.”

(b) Response: In response to the comments regarding dietary services and the medical examination, please see the above response to Mary Nell Bouvier, BeeHive Homes of Grayson County.

SB 11 created a new state law, KRS 194A.704, that requires apartment-style personal care homes to convert their licensure to an ALC.

(a) Comment: Rob Simpson and Amy Payne, Fern Terrace of Owensboro, submitted the following comments: “Fern Terrace of Owensboro, LLC is located in Owensboro. We are committed to providing high quality care and continually strive to do the best for the people we serve. When we developed our business model we knew from the beginning that we wanted to develop a social model environment for our clients with more space, more services and amenities, with less people. That is why we only have 36 apartments. We are also Kentucky’s oldest and largest personal care provider beginning in 1963 and serving over 400 mostly indigent and mentally ill residents.

Proposed regulation 902 KAR 20:480 (The filed regulation attempts to legislate by regulation in direct conflict with the express wording and intent of SB 11 as overwhelmingly enacted by the general assembly.)

With our company being in the Personal Care business primarily since its conception, (1963) and the Assisted Living business since 1997, I have been fortunate enough to be a part of the ebb and flow of our industry for over 30 years personally and it seems to me that the over regulation of a business model that was and still should be about resident choice and the right to stay independent as well as be able to age in place is being forgotten.

The whole idea of SB-11, at least my understanding is to clarify the difference between the traditional free standing personal care homes and the new assisted living apartment style personal care facilities, as well as strengthen our regulations on the much needed memory care population. We were told from the beginning that if we chose to stay with a social model that there would be very little change for our clients, after reading the proposed regulations, I see the social model mirroring PC

Regs in key areas like dining and charting, which is getting into basic health and health related services.

I applauded the fact that the state allowed representatives from our industry to participate in the process of SB-11 and would like to suggest that they invite us to the table on the regulatory side as well. A lot of the issues that we are pointing out are obvious to us on this side of the fence and can be worked through with proper representation.

I have personally spoken to some of my clients about the proposed changes and they are very excited to hear about some of the options that were listed in SB-11, but after reading the proposed regulatory changes in key areas will devastate the smaller market facilities due to either lack of skilled employees (RN's, LPN's, and KMA's) or the small size of the building with a smaller profit margin that can't afford to keep up with the SNF's and hospitals on wages and benefits."

(b) Response: In the long-term care associations' testimony before HWFS committee members last year, they said that they reviewed the rules and regulations of other states as they drafted SB 11 but they were heavily influenced by Minnesota's state laws governing ALCs. Likewise, the cabinet also researched other states' laws and modeled much of 902 KAR 20:480 on Minnesota's rules, adding key standards to the proposed regulation that were not included in SB 11. The proposed regulation is not more stringent that comparable states' ALC rules. Please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding staffing and certified medication aides.

(a) Comment: Theresa McFarlin, Chandler Senior Living, submitted the following comments regarding the requirement for assisted living communities to develop and implement a staffing plan: "This is not even a requirement for SNF's. Reputable communities assess staffing ratio's on an ongoing basis anyway. There's no magic number."

(b) Response: Long-term care industry representatives told HWFS committee members last year that they reviewed the rules and regulations of other states as they drafted SB 11 but they were heavily influenced by Minnesota's state laws governing ALCs. Likewise, the cabinet also researched other states' laws and modeled much of 902 KAR 20:480 on Minnesota's rules, adding key standards to the proposed regulation that were not included in SB 11.

Therefore, the requirement for developing and implementing a staffing plan for determining staffing levels, including an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility is a reasonable standard to expect from assisted living communities. It requires that an ALC look at the make up of its residents and staff every six months since the mix of residents and their needs will change over time. The ALC should consider whether its staffing still fits the needs of the residents or if changes are warranted. The requirement is consistent

with some other states' and it mirrors the Minnesota rule in Section 144G.41, Subd. 1(11) at the following link: https://www.revisor.mn.gov/statutes/cite/144G.41

(a) Comment: Joe Jurgenson, Crescent Place Assisted Living and Fairview Place Senior Living submitted the following written comments: "I appreciate the opportunity to provide comments on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' I am very concerned that the changes in this proposed rule would not only impact our assisted living communities and the residents we serve but thousands of Kentuckians who will no longer be able to afford private pay assisted living in Kentucky.

Currently, Kentucky is one of four states that has no Medicaid help when it comes to assisted living. That in and of itself speaks volumes. How can we be one of four states that has no Medicaid assisted living yet here we are promulgating regulations that will make it even harder for people to afford assisted living? We are going backwards, not forwards. Since we have no Medicaid help, if someone needs the services of an assisted living provider yet can't afford to write a personal check each month for $2,500+, then there is no place that the State of Kentucky has for that person. There is nowhere for them. If the person does not suffer from a severe mental illness, then they would not be appropriate for a specialized personal care home and if they do not have needs that would qualify them for skilled nursing then, there is no place for that Kentuckian to live. If these regulations go through, as written, they will put significant additional expenses onto the assisted living communities. Just having a CMT around the clock to perform medication services would cost a community in excess of $150,000 per year. Per the regs, it would require a community to have a CMT 24 hours a day, seven days a week, 365 days a year. That cost will get passed onto the current residents and potential residents. There is already a gap between those who can afford assisted living in Kentucky and those who can't. These regulations will only increase that gap by leaps and bounds. That regulation is unnecessary. Personal Care Homes have performed these services for decades with little adverse events. We can't take one isolated event and extrapolate that to cover all and come up with regulations like this. The requirement to have a CMT, or above, to deal with medication assistance is an unnecessary requirement and cost. If it's OK for unlicensed, or non-certified staff, to assist with medication administration for the indigent in personal care homes then one would think it's simultaneously OK for those with money in assisted living. Just because this population has enough money to cover private pay assisted living, does not mean it's OK for the state to impose higher costs on the assisted living residents just because they have money. In addition, finding CMTs in Kentucky has become extremely difficult. It was hard to find them across the state 15 years ago and it's really hard to find them now. If a community could not admit and keep people, simply because they can't find CMTs to hire, then that would be a tragic shame and go against everything this bill was intended to do, such as allowing Kentuckians to age in place as long as possible. So, to have a regulation requiring a segment of staff that hardly exists anymore and would add over $150,000 per year to a community's expenses is not the best way to move forward.

The additional expenses for the community that will get passed onto the customer is the first unintended consequence. The second unintended consequence of this regulation would be the potential loss of housing for so many people. Currently, there are hundreds, if not thousands, of Kentuckians who are living in an apartment style personal care home and getting the care they need from the staff the community hires. If the apartment style personal care homes are forced to change their license from a personal care home to an assisted living medical model yet will then need to hire staff that is unavailable, that individual will have no choice but to move. It's one thing to put the additional expense on the back of the individuals but it's an entirely different scenario to enact regulations that require staff that hardly exists in Kentucky. Finding KMA's has become extremely difficult over the past 10+ years and this is not a issue that can be solved over night or in a matter of months. It's taken us years to get to this point and it will take many years to correct this problem. If these communities are forced to hire certain staff to perform the same duties that they are doing today with unlicensed staff, and are unable to find that staff (forget about the cost of them), then that individual will be forced to move. They and the community will have no choice.

Our assisted living communities are located in Shelbyville and Carrollton, KY. We are committed to providing high quality care and continually strive to do the best for the people we serve. We have been providing assisted living services to this population for over 17 years. We see everyday how important our services are. We also see how so many of our clients barely get by month to month with the current costs. This regulation adds significant costs in several categories including staffing, dietary and TB testing. These homes already operate on an extremely thin margin and some struggle to break even each year. Just because the facilities look beautiful and provide great service does not mean they are rolling in dough. The expenses are very high to operate these communities at a top level.

Proposed regulation 902 KAR 20:480 violates KRS 13A.120, section 2(h) and (i). Certain provisions within the proposed regulation are not authorized by SB 11, which was passed by the Kentucky General Assembly during the 2022 regular session. Additionally, certain provisions of the proposed regulation modify the legislative intent of SB 11. Specifically, we are concerned with the following:

The intention of the regulation was to allow communities to choose what services they provide and to have the ability change with their client's needs. The regulations were written while ignoring the intention of SB 11. The two licensure categories goes against the law as written and again, only affects Kentuckians seeking this level of care. It's a hindrance to all Kentuckians. If the state wanted to solve the problem that this law is trying to solve then all they would have had to do was allow temporary conditions in personal care homes just like they're allowed in assisted living communities.

We also have concerns about the dietary requirements. One must keep in mind that

this is still a social model with residents who sign a lease agreement, just as if they were living in an apartment. Anyone can choose to move into a community. They should not have the burden of having to get a health and physical by a doctor before moving in. It's completely unnecessary. Current apartment style personal care homes should have the choice to remain a PCH or to get an assisted living license. They should not be forced to change if they don't want to. The current regulations allow for in-services to be done within the first 90 days of hire. I am not aware of issue related to this, therefore, we see the requirement to change that to 30 days as unnecessary. There are also too many situations in the regs where an RN would be required to oversee or observe other staff performing their duties. This is yet again, another significant cost that will get added to the facility expenses and passed onto the end consumer. There is also verbiage to move to a state-made functional needs assessment. There is no need for this. Each community has been using their own internal FNA since the advent of Kentucky assisted living and all has been fine. It's not broken, so there is no need to try and fix it. I have not heard anyone voice that they want a standard FNA, and in fact have heard the opposite.

We are passionate about the care we provide to our residents and if the Cabinet for Health and Family Services moves forward with the proposed regulation as drafted, we are concerned about the impact this would have on our ability to continue to operate and provide quality care to our residents."

(b) Response: The issues in the comments have been addressed in other sections. However, the cabinet will again respond as follows:

In response to the comment regarding Medicaid funding, ALCs initially established themselves in Kentucky as a private pay non-health care model for residents who are mostly independent except for needing some assistance with everyday tasks. Issues involving payment are beyond the OIG's scope of operations.

In response to the comments regarding registered nurses, the cabinet replaced "registered nurse" with "nurse" so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comment about medication aides, please refer to the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this matter.

In response to comments regarding current requirements for PCHs, it is important to note that KRS 194A.700(8)'s definition of "basic health and health-related services" for ALCs is similar but not identical to the description of "basic health and health related services" in the PCH regulation, 902 KAR 20:036, Section 4(1). The notable difference is that the ALC statute includes "administration of medications" under the definition of "basic health and health-related service" while Section 4(1) of the PCH regulation requires only the "supervision of self-administration of medications."

Beyond the requirement for "supervision of self-administration", the PCH regulation

contemplates additional health services such as medication administration because it requires controlled substances to be administered only by a nurse in accordance with 902 KAR 20:036, Section 4(1)(g)3.d.

Although the PCH regulation is silent on who can administer non-controlled medications, 902 KAR 20:036, Section 4(1)(j)1.a. requires PCHs that store and administer non-controlled substances in an emergency medication kit (EMK) to have licensed personnel as established by the Kentucky Board of Pharmacy's (KBP) regulation 201 KAR 2:370, Section 2(4)(i). Both the OIG and KBP regulations therefore recognize that staffing in a PCH should include a nurse if medication administration is taking place or otherwise delegated.

The cabinet further acknowledges that the conditions under which PCH staff may administer medications is potentially confusing. Therefore, the cabinet intends to collaborate in the future with KBN and stakeholders, including providers, on the addition of clarifying language consistent with nursing laws and practice as it relates to the delegation of nursing tasks in the PCH setting.

In response to the commenter's suggestion that "current apartment style personal care homes should have the choice to remain a PCH or to get an assisted living license", the long-term care associations responsible for drafting SB 11 submitted written comments stating that, "The purpose of SB 11 was to blend the two private-pay levels (assisted living and personal care) into one continuum of care." As such, SB 11 created a new statute (KRS 194A.704) that requires apartment-style PCHs to convert their licensure to ALC licensure. Based upon this statutory mandate, the cabinet does not have the flexibility to permit apartment-style PCHs to retain their PCH license after adoption of this administrative regulation.

Long-term care association representatives told HWFS committee members last year that they reviewed the rules and regulations of other states as they drafted SB 11 but they were heavily influenced by Minnesota's state laws governing ALCs. Likewise, the cabinet also researched other states' laws and modeled much of 902 KAR 20:480 on Minnesota's rules, adding key standards to the proposed regulation that were not included in SB 11. The proposed ALC regulation is not more stringent that what other states require for his level of care.

In response to the comments regarding tuberculosis (TB) testing for ALC staff and residents, SB 11 added ALCs to the definition of "long-term care facility" in KRS 216.510(1) and 216.535(1), and also added ALCs to the definition of "health facility" in KRS 216B.015(13). Because elderly individuals are more susceptible to contagious disease, ALCs will be subject to the same TB screening and testing requirements established for staff and residents of other long-term care settings regulated by the OIG.

In response to the comments regarding the licensure categories, please see the response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the

cabinet's rationale for three licensure levels, including why the tiered licensure structure does not violate KRS 13A.120 or interfere with a resident's ability to safely age in place to the extent that basic health services are needed.

In response to the comments regarding dietary services, the cabinet agrees to amend the regulation so that social model ALCs will continue to be subject to the current requirements as established by KRS 194A.705(1)(b) which require only that three meals and snacks be made available each day.

According to comments submitted by Kentucky's three long-term care associations who brought SB 11 forward, the associations sought to "blend the two private-pay levels (assisted living and personal care) into one continuum of care." Therefore, to ensure that apartment-style PCHs required by KRS 194A.704(1) to convert to ALCs adhere to the same dietary service standards as they do currently as well as require the same standards for ALCs-BH, the cabinet's inclusion of a section on dietary services in 902 KAR 20:480 mirrors the same requirements established in the PCH regulation, 902 KAR 20:036, Section 4(3)(c).

Additionally, although the PCH regulation requires that "modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician", the definition of "assisted living services" in KRS 194A.700(7)(f) refers to "modified diets ordered by a licensed health professional." Therefore, the cabinet will amend the ALC regulation to replace "physician" with "licensed health professional".

In response to the comments regarding the requirement for a medical examination, SB 11 amended KRS 216.765 to require "a medical examination that includes a medical history, physical examination, and diagnosis" prior to admission to a personal-care home or assisted living community.

Please refer to the section of this Statement of Consideration for the cabinet's response regarding the Functional Needs Assessment required by KRS 194A.703(6) and KRS 194.717(1).

(a) Comments: Mark Lee, Paragon, submitted the following comments. In addition, Mr. Lee presented verbal comments during the public hearing held on January 23, 2023, that are similar in nature to the following: "I own and operate assisted living, personal care, independent living, and adult day health care programs in Kentucky. I am an attorney licensed in three states including Kentucky and began practicing law in 1977. I am a Kentucky Executive Agency Lobbyist and Legislative Agent. I also provide consultation services to long-term care and senior housing providers throughout the Commonwealth, as well as provider associations. With others, I was actively involved in writing and advocating for Kentucky's initial assisted living statute, KRS 194A.700-194A.729, enacted in 2000. Similarly, I was very involved with writing and advocating for House Bill 444, which was passed without a dissenting vote by the General Assembly in 2010, permitting assisted living

communities to provide additional services to residents. Working with Coalition Partners, comprised of KY Senior Living Assn. (KSLA), KY Assn. of Health Care Facilities (KAHCF)/KY Center for Assisted Living (KCAL), and LeadingAge Kentucky, I actively participated in developing, writing, testifying, and lobbying for Senate Bill 11 which was passed during the 2022 regular session 30-2 by the Senate, and 94-0 by the House.

The Cabinet for Health and Family Services (CHFS) was involved with Coalition Partners during the lengthy, intentional development of Senate Bill 11. Some of the dates and individuals involved in the meetings are listed below:

September 9, 2019	CHFS Inspector General Steve Davis
February 11, 2020	CHFS Secretary Eric Friedlander and Kelli Rodman, Executive Director of CHFS Office of Regulatory Affairs
February 11, 2020	Inspector General Adam Mather and staff
March 4, 2020	Inspector General Adam Mather
August 31, 2021	Dr. Keith Knapp, Senior Advisor on Adult Programs, Office of the Secretary, CHFS and Kelli Rodman, Executive Director of CHFS Office of Regulatory Affairs (Rodman in person; Knapp via Zoom)
January 27, 2022	Inspector General Adam Mather (telephone)

The cabinet did not testify concerning Senate Bill 11 at any point during the legislative process.

The cabinet verbally and via emails assured Coalition Partners publicly and privately that the group would be at the table to collaboratively develop the regulation. On April 21, 2022, Coalition Partners told the cabinet it was ready to work on the regulation with the cabinet. In response to repeated attempts by the Coalition during Spring and Summer of 2022 to start the promised collaborative process, the cabinet indicated that the Coalition would be involved when the cabinet was ready to work on the regulation. As late as August 11, 2022, an email from the cabinet stated that Coalition Partners would be ‘included when we start discussions.’ The next related communication to Coalition Partners from the cabinet was a September 28, 2022 email with the fully developed regulation attached.

There are nearly two dozen problems with the filed regulation. Coalition Partners addressed each issue when it laboriously prepared and provided to the cabinet a proposed alternate regulation within thirteen days of the draft regulation being emailed to the Coalition for review on September 28, 2022. The alternate regulation addressed each of the concerns the Coalition had, from minor to major.

On October 13, 2022 a three-hour Zoom meeting was held during which Coalition Partners conveyed highly detailed grave concerns about the proposed regulation to the Inspector General and others from CHFS. The alternate regulation Coalition Partners prepared and emailed to the cabinet prior to the Zoom meeting was also

discussed. On November 3, without further substantive communication with the provider associations comprising Coalition Partners that represent the entire long-term care continuum, the cabinet filed 902 KAR 20:480, virtually unchanged from the original draft document emailed to Coalition Partners on September 28.

While the cabinet owes no legal duty to consult with any outside group or to provide an opportunity to review a draft copy of a regulation in advance of its filing, the cabinet in 2000 and 2010 invited provider groups to the table to assist with the development of the assisted living regulations. I was very involved in that work with the cabinet both times, and the lengthy and significant mutual effort was very productive and worthwhile, resulting in workable regulations that aligned with and reflected the associated statutes and were embraced and understood by the cabinet and providers. I anticipated the same collegial, collaborative process after the General Assembly overwhelmingly passed Senate Bill 11, largely because such an approach was promised publicly on April 21, 2022 by a key representative of the cabinet before nearly 100 attendees of an annual provider association conference. To my disappointment, the cabinet did not fulfill its promise to work collaboratively. Yet my strong opposition to the filed regulation is for other critical reasons.

If the regulation as filed is allowed to be implemented, irreparable harm will be suffered by thousands of current and future residents of assisted living communities across the Commonwealth. The regulation also violates KRS 13A.120.

In pertinent part, KRS 13A.120(2) reads as follows:

‘An administrative body shall not promulgate administrative regulations:

(d) When the administrative body is not authorized by statute to regulate that particular matter;
(e) When a statute prescribes the same or similar procedure for the matter regulated;
(f) When a statute sets forth a comprehensive scheme of regulation of the particular matter;
(g) On any matter that is not clearly within the jurisdiction of the administrative body;
(h) On any matter that is beyond the statutory authorization of the administrative body to promulgate administrative regulations or that is not clearly authorized by statute; and
(i) That modify or vitiate a statute or its intent.’

KRS 13A.120(4) states, ‘Any administrative regulation in violation of this section or the spirit thereof is null, void, and unenforceable.’

902 KAR 20:480 as filed by the Cabinet for Health and Family Services attempts to legislate by regulation, as numerous sections of 902 KAR 20:480 are in direct conflict with the statutes to which the filed regulation relates. Despite the cabinet not testifying during the legislative process, the regulation appears to attempt to

circumvent and defeat several of the most essential components of Senate Bill 11, thereby attempting to supplant and negate the will and exclusive jurisdiction of Kentucky's General Assembly. As a result, the filed regulation is fatally flawed and clearly violates KRS 13A.120 by modifying or vitiating the wording or intent of the related statutes.

What makes this more egregious as a usurpation of the General Assembly's authority is that the obvious conflicts between the regulation and related statutes were pointed out to cabinet leadership in writing, and subsequently during a three-hour virtual meeting with the Inspector General and his staff on October 13, 2022, three weeks before 902 KAR 20:480 was filed.

KRS 194A.710(2), as amended by Senate Bill 11, mandates: 'The following categories are established for assisted living community licensure: (a) An assisted living community license for any assisted living community without a secured dementia care unit; and (b) An assisted living community with dementia care license for an assisted living community that provides assisted living services and dementia care services in a secured dementia care unit.' The statutory language passed overwhelmingly by the legislature cannot be misunderstood. There are two licensure categories, specifically and intentionally designed to allow for and promote safe aging in place, utilizing a continuum of care approach. I testified along with Senator Ralph Alvarado, the sponsor of Senate Bill 11, before the Interim Joint Committee for Health, Welfare, and Family Services in 2021, and again before the Senate Health and Welfare Committee and the House Health and Family Services Committee in 2022. That testimony emphasized that Senate Bill 11 intentionally established one assisted living license for all operations that do not have a secured dementia care unit so that care delivered in residents' apartments could change in acuity as appropriate to meet the evolving needs of the residents.

Section 2 of the filed regulation would create three assisted living licenses. One license would be for an assisted living community (ALC) that has a secured dementia care unit. The other two licenses would be for ALCs that do not have a secured dementia care unit. Under this proposed regulatory scheme that is in direct conflict with the clear expression of the General Assembly as described in the foregoing paragraph, a provider would be forced to choose between delivering basic health services (thereby receiving a basic health services license) or not delivering basic health services (receiving a social model license). Not only is this proposed licensing structure in direct conflict with that established by the statute, it would defeat a core goal and intention of the General Assembly when it overwhelmingly passed Senate Bill 11: permitting and encouraging safe aging in place of assisted living residents in their apartments by allowing a continuum of care under one license to be delivered to meet the advancing needs of residents, so long as skilled nursing or a secured dementia care unit are not required.

There are additional provisions of 902 KAR 20:480 that would significantly harm the thousands of Kentucky citizens who reside in assisted living communities, as well

as the providers who care for them, potentially limiting access to much needed services. Other provisions of the filed regulation conflict with statute. Still others exceed the jurisdiction and authority of the cabinet or are not authorized by statute, once again violating KRS 13A.120. Some of these provisions are:

Section 7(2)(k)2 would require staffing to meet scheduled and "*reasonably foreseeable unscheduled needs*" of residents. The related statute, KRS 194A.717 states: "Staffing in an assisted living community shall be sufficient in number and qualification to meet the twenty-four (24) hour *scheduled* needs of each resident pursuant to the lease agreement, functional needs assessment, and service plan." The filed regulation would unlawfully modify and expand the express language and intent of the related and controlling statute.

Section 14(3)(b) would require "at least one staff person shall be awake and on-site at all times at each licensed entity *or building on the same campus for two (2) or more buildings operated by the same licensee.*" KRS 194A.717 as amended by Senate Bill 11 in 2022 provides: "One awake staff member shall be on site at each licensed entity at all times." Once again, the filed regulation would unlawfully modify and expand the express language and intent of the related and controlling statute.

Section 14 requires a registered nurse in situations when they are not required by the Nurse Practice Act or the Kentucky Board of Nursing, the governmental entity with jurisdiction over supervision and delegation by licensed personnel to non-licensed staff. This mandate unauthorized by current law and in conflict with the governmental agency with jurisdiction would drive costs ever higher during a severe shortage of registered nurses, would result in higher costs for residents, and would not increase their safety and protection. Once again, this section of the filed regulation violates KRS 13A.120.

Section 15 limits medication administration duties to nurses or staff members who have completed the Kentucky medication aide training program. This exceeds any provision of the Nurse Practice Act or requirement of the KY Board of Nursing. Further, there is no such requirement in licensed Personal Care or higher levels of care. This constitutes an invasion of Kentucky Board of Nursing jurisdiction and conflicts with existing law, thereby violating KRS 13A.120. Additionally, it is wholly unworkable. There are only two locations in the Commonwealth where the medication aide training program is offered, with no site located in the western half of the state. Consequently, the ability to hire certified medication aides is virtually nonexistent. This would result in providers having to hire only nurses to perform all aspects of medication administration. Not only is there a severe shortage of nurses currently, but the significantly higher cost would undoubtedly result in much higher costs being borne by Kentucky's elderly, that are already shouldering the entire cost of meeting their needs in assisted living communities with no financial assistance from state or federal government.

Section 15 also imposes significantly more requirements related to medication management than in current Personal Care regulations which have been in effect in excess of thirty years. Pursuant to Senate Bill 11, private-pay, apartment-style Personal Care and private-pay assisted living are merged to henceforth be known and licensed as assisted living communities in order to reduce consumer confusion. The permitted level of care is basic health services, which is the same as that which is currently permitted in Personal Care facilities. It makes no sense to impose significant additional requirements on assisted living communities that have not ever been imposed on Personal Care facilities. These additional burdens provide no additional protection for residents and will result in higher costs borne solely by the residents, resulting in a restriction of access to needed services. This will only increase demand for higher levels of care that are largely funded by the state and federal governments.

Section 19 would require that all providers utilize a specific functional needs assessment (FNA) form incorporated into the regulation. The incorporated FNA clearly was not created with operational realities in mind, and would have negative consequences for residents. Additionally, KRS 194A.705(6) as amended by Senate Bill 11 is clear that providers may design and utilize their own FNA form so long las it “pertains to the resident’s ability to perform activities of daily living and instrumental activities of daily living.” Specific wording included in Senate Bill 11 added the provision that providers could address “any other topics the assisted living community determines to be necessary.” It is obvious that the legislature intended for providers to have the ability to design their own document to best assess their residents, so long as it assessed for the required criteria set forth in the statute. Again, this section of the filed regulation violates KRS 13A.120 due to the conflict with statute.

I am at a loss to understand the rationale for the cabinet’s approach and attitude. Assisted living is governed by leases and landlord/tenant law, is wholly paid for by elderly residents, and receives no government funding. Had assisted living communities not earned a reputation for excellent care with strong support from the public during the first decade following passage of Kentucky’s initial assisted living statute, I seriously doubt that the General Assembly would have voted for House Bill 444 in 2010 without one dissenting vote in either chamber. Had assisted living communities’ excellent reputation with strong public support not continued during the second decade, surely the General Assembly would not have passed Senate Bill 11 in 2022 with only two dissenting votes out of 126 total votes cast in both chambers. The vast majority of assisted living communities enjoy excellent reputations as places that are safe and where their residents have choices, thereby preserving their dignity. They care for people who frequently would be at risk if they were still living alone, but are entirely appropriate in an assisted living community.

If implemented, my concern is that the filed regulation will cause many individuals

living safely in assisted living communities to have to move to nursing facilities, when the intent of Senate Bill 11 was exactly the opposite. The personal and financial cost of displacing these older citizens will be significant and detrimental. It will also strain the state budget by forcing more elderly persons unnecessarily into nursing beds when they were choosing to safely live in assisted living communities for which they were paying privately.

I fail to see how the proposed regulation, 902 KAR 20:480, does not violate the prohibitions set forth in KRS 13A.120. I urge the cabinet to permissively withdraw 902 KAR 20:480 in its entirety pursuant to KRS 13A.310. Further work must be done to create a regulation that aligns with the express wording and intent of the statutory provisions created and amended by Senate Bill 11, and one that does not harm older citizens of this Commonwealth in contravention of the clear and overwhelming expression of the General Assembly."

In addition to Mark Lee's comments, Maria Lee of Paragon of Madisonville, submitted the following : "The regulation is unenforceable pursuant to KRS 13A.120 because numerous sections conflict with basic tenets of related statutes.

- Mandates three assisted living licenses, rather than two as specifically prescribed by KRS 194A.710, as amended by Senate Bill 11
- Numerous sections exceed authority of the cabinet by attempting to regulate matters within the exclusive jurisdiction of KY Board of Nursing and conflict with KRS Chapter 314

The regulation is bad public policy that will harm Kentuckians because it would:

- Defeat a core element of Senate Bill 11 that was intended to encourage safe aging in place
- Increase state budget costs by unnecessarily forcing private-pay residents to prematurely move to nursing beds
- Raise resident costs by unnecessarily requiring registered nurses and certified medication aides during a severe staffing shortage with no resulting increase in resident safety
- Reduces resident choice and limits resident access to much needed services

I encourage the Cabinet for Health and Family Services to withdraw this regulation as it is fundamentally flawed. If not withdrawn, absent a total re-write I will add my voice to many others in urging the Administrative Regulation Review Subcommittee to find the regulation deficient."

(b) Response: In response to the comments, Kentucky's long-term care associations and Mr. Lee, as the principal author of SB 11, first sought input from the cabinet on the draft legislation on August 31, 2021. This was after the associations had reportedly spent two years drafting the proposal and had already submitted it to the Legislative Research Commission in anticipation of prefiling the bill.

Although the cabinet was not invited to participate in development of the legislation until receiving the jacketed copy of the bill which was prefiled on October 13th, cabinet staff met with long-term care representatives on October 21, 2021, and sent a follow-up letter on November 8, 2021, identifying several areas of concern, most of which were not addressed by changes to the bill. The long-term care associations did not make the following changes to BR 137 (SB 11):

SB 11 weakens the OIG's enforcement role as follows:

KRS 194A.722(11) and KRS 216.597(7)(b): Under these statutes, the cabinet can only conduct additional on-site visits of ALCs, PCHs, and specialized PCHs if "the cabinet has reasonable cause to believe the [facility] is not in compliance". This narrow restriction introduces uncertainty about which follow-up visits and complaint investigations are supported by reasonable cause and further appears to conflict with KRS 216B.042(2), which establishes the cabinet's authority to enter upon the premises of any health facility, including ALCs, for purposes of inspection.

In addition, KRS 216.597(7)(b) weakens the existing standard for PCHs and specialized PCHs as the cabinet does not currently have to meet an a particular legal threshold to enter a facility to conduct follow-up inspections or otherwise investigate a complaint.

SB 11's standards for ALCs are significantly more lenient than requirements for other long-term care facilities as described below:

1. KRS 194A.717: SB 11 retained the minimal qualifications for ALC administrators (high school diploma or equivalent) even though most ALCs will begin providing health care services in their facilities. Moreover, many facilities already have or will have secure dementia care units in which case the delivery of basic health and health-related services are mandatory.
2. KRS 216A.030: Although SB 11 added ALCs to the statutory definition of "long-term care facility (LTCF)", the legislation exempts ALCs from the requirement that LTCFs operate under the supervision of a licensed LTC administrator. It is important to note that "nursing home administrator" changed to "LTC administrator" years ago in recognition of how the LTC industry has evolved and in acknowledgment of efforts to allow residents in settings like ALCs to age in place rather than transfer to a nursing facility. Although ALCs may not be required to employ a licensed LTC administrator, ALC managers hired after the transition to the health care model is complete should be subject to enhanced qualifications. See above comment.
3. KRS 216.557-216.577: SB 11 exempts ALCs from the Type A and B violation statutes currently applicable to other LTCFs, thereby resulting in significantly lower fines for ALCs than for other levels of long-term care

including specialized personal care homes and family care homes.

4. KRS 194A.719: SB11 retained language that allows CPR training to be optional. To ensure resident safety, the cabinet recommended that each direct care staff member have current CPR and first aid certification. This is a reasonable and common sense requirement for direct care staff working in a facility with aging residents with healthcare needs, yet the long term care associations declined to make this change. It is also important to note that other levels of care regulated by the OIG such as child day care centers are required to have all of their staff members trained in first aid and CPR, see 922 KAR 2:120, Section 7(8).

Additional Issues:

1. KRS 194A.719: The cabinet advised the long-term care associations that it supported the Alzheimer's Association's concerns that the training requirements are insufficient because a minimum number of annual in-service hours was not established.
2. KRS 194A.7061: Subsection (5) of this statute limits the inspection of an existing secured dementia unit that is part of a certified ALC or licensed PCH seeking to convert its licensure status to an ALC-DC by restricting the survey to ensuring compliance with the physical environmental requirements only. The statute does not allow the cabinet to conduct a full licensure inspection to ensure compliance with health and safety standards.

Although the above concerns were not addressed, the cabinet did not testify against SB 11 as noted in the comments. During the drafting phase of the new regulation, the cabinet sought input from the long-term care associations prior to filing it with the Legislative Research Commission. During a three-hour Zoom meeting held on October 13, 2022, the cabinet considered their feedback in addition to the associations' marked-up copy of the draft regulation before filing the final proposal on November 3, 2022.

Although the issues raised in the comments have been addressed in other sections, the cabinet will repeat its response as follows to each item in the order in which they are presented in the comment.

In accordance with the 2022 passage of SB 11, the cabinet filed 902 KAR 20:480 to replace the current structure of certification for social model assisted living communities (ALC) with a new framework that will allow ALCs to seek licensure to continue providing social model services, optional basic health and health-related services, or maintain secure dementia care units in which case the delivery of basic health services will be mandatory.

The overall goal of allowing ALC residents to age in place to the extent that they require basic health and health-related services is a shared goal of the cabinet and Kentucky's three long-term care associations. However, in response to the

commenter's assertion that 902 KAR 20:480 conflicts with the express wording and intent of SB 11 by creating three licensure categories, the cabinet disagrees.

The cabinet is authorized to regulate health facilities and establish licensure classifications pursuant to statute. KRS 216B.042(1)(c) not only grants clear statutory authority regarding licensure classification and safety standards, it makes it the responsibility of the cabinet to:

> Establish licensure standards and procedures "to ensure safe, adequate, and efficient . . . health facilities . . ."; and
> Establish ". . . classification of health facilities and health services according to type, size, range of services, and level of care. . ."

Given that SB 11 added ALCs to the definition of "health facility" in KRS 216B.015(13), the cabinet has clear authority under KRS 216B.042(1)(c) to establish appropriate licensure and classification standards for ALCs just as the cabinet has long had the authority through administrative regulation to create licensure levels to fit the services provided. There are at least 40 different categories of health facilities that the cabinet licenses and many of those classifications are created by regulation and are not prescribed anywhere in the statutes.

Although the existing statutory language enacted by SB 11 prescribes two categories, it does not limit the cabinet's authority to create additional categories.

The regulation creates the two categories that were prescribed, but also creates the social model category to allow providers that choose not to offer basic health services to be licensed in a category that is consistent with the more limited services they provide. As stated above, it is within the cabinet's authority and responsibility to establish classification of health facilities according to "type, size, range of services, and level of care" as prescribed by KRS 216B.042(1)(c).

Last spring, Mr. Lee told members of the Health, Welfare, and Family Services (HWFS) committee that ALCs would be allowed to retain their social model status rather than transition to a basic health care model. Additionally, the bill's sponsor, Sen. Ralph Alvarado, testified before committee as the bill moved through the House that any ALC that wished to remain a social model would be able to do so and would not be required to add services. The cabinet's Department for Aging and Independent Living staff also report that they have heard from several ALC providers who have expressed their interest in remaining a social model facility. Adding the third category will benefit those providers who wish to remain a social model by reducing the number of regulatory requirements they will need to follow and it will help reduce consumer confusion and ensure appropriate marketing.

The three-tiered licensure structure will not interfere with a resident's ability to safely age in place to the extent that basic health services are needed or in situations in which a resident experiences a "temporary condition" as defined by KRS

194A.700(26). If an ALC intends to provide services to a mix of residents on the same campus who need social model assisted living services as well as residents who need basic health and health-related services, the ALC must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time.

The cabinet will not amend the regulation in response to the comments and would further like to address concerns the cabinet has heard from family members, including Sean McElroy who spoke during the public hearing on January 23, 2023, regarding recent rate increases. Mr. McElroy testified that the ALC where his mother resides has already begun charging residents increased fees citing the delivery of health services under SB 11 as justification for the increases. It is important to remind providers that converting to a health care model is premature at this time because there is no mechanism in place for ALCs to seek licensure from the OIG to provide basic health and health-related services until 902 KAR 20:480 is fully implemented.

In response to the comment that Section 7(2)(k)2 conflicts with Section 14(3)(a), it is important to note that there is no subparagraph 2 under Section 7(2)(k). Presumably, the commenter meant to cross-reference Section 7(2)(j)2. This is the section that requires ALCs to “ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident’s functional needs assessments and service plans on a twenty-four (24) hour per day basis.” It is important to note that the proposed requirement aligns with the same requirement in the Minnesota statute, Section 144G.41, Subd. 1(11)(ii): https://www.revisor.mn.gov/statutes/cite/144G.41.

In response to the commenter’s assertion the above requirement conflicts with Section 14(3)(a), the key phrase is “reasonably foreseeable”. The expectation is not to staff for every possible scenario. But, if a resident’s care needs have increased and they are requesting assistance more often than previously, then a reasonably foreseeable unscheduled need may be to staff for the ability to conduct more frequent safety checks on the resident. It is within the cabinet’s authority under KRS 216B.042(1) to establish a safety standard like the one proposed by Section 7(2)(j)2, especially given that neither the law nor regulation establish staff-to-resident ratios.

In response to the comments regarding Section 14(3)(b), this section of the regulation refers to KRS 194A.717(2) which requires only one awake staff member to be on site at each licensed entity at all times. However, the law overlooks an important safety standard for ALCs that have more than one building on campus. Licensees should ensure sufficient staffing in each building at all times, including during nighttime hours to respond promptly and effectively to individual resident emergencies. Moreover, KRS 194A.717(2) is less stringent that the PCH regulation’s staffing requirement in 902 KAR 20:036, Section 3(8)(j) that requires “no less than one (1) staff member shall be awake and on duty on each floor in the

facility at all times."

Given that KRS 194A.704 requires apartment-style PCHs to convert their licensure to ALC licensure, the cabinet believes that PCHs should continue to comply with the same staffing levels as they do currently rather than be held to the weaker standard established by KRS 194A.717(2), which does not guarantee resident safety.

The cabinet will therefore retain the proposed requirement in 902 KAR 20:480, Section 14(3)(b) for at least one staff person to be awake and on-site at all times at each licensed entity *or* in each building on the same campus if two or more buildings are operated by the licensee.

The cabinet replaced "registered nurse" with "nurse" throughout the body of the regulation so that a licensed practical nurse may provide services and delegate nursing tasks in an ALC-BH or ALC-DC.

In response to the comments regarding the delegation of medication administration to unlicensed personnel as well as concerns regarding the availability of training for certified medication aides, the cabinet contacted KBN and discussed these issues during a Teams meeting held on January 26, 2023.

KBN reported that a workgroup is currently reviewing issues related to the delegation of nursing tasks, including medication administration. KBN also indicated that they are aware of limited opportunities to sufficiently meet the demand for training unlicensed personnel on medication administration. However, both KBN and the cabinet agree about the importance of ensuring unlicensed personnel are properly educated and competency evaluated prior to administering medications to elderly residents.

In response to KBN's recommendations on this matter, the cabinet will amend Section 15(7)(a) as follows by replacing the requirement for completion of the Kentucky medication aide training program with a requirement for any unlicensed personnel who administers medication to be certified as a medication aide or have successfully completed medication aide training accepted by KBN:

> (7) Delegation of medication administration.
> **(a)** Unlicensed personnel **who meet the requirements of subparagraph 1. of this paragraph** may only administer oral or topical medication**, or preloaded injectable insulin** if delegated to them by a **nurse or appropriate** licensed health **[~~care~~]** professional. If medication **administration** is delegated to unlicensed personnel, the ALC-BH or ALC-DC shall ensure that the **[~~registered~~]** nurse or licensed health **[~~care~~]** professional has:
> **1. [~~(a)~~]** Delegated medication administration to a staff person who**:**
> **a. Is a certified medication aide; or**

b. Has **[~~: 1.~~]** successfully completed **a:**
i. [~~the Kentucky~~] Medication aide training program **accepted by the Kentucky Board of Nursing (KBN)**; and
ii. Skills competency evaluation;
2. [~~Demonstrated the ability to competently follow the procedures; (b) Instructed the unlicensed personnel in the proper methods to administer oral or topical medications;~~
~~(c)~~]) Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and
3. [~~(d)~~] Communicated with the unlicensed personnel about the individual needs of the resident**.**

This change will help ensure that unlicensed personnel are competent to administer medications and not restricted only to training offered by the Kentucky Community and Technical College System. In addition, this change expands upon what medication aides will be able to do in long-term care settings by allowing certified medication aides to administer preloaded injectable insulin in addition to oral or topical medications.

Upon adoption of this change in 902 KAR 20:480, the cabinet will amend other long-term care facility regulations under 902 KAR Chapter 20 to align with the above change.

As it relates to comparisons between ALCs and personal care homes (PCH), there is an important difference between the two categories. Please note that the definition in KRS 194A.700(8) of “basic health and health-related services” for ALCs is similar but not identical to the description of “basic health and health related services” in the PCH regulation, 902 KAR 20:036, Section 4(1). Although the ALC statute includes “administration of medications” under the definition of “basic health and health-related service”, Section 4(1) of the PCH regulation requires only the “supervision of self-administration of medications.”

Beyond the requirement for “supervision of self-administration”, the PCH regulation contemplates additional health services such as medication administration because it requires controlled substances to be administered only by a nurse in accordance with 902 KAR 20:036, Section 4(1)(g)3.d.

Although the PCH regulation is silent on who can administer non-controlled medications, 902 KAR 20:036, Section 4(1)(j)1.a. requires PCHs that store and administer non-controlled substances in an emergency medication kit (EMK) to have licensed personnel as established by the Kentucky Board of Pharmacy’s (KBP) regulation 201 KAR 2:370, Section 2(4)(i). Both the OIG and KBP regulations therefore recognize that staffing in a PCH should include a nurse if medication administration is taking place or otherwise being delegated.

The cabinet acknowledges that the conditions under which PCH staff may

administer medications is potentially confusing. Therefore, the cabinet intends to collaborate in the future with KBN and stakeholders, including providers, on the addition of clarifying language consistent with nursing laws and practice as it relates to the delegation of nursing tasks in the PCH setting.

Long-term care association members told HWFS committee members last spring that they were heavily influenced by Minnesota's state laws governing ALCs when they drafted SB 11. This is evidenced by the fact that SB 11 created a definition of "assisted living services" (which includes medication management in its list of services) and a separate definition of "medication management" that is similar to Minnesota's definition of both terms, see Section 144G.08, Subd. 9 and Subd. 39: https://www.revisor.mn.gov/statutes/cite/144G.08.

However, unlike Minnesota's state laws, SB 11 does not include any requirements related to medication management other than the above definitions and a requirement in KRS 194A.708(1)(d) for ALCs-DC to develop and implement policies and procedures that address medication management pursuant to orders from a resident's health care practitioner. Because SB 11 did not include any relevant standards, the cabinet added Section 15, Medication management, to the proposed ALC regulation which is similar to Minnesota's rules for medication management under Section 144G.71: https://www.revisor.mn.gov/statutes/2021/cite/144G.71.

SB 11 does not include any requirements related to medication management other than the above definitions and a requirement in KRS 194A.708(1)(d) for ALCs-DC to develop and implement policies and procedures that address medication management pursuant to orders from a resident's health care practitioner. It is typical for a statute to establish a framework of requirements and for an associated regulation to implement those requirements in more detail. The cabinet added Section 15, Medication management, to the proposed ALC regulation which is similar to Minnesota's rules for medication management under Section 144G.71: https://www.revisor.mn.gov/statutes/2021/cite/144G.71.

In addition, at the request of the long-term care associations in their marked-up version of the regulation, the cabinet added Section 15(21) and (22) to mirror the personal care home regulation's language under 902 KAR 20:036, Section 4(1)(g) and (j).

Please see the cabinet's response in section on the Functional Needs Assessment.

(a) Comment: Tracey Javid, Pleasant Meadow Assisted Living, submitted the following comments: "To understand our perspective, it is important to know that my husband and I are the sole owners of two small AL communities: Our Lexington community opened in June 2014 and has 15 rooms; our Frankfort location opened September 2016 with 19 rooms. We provide all-inclusive care and do not add care levels for assistance like others do. This allows us to offer a consistent rate to our residents and make it more affordable for them. We intend to remain as a social model and as

a social model we feel we will continue to meet a very real need for 24/7 affordable care that does not require the medical component and the higher cost of that model. Many of our residents can barely afford to live with us due to their fixed incomes, but they very much need to live in our community based on their various needs. Most residents move in with us not only to assist with ADL's but often for the following reasons: regular, nutritious meals, safety and security, increased socialization and stable medication reminders.

Furthermore we are choosing to remain as a social model, not only to fill an affordable, yet high quality care niche for seniors, but also due mainly to two concerns: 1) the proposed licensed staffing requirements which would be very difficult for us as a small, two community business to build in to our rate and to even hope to compete with other communities to staff for, and 2) the increased insurance liability we would have to carry for becoming a AL-BH that would cause our rates to have to raise significantly. We've looked in to that multiple times before and see that level of insurance to be cost-prohibitive for us.

After carefully reviewing the SB11 regulations, we see that ultimately all these added administrative tasks and paperwork, along with other requirements outlined in the below letter, will drive up our current costs even higher. As small business owners, we work hard to maintain and still offer the best quality of life possible for the residents we have been entrusted with. Our residents and their families cannot afford any more increased costs for the same level of care they have currently been receiving. We work really hard to combat the ever-increasing cost of food in order to offer highly quality, nutritive meals, the increased costs of labor to provide loving, dedicated staff and other costs – so adding "non-resident care" work on our staff and our budget would cause us to most probably have to hire more staff to meet these proposed regulations – driving up our costs and in turn, pushing up our residents rates.

Our goal for our residents is to be an atmosphere where it 'feels like home' and is run like home. All these added administrative tasks, postings, charts, reports, etc. create a sterile, and very skilled care-type environment that we fight not to emulate. Behind the scenes we have always met all the DAIL requirements and continue to operate very efficiently. We are happy to say we have a great reputation based on offering high quality and affordable care over the years and we ask 'why change that' and bring in all these regulations if we are choosing to stay the social model. Though many of the proposed changes are good, we know that we self-manage our processes and 'police' our communities without all the added paperwork that has been proposed that will be inspected and regulated by the OIG. In other words, we have been successful, so why add layers of we what feel is unnecessary work that would require hours and hours of added tasks and be a burden to all levels of our staff. We want to focus on resident care, not extra paperwork.

There are many items in SB11 that cause us concern and will cause an 'overhaul' to more of a daily document-driven business and less of a people-focused community.

The result of what appears to be like a mini skilled-care community.

The remainder of this letter calls out what we feel are the highlights of our concerns of SB11. These concerns are the following:

1. Proposed FNA – we do not oppose changing to a standardized FNA. Actually ours goes into more detail in relation to specific AL and IADL needs and potential levels of dementia. We use our detailed FNA to create our Resident Care Plan for our staff. Our comment focuses on exclusion question #5 which is about dementia. We have accepted residents that have 'left their residence and become lost or disoriented'. This reason could be rectified by diagnosing and treating an urinary tract infections or dehydration, both of which mimic dementia and are treatable. Also a person could need to start on a dementia medication that could arrest and resolve that issue. Sometimes dementia-type symptoms fluctuate. The majority of all of our residents have often moved in with mild dementia and many are on medication for it. Some have lived with us for many, many years and though their dementia is stable or maybe somewhat increased, they are happy and active, they know us, their neighbors, function very well, and very importantly, they are not exit-seeking, not 'a danger to self or others' and know how to evacuate in case of any emergency. We train our staff at orientation and again annually to recognize and understand dementia. We have the experience to recognize when an individual needs to move on to dementia care. I would like to see question #5 re-worded or eliminated since question 4 asks the question in a similar way).

2. Page 11, Section 7, line 6 - about requiring a medical examination before admission. Being a social model, this has never been required and we do not see the need for this new requirement. The FNA, combined with our current admission paperwork asks questions about current diagnoses and the family and resident provide us the baseline and history of what we need to know to provide care.

3. Page 12, Section 7, line 17 – discusses utilizing "a person-centered planning and services delivery process", but we don't see any additional detail or information about this particularly worded item and question what the expectation is.

4. Page 13; Section 7, line 10-11 - regarding "develop and implement a staffing plan that includes an evaluation conducted at least twice a year…". We question what kind of detailed paper trail is requested or needed here. We are constantly looking at our staffing level and don't feel we need any documented evaluation of this sort. We are not a skilled care community (that we often hear are) understaffed with one person caring for multitudes. We have been inspected by DAIL in the past as being perfectly sufficient with our staffing, plus as private pay if we did not staff adequately, we would not be able to maintain our standards and our residents would move elsewhere.

5. Page 13, Section 7, line 12-14 - This section pertains to ‘sufficient staffing’ and is there enough “to meet scheduled and reasonably foreseeable unscheduled needs…” This wording of “foreseeable unscheduled needs” appears to place more regulation on what level of staffing we have very successfully been managing and providing already. We question why the need to change this wording (Note: we found similar yet conflicting wording about meeting scheduled needs, so this is confusing).

6. Page 13, Section 7, line 22 through page 14, lines 1-3 – this outlines that we at ‘the request of the resident, provide directly or assist with arranging transportation’ to a medical appointments, shopping and recreation. We do assist with this but only when the family is not available or able to assist. As AL, our families can easily assist our residents with all planning and even transporting if needed. We don’t believe this needs to be outlined nor directed as our responsibility. Our overarching goal is to assist the resident with things they cannot do for themselves. By taking this on ourselves and not passing to the family, this could take a great deal of time from our day where we should be caring for other residents’ ADL needs, etc. We would like to see this removed.

7. Page 14, Section 7, line 10-11 – refers to ‘resident’s service plan’. We would like to see more detail on what is expected of a service plan. We currently use a ‘Resident Care Plan’ that we complete from the FNA as a single page of information at move-in. It is an internal document and provides staff with information ‘for their eyes only’ with direction to care for the ADLS of the resident. We only update it periodically on an “as needed” basis.

   Service plans are further discussed In another section of SB11, Section 14, page 23, line 13 - it appears to be a plan with ‘any required orders received from the resident’s health care practitioner’. We question what the regulation outlines as a “service plan” since it appears to be more medical and “skilled care” in nature.

8. Page 16; Section 8, line 19 through page 17, line 7 - Quality Management. This is another addition of paperwork that we don’t believe is needed. We don’t see the need to this information to be documented in writing and regulated and inspected. We have a formal grievance policy with accompanying forms and a process that we would expect to be reviewed, but standard operational, day to day issues would take an inordinate amount of time away from our important tasks of resident care. Complaints can be anything from wanting the brand of strawberry jelly that is Smuckers vs Great Value from Walmart to a true grievance. This is just not necessary. We constantly self-manage and check ourselves for providing excellent resident care by reviewing our ‘resident services, complaints made, and other issues that have occurred’. We meet with our community managers and staff regularly to hear what we can do to satisfy our residents’ needs, plus we have resident meetings, question our families, etc.

We do not need legislation that requires even more administrative tasks.

9. Page 18, Section 9, line 23 – discusses 'modified diets, nutrient concentrates and supplements' and how they can only be given by 'written order of a physician'. Being AL, we follow the requests of the residents and POA's, with or without the guidance of a physician, in regard to OTC needs such as using Ensure, Boost, supplements, diet, etc. The family with the resident's consent should be able to make choices for themselves. Our families play an integral part of our community 'family' which we greatly welcome. We strongly suggest this sentence be removed. It seems to apply more to a skilled care environment and definitely not AL.

10. Page 19, Section 9, line 11 - discusses maintaining a 'file of tested recipes…'. We feel this is very over-reaching and a completely unnecessary regulation. We use tried and true recipes from cookbooks, but also from on-line that yield wonderful meals. Plus we have cooks that are so talented they don't need a recipe. We feel it would again, be extra administrative paperwork to maintain. Plus we don't want to serve the same, repetitious meals and instead serve new and fun flavors. Being small in size, we can do this more easily than the large places. This was written for a large community or taken from a skilled care regulation and we don't feel this is necessary at all.

11. Page 19, Section 9, line 13-14 – discusses recorded what an individual wanted substituted. Again, we question the need for this overreach. We offer standard substitutions based on what the resident wants at that time. This creates additional paperwork for our staff that is unnecessary.

12. Page 20, Section 10, line 19, and page 20, Section 11, line 4-8 – this discusses required TB Testing required for staff and for residents. This is not a current requirement and never has been for either staff nor resident. If a staff member does not have insurance, then we would have to source and pay for this testing which would be a cost for us, but also a barrier to hire for the potential staff person who already has to go for the KARES fingerprinting on their own time. As we outlined earlier, we don't agree with the potential resident having to get a physical before they can move-in, this is another barrier to prevent them from moving-in. This would cause residents to have to wait to move in to receive the care they need. Note: we have not ever had any issues to date with TB ever for either staff or residents. This is another example of requiring the social AL to become like the medical AL-BH. We respectfully ask this be removed as a requirement.

13. Page 22, Section 13 line 20 through page 25, line 8– this entire section is related to acquiring, recording and maintaining medical records, communications, services provided per the service plan, "verbal prescription orders received by phone", recording diagnoses, "all records of communications pertinent to resident's services" and a great deal more medical-related tasks

that we have typically never had to be involved with. This section also states we will be have to be HIPAA compliant, yet as a social/non-medical community we have never had to do.

We do have a wide variety of paperwork that captures much of the requested information outlined in the first part of this section specifically lines 10-19. But from line 20 and on, we feel this entire section is filled with a multitude of medical information needed that we have typically not ever had to maintain as a non-medical/social community. Perhaps the wording or labels used relate to what we currently maintain, but there seem to be a great deal of medical documentation that we don't feel we should be required to adhere to. We ask that this section be re-evaluated from the AL only perspective since it seems to focus so heavily on the medical BH model and borders on skilled care requirements."

(b) Response: The cabinet's response to the 13 comments and questions posed by the commenter are as follows:

1. Please refer to the cabinet's response to Kentucky's three long-term care Associations under the section on the Functional Needs Assessment.

2. In response to the comments regarding the medical examination, SB 11 amended KRS 216.765 to require "a medical examination that includes a medical history, physical examination, and diagnosis" prior to admission to a personal-care home or assisted living community. This is a requirement that was added by SB 11 and implemented by the regulation. The proposed ALC regulation therefore aligns with state law in this respect.

3. In response to the comments regarding "person-centered care", SB 11 added a definition of this term to KRS 194A.700(21) as follows:

> "Person-centered care" means respecting and valuing the individual, providing individualized care that reflects the individual's changing needs, understanding the perspective of the person, and providing supportive opportunities for social engagement.

In addition, because Kentucky's three long-term care associations have stated that they were heavily influenced by Minnesota's ALC's rules when they drafted SB 11, the cabinet suggests reviewing the following article posted by LeadingAge Minnesota on the topic of "person-centered planning and service delivery process in assisted living." The article may be downloaded from this link and it an excellent resource for guidance regarding this issue: https://www.leadingagemn.org/news/person-centered-planning-and-service-delivery-process-in-assisted-living/

4. The requirement for developing and implementing a staffing plan for

determining staffing levels, including an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility is a reasonable standard. It requires that an ALC look at the make up of its residents and staff every six months since the mix of residents and their needs will change over time. The ALC should consider whether its staffing still fits the needs of the residents or if changes are warranted. The requirement is consistent with some other states' and it mirrors the Minnesota rule in Section 144G.41, Subd. 1(11) at the following link: https://www.revisor.mn.gov/statutes/cite/144G.41

5. In response to the comment regarding the requirement in Section 7(2)(j)2 for ALCs to "ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the resident's functional needs assessments and service plans on a twenty-four (24) hour per day basis", it is important to note that the proposal aligns with requirements in other state, including Minnesota. For example, see Section 144G.41, Subd. 1(11)(ii): https://www.revisor.mn.gov/statutes/cite/144G.41.

   The key phrase in the requirement is "reasonably foreseeable". The expectation is not to staff for every possible scenario. But, if a resident's care needs have changed and they are requesting assistance more often than previously, then a foreseeable unscheduled need may be to staff for the ability to conduct more frequent safety checks on the resident.

6. Transportation has always been included in the statutory definition of "instrumental activities of daily living (IADL)" in KRS 194A.700. However, SB 11 also added IADLs, including transportation, to the definition of "assisted living services" in KRS 194A.700(7)(b). Because the commenter reports that they already assist with transportation if family members are unable to assist with transporting the resident to medical or other appointments, shopping, or recreation, the commenter is compliant with this standard. This is not a new requirement considering transportation has always been included in the definition of IADL.

7. In response to comments regarding the service plan, SB 11 added a definition of "service plan" to KRS 194A.700(24). SB 11 also added language to KRS 194A.705(6)(b) that characterizes service plans as being designed to meet a resident's identified needs. Additionally, SB 11 added service plans to KRS 194A.717(1) by requiring ALCs to establish their own staffing levels based on each resident's lease agreement, functional needs assessment, and service plan. The proposed regulation therefore aligns with SB 11's requirement for ALCs to maintain a service plan for each resident.

   In response to the question regarding Section 14 of the regulation, page 23, line 13, the requirement is for the ALC to document in the resident's record that the facility has in fact provided the services identified in the written agreement or "service plan" between the resident and the ALC. The ALC must also document

in the resident's record whether the facility provided any services in accordance with orders from the resident's health care practitioner, which would not be applicable if the ALC remains a social model facility.

8. The proposed regulation's requirement for quality management is a reasonable standard similar to Minnesota's rules under Section 144G.42, Subd. 2: https://www.revisor.mn.gov/statutes/cite/144G/full#stat.144G.42. Moreover, formalizing internal quality management activities will help ALCs identify any corrective actions and system changes as necessary to ensure any insufficient services are corrected and regulatory compliance is maintained as well as ensure that evaluation of resident services, complaints, and other issues is ongoing.

   The quality improvement plan is also required by KRS 216B.160(5) for all health facilities licensed under KRS Chapter 216B, which now includes ALCs because SB 11 added ALCs to the definition of "health facility" in KRS 216B.015(13). See Section 40 of SB 11: CHAPTER 20 (SB 11, Alvarado and others) (ky.gov)

9. In response to the comments on dietary services, the cabinet agrees to amend the regulation so that social model ALCs will continue to be subject to the current requirements for dietary services as established by KRS 194A.705(1)(b) which requires only that three meals and snacks be made available each day.

   According to comments submitted by Kentucky's three long-term care associations who brought SB 11 forward, the associations sought to "blend the two private-pay levels (assisted living and personal care) into one continuum of care." Therefore, to ensure that apartment-style PCHs required by KRS 194A.704(1) to convert to ALCs adhere to the same dietary service standards as they do currently as well as require the same standards for ALCs-BH, the cabinet's inclusion of a section on dietary services in 902 KAR 20:480 mirrors the same requirements established in the PCH regulation, 902 KAR 20:036, Section 4(3)(c).

   Additionally, although the PCH regulation requires that "modified diets, nutrient concentrates, and supplements shall be given only on the written order of a physician", the definition of "assisted living services" in KRS 194A.700(7)(f) refers to "modified diets ordered by a licensed health professional." Therefore, the cabinet will amend the ALC regulation to replace "physician" with "licensed health professional".

10. Please see the same response under item 9 above.

11. Please see the same response under item 9 above.

12. In response to the comments regarding tuberculosis (TB) testing for ALC staff and residents, SB 11 added ALCs to the definition of "long-term care facility" in

KRS 216.510(1) and 216.535(1), and also added ALCs to the definition of "health facility" in KRS 216B.015(13). Because elderly individuals are more susceptible to contagious disease and are living quite close to each other in the ALC setting, ALCs will be subject to the same TB screening and testing requirements established for staff and residents of other long-term care settings regulated by the OIG.

13. Because SB 11 did not include detailed standards related to resident records, the cabinet added Section 13 to the proposed ALC regulation. Section 13 of 902 KAR 20:480 is similar to Minnesota's rules for resident record content under Section 144G.43, Subd. 3: https://www.revisor.mn.gov/statutes/cite/144G.43.

    For residents who receive social model assisted living services only, the cabinet agrees that some information would not be collected or included in the resident's record because the ALC is not providing those basic health services.

(a) Comment: Conjuna Collier, SR VP of Risk Management & KAHCF Regulatory Chair, submitted the following comments: "Please accept this letter of comment on the recently filed proposed regulation, 902 KAR 20:480 proposed rule, 'assisted living communities.' The changes in this proposed rule would not only impact our assisted living operations and personal care operations but also the residents we serve. My assisted living facilities and personal care facilities are located in Shelbyville and Louisville, Kentucky in Shelby and Jefferson Counties. We are the largest CCRC in Louisville and serve over 900 seniors on any given day. Our fear is that there are several items in the proposed regulations that will add significant expenses to our operation, namely the staff we would need to hire in order to perform certain services such as assistance with medications. The regulation also places an unnecessary burden on overall operations of all 4 of our facilities. Having been a Personal Care Administrator for over 30 years I am very familiar with personal care homes and know that they perform the same services without the staff requirements that SB 11 is calling for. I understand there is a thought process that the residents that reside in this types of facility have different medical needs than the ones we serve and I disagree with this assessment. In fact, many times they are even more compromised. Although we are mainly private pay, we are one of the few that accept public assistance. This places an undue hardship on the facility, not to mention the fact that what is required of a facility should not be based on ability to pay privately. If I must incur more expenses, the only way to keep the operation going is to pass on the increases to our clients but that will be one -sided because as you are aware we cannot pass the expenses on to public assistance. We strive to keep our rates as low as possible but expenses like these would give us no choice. I can assure you that as a profession we are not seeing medication errors in personal care due to using trained medication aides. With proper training, unlicensed staff can perform the basic services that are needed. In addition, when work force is in the worse crisis our profession has seen, there is a severe shortage of CMTs in Kentucky. The few that are available are getting hired by the skilled

nursing homes or hospitals. This is an ill-advised portion of the regulations and will only hurt those Kentuckians who need assisted living services. This may look a little different if we had Medicaid for assisted living but we do not. We cannot put in place regulations with the hopes that funding comes later.

I have also read Senate Bill 11 and there are many items included in the proposed regulation that are not listed within this bill. Below I will list my questions and or comments as to why I oppose this set of regulations as they are written.

1. This regulation does address facilities that are a mixture of private pay and public assistance. This regulation as it stands may force our company to stop accepting public assistance. We know that there is already a shortage of facilities that accept this payer source.
2. The bill doesn't have 3 separate distinct licensure categories. It only allows for 2 categories. One for assisted living for either basic health or social model and one for Assisted Living with Dementia Services. This goes to the intent of the bill to allow residents to age in place. By forcing a facility to choose between basic health and social model it contradicts the "Age in place" theory.
3. Nurse Delegation of Task is regulated by the Kentucky Board of Nursing. This proposed regulation exceeds the very board that was given statutory authority over the tasks that included delegation of administration of medications to unlicensed assistive personnel. The proposed regulation exceeds what KBN requires for delegation of tasks, especially the direct supervision of UAP and requiring completion of "the Kentucky medication aide training" program.
4. The proposed regulation exceeds what is currently in personal care facilities for handling, storage and labeling of medication and in parts of the draft it exceeds what is in the federal regulation for skilled care. These items are not within the bill, therefore they exceed the scope of the bill. The overall language involving medication management exceeds all levels of care.
5. The language used in this regulation that reads "if the resident presents with symptoms or other issues that may be medication related": requires reassessment of medications. This language is too broad and could be literally in most health concerns with residents. This exceeds what is even expected for skilled facilities if it remains as written.
6. Regulation requires a facility to document the explanation of consequences to a resident when refusing medications, not taking into account the cognitive status of a resident. The language needs to be changed to reflect "if resident cognitively able to understand."
7. The regulation requires the facility to document, in the resident record, who is responsible for ensuring medications are ordered including refills. This should be managed through a facility's policies not dictated to be recorded in every resident's record. We request the language be changed.
8. On both of our campuses we have both assisted living and personal care facilities and should be able to continue to operate them in 2 different types of categories. We are a CCRC and this ability is imperative to maintaining the age in place process as well as the intent of the bill. Not only is this broader than the

scope of the bill it will also force residents to enter a heavier care category even if it is not need. For residents that are private pay this will increase their cost and in turn have an impact on the timing of when they may need public assistance which creates a burden on the Medicaid budget. It forces these people to pay for care they don't yet need. There is also a great deal of data that shows an elder that is placed in higher levels of care before the need arises has a negative impact on the overall social and cognitive status of the resident.

9. The proposed regulation doesn't address the fact that there are facilities that chose to provide health services by utilizing home health. Although this is common practice among assisted living facilities, since they are not currently a medical model, some personal care facilities in KY also chose to do this versus the hiring of their own staff. It appears that this draft would not allow for this. Again in a time where work force crisis is at an all-time high if this is not allowed it will increase the need for licensed nurses.
10. The proposed regulation includes the need to implement a staffing plan for determining staffing levels that is reviewed at least twice a year among many other things. Although it is expected that a facility has necessary staff to care for the residents they admit, this language exceeds that of a skilled facility and should be addressed in the operation procedures.
11. Currently personal care facilities have admission agreements versus lease agreements. We request that these be used for Basic health and Dementia categories. When using a lease agreement facilities will fall under many laws of tenant / landlords versus being a resident of a health care facility. Being the largest CCRC in Louisville we are keenly aware of the conflicts of these 2 types of laws/regulations.
12. The burden of providing a resident or family member a copy of every facility policy and procedure is not achievable. Although we understand the need for residents and families to be informed of expectations there will be literally 100's of polices that range from human resources, infection control, disaster management, the list is limitless. This also exceeds that of skilled care and broadens the scope of the bill. I realize that this is a part of the bill but expectations on which polices need to be addressed should be reflected in the language. This language is already the assisted living regulation but given the fact they are a social model currently the need for polices is drastically reduced, which makes this more achievable. Once the regulation is effective taking into consideration the basic health and dementia models the need for polices will be endless.
13. Currently CPR in an assisted living is considered a health service and isn't performed by staff. However the proposed regulation appears to allow this if a facility has policies to support even in a social category.
14. The proposed regulation as written doesn't allow for a staff member to be a resident's designated contact person. As it is written it doesn't allow for staff to have a family member in the facility that they assume responsibility for. I do not believe that is the intent of this regulation but the language suggest that it is. The same goes for a staff member being designated as a legal representative. This exceeds the scope of the bill and exceeds the federal regulation for skilled.

15. The proposed regulation indicates the need for posting of a menu when in fact most of these facilities use select menus allowing the resident to choose their meals. There needs to be an exception to this regulation if select menus systems are utilized included in the language.
16. The proposed regulation dictates 2 hot meals a day. We believe that as long as the facility is offering nutritious meals as indicated through other parts of the regulation the term “2 hot meals” should not be dictated. This is stronger than that of the skilled facilities. We request that this part of the language be removed.
17. When referring to employee records the regulation couples volunteers as needing the same information. These are 2 very different types of files and documentation maintained and therefore the language should not be as written as such. This regulation also exceeds that of skilled.
18. When referring to providing education on influenza the regulation is stronger than skilled regulating what date it must be completed by. We request the exact date be removed.
19. Posting of emergency plans. We request that the language be changed to indicate that emergency disaster plans be available. Facilities emergency disaster plans are large in nature and it is not reasonable to think 100’s of pages be posted versus available. Again this exceeds the skilled, federal regulation.
20. When referring to resident records it appears that the social category will be required to follow the same requirements as Basic health and Dementia. Currently in assisted living, resident records /charts are not required. We asked that this continue to be the regulation for the social category. If a facility is not providing health services the need to obtain resident’s medical information including medication information, medical history, documentation of medication administration, treatments ETC is not needed. In a social category this information should not be collected as without licensed staff providing care the information will not be necessary. We request that the social category be relieved of this burden.
21. The need to place all communication pertinent to resident’s service is too broad and lends to be over burdensome. There are many conversations concerning resident’s services that include but are not limited to emails, appointment cards and text messages. The language reads that these types of communication would need to be placed in the record. We ask that the language be removed. This also is beyond scope of the skilled regulations.
22. The proposed regulation surrounding documentation of an incident exceeds that of skilled. It would be sufficient for the regulation to indicate the need to document an incident without defining exactly what needs to be documented as this is not done for any level of care including acute care where patients are critical or acutely ill. We request the details of what is required to be documented be removed.
23. The proposed regulation indicates the need to document the services provided as indicated in the service plan. We request this language be removed as it is not currently required in personal care or assisted living. There is no

requirement to document ADL's, consumptions or other routine services. There are plans of care in personal care but there is not a regulation as to how the services to be documented. We request that this overreaching regulation be removed.

24. Much of the language that is included in the proposed regulation such as documentation of medication administration doesn't apply to the social category. The regulation implies that all categories must meet these requirements. The regulation needs to separate the requirements of each category as certain elements only apply to certain categories. Instead this regulation lumps them into one requirement.
25. Complaints and or grievances are not required to be documented in a resident record currently in any level of care. The facility is required to have a process to investigate and document these. This regulation requires a facility document these in the actual record. We ask that this specific language be removed and allow the facility to determine how these will be documented and recorded.
26. Many parts of the prosed regulation refer to providing the resident information but doesn't lend to the fact the resident may have cognitive impairment. The terms resident representative needs to be added in the language in these areas.
27. The proposed regulation indicates that owners need background checks. For companies that are directed by a board how is this handled? For companies that have shareholders, how is this handled? Also this exceeds the requirement for skilled facilities. Annual background checks, Adult Misconduct checks, Central Registry checks and nurse aide abuse checks every 2 years exceeds the skilled requirement and adds an extra cost burden that PC licensed and skilled facilities are not required to do. This lends to the fact that the method of payment dictates the type of protection a resident is allotted. The Central Registry is a burden to assisted living providers currently and obtaining is troublesome to say the least. It is not required in personal care or skilled. We ask that this be removed from the new regulation. If a person has a criminal record it will be on a criminal records background check the same as it is on Central Registry check.
28. The need to obtain an RN to consult is not necessary and is not required for personal care or assisted living currently. The ability to obtain an RN in a time where work force is in a crisis places an unnecessary burden on the facilities.
29. The proposed regulation dictates the need to document in the resident record instructions for the delegation of task. This is over burdensome, unachievable and open ended as to what the expectation would be surrounding this regulation. We ask that this language be removed.
30. The proposed regulation indicates the need to have direct observation of unlicensed staff while they are providing service. This is unachievable as written in this language. This exceeds any level of care and is not necessary. It lends to the fact a service could not be completed for a resident without observation while an UAP is performing it.
31. The proposed regulation indicates that once a prescription is written or electronically prescribed it would need to be communicated to the RN in charge.

Again that exceeds the KBN requirements as well as the skilled requirements. It is over burdensome during a time where RN's are in large demands in other setting where wages can be higher. Lastly it is an unnecessary requirement and we ask that it be removed.

32. The regulation indicates that if a family member brings in outside medication that is not included in the medication assessment of the facility, an RN in charge would be notified. Again that exceeds the KBN requirements as well as the skilled requirements. It is over burdensome during a time where RN's are in large demand in other settings where wages can be higher. Lastly it is an unnecessary requirement. The same goal could be meet with an LPN if even needed.
33. The requirement of the disposition of the medication process is over burdensome with the requirement to document on the resident record each time a medication is discontinued or expired, death of a resident or change of service plan. Documenting the destruction of controlled substance is not a new requirement but for non-controlled substances this process is unreasonable and frankly unachievable. When non-controlled drugs are returned to pharmacy for credit this is not required to be written in each resident records indicating who sent it back. We request that this language be removed.
34. The need to have controlled substances recorded in "bound" book is not necessary and exceeds the skilled requirement. When using an outside pharmacy in this setting typically the pharmacy sends a narcotic sheet for each controlled substance for authorized staff members to sign off that the drugs are accounted for. This process should be managed by a policy and procedure surrounding prevention of diversion versus a regulation that dictates the use of a "bound" record.
35. When an assessment is completed for a resident for self-administration of medication and it is determined the resident has the capability to self-administrator medication, this regulation would require supervision of self-administration. Once it has been determined that resident is safe to administrator medication the need to supervise the resident while taking the medication is not needed. When assuming responsibility for medications that family members bring in there is a liability for the facility.
36. When a controlled substance is lost, unaccounted for or destroyed, unless an investigation shows it was stolen, the need to report to the OIG, Division of Health Care and Division of Audits and Investigations is an over reach. This language doesn't account for spillage the way it is written. The DEA already has regulations and requirements on how this is handled, the added oversite is overreaching and unnecessary.
37. The regulation doesn't seem to address the section of the bill "Temporary condition" as it pertains to Hospice services and being allowed to age in place if risks are mitigated.
38. The regulation doesn't seem to address the section of the bill on issuing of move out notices. Currently personal care follows the transfer and discharge regulation used with skilled care but assisted living does not. The expectations of this process doesn't seem to be addressed in the draft. Laws of surrounding

tenants / landlords are conflicting with regulations surrounding discharge.

39. The regulation doesn't seem to address the reporting aspect of abuse. Currently assisted living reports to DCBS and Personal care reports for DCBS and OIG. The reporting aspects do not appear to be addressed in the proposed regulation.

(b) Response: The cabinet's response to the comments and questions posed by the commenter are as follows:

1. Please refer to the cabinet's response to other commenters as it relates to allowing residents to age in place to the extent that basic health and health-related services are needed by ALC residents, including during a "temporary condition" as well as replacing the requirement for a registered nurse in assisted living communities that provide basic health services with a licensed practical nurse.

2. In the long-term care associations' testimony before HWFS committee members last spring, association representatives said that they reviewed the rules and regulations of other states as they drafted SB 11 but they were heavily influenced by Minnesota's state laws governing ALCs. Likewise, the cabinet also researched other states' laws and modeled much of 902 KAR 20:480 on Minnesota's rules, adding key standards to the proposed regulation that were not included in SB 11.

   Please see the previous response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky regarding the cabinet's rationale for the three-tiered licensure structure. The three-tiered structure is consistent with the language and intent of SB 11 and within the authority and responsibility of the cabinet to establish licensure classification of health facilities according to type, range of services, and level of care.

3. In response to the comment about medication aides, please refer to the cabinet's response to KSLA, KAHCF/KCAL, and LeadingAge Kentucky on this issue as the cabinet has agreed to make additional changes to the regulation that expands the types of training that would meet the requirement for certified medication aides.

4. The proposed regulation's section on controlled substances (Section 15 (21)) mirrors the language of the PCH regulation in 902 KAR 20:036, Section 4(1)(g), a change recommended by the long-term care associations in their marked-up version of 902 KAR 20:480 before it was filed.

   As stated above, long-term care association members told HWFS committee members last year that they were heavily influenced by Minnesota's state laws governing ALCs when they drafted SB 11. This is evidenced by the fact that the bill created a definition of "assisted living services" (which includes medication

management in its list of services) and a separate definition of “medication management” that is similar to Minnesota’s definition of both terms, see Section 144G.08, Subd. 9 and Subd. 39: https://www.revisor.mn.gov/statutes/cite/144G.08.

SB 11 does not include any requirements related to medication management other than the above definitions and a requirement in KRS 194A.708(1)(d) for ALCs-DC to develop and implement policies and procedures that address medication management pursuant to orders from a resident’s health care practitioner. It is typical for a statute to establish a framework of requirements and for an associated regulation to implement those requirements in more detail. The cabinet added Section 15, Medication management, to the proposed ALC regulation which is similar to Minnesota’s rules for medication management under Section 144G.71: https://www.revisor.mn.gov/statutes/2021/cite/144G.71.

5. The proposed requirement for an ALC-BH or ALC-DC to reassess a resident's medication management services if the resident presents with symptoms or other issues that may be medication-related is a reasonable safety protocol that helps ensure ongoing assessment of residents’ needs and safety. It is consistent with other states’ requirements including Minnesota’s rules for medication management under Section 144G.71, Subd. 3: https://www.revisor.mn.gov/statutes/2021/cite/144G.71. As mentioned before, the associations that drafted SB 11 have stated they were heavily influenced by Minnesota’s ALC requirements.

6. In response to the comment, the cabinet will add a clarification to require an ALC-BH or ALC-DC to discuss the possible consequences of a resident’s refusal of an assessment for medication management with the resident, resident’s designated contact person or legal representative, or both.

7. The proposed requirement for an ALC-BH or ALC-DC to identify and document the name of person(s) responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis in the individualized medication management record is a reasonable requirement that will help ensure clarity surrounding who bears responsibilities for those duties. It is also consistent with Minnesota’s rules for medication management under Section 144G.71, Subd. 5(4): https://www.revisor.mn.gov/statutes/2021/cite/144G.71.

8. KRS 216B.015(11) defines a "continuing care retirement community" as “a community that provides, on the same campus, a continuum of residential living options and support services to persons sixty (60) years of age or older under a written agreement. The residential living options shall include independent living units, nursing home beds, and either assisted living units or personal care beds.”

Although a CCRC may elect to have either AL units or PC beds, there is no prohibition against operating both on a CCRC campus. It is not clear what specific sections of the regulation the commenter believes will interfere with a resident's ability to age in place in AL units or PC beds on the campus of a CCRC.

Moreover, the proposed ALC regulation will not "force" residents to pay for care that they do not need. Both the number of and the type of services necessary to meet an ALC resident's care needs should drive the rates charged to residents. The use of three licensure categories instead of two helps to clarify which services are provided by the ALC, which should be consistent with amount charged by the facility. A social model ALC that remains a social model will not be required to provide basic health services and should be able to charge residents less.

9. Contrary to the commenter's assertion, Section 7(2)(d) of the proposed regulation requires each ALC, ALC-BH, or ALC-DC to permit a resident to arrange for additional services under direct contract or arrangement with an outside party pursuant to KRS 194A.705(3) if permitted by the policies of the facility.

10. The requirement for developing and implementing a staffing plan for determining staffing levels that includes an evaluation conducted at least twice a year of the appropriateness of staffing levels in the facility is a reasonable standard to expect from assisted living communities, especially considering that neither SB 11 nor the regulation establish minimum staff-to-resident ratios. It requires that an ALC look at the make up of its residents and staff to determine appropriate staffing since the mix of residents and their needs will change over time. The requirement is consistent with some other states' and it mirrors the Minnesota rule in Section 144G.41, Subd. 1(11) in the following link: https://www.revisor.mn.gov/statutes/cite/144G.41

11. Both prior to the passage of SB 11 and afterwards, several statutes under KRS Chapter 194A use the term "lease agreement" exclusively, see KRS 194A.700, 194A.705,194A.713, 194A.717, and 194A.729. This is the statutory term that was not changed by SB 11. The regulation accordingly refers to this type of contract between facilities and residents.

12. KRS 194A.705(4) requires each ALC to inform the resident in writing about policies relating to the provision of services by the facility and contracting or arranging for additional services. This does not mean that each facility must provide residents with all of the facility's operational policies. Rather, the law only requires facilities to provide copies of policies related to the specific services provided or otherwise would allow the resident to contract or make arrangements to receive from third parties.

13. KRS 194A.719(1)(d) permits but does not require employees to receive training in cardiopulmonary resuscitation, although it would be reasonable to require this training for direct care staff working in a facility with aging residents with healthcare needs. Moreover, facilities such as child day care centers are required by state regulation to ensure that their staff have first aid and CPR training, a requirement that is much more stringent than requirements for ALCs.

14. In an effort to prevent any conflict of interest, the proposed regulation prevents an assisted living staff person from serving as a resident's designated contact person or legal representative. However, the cabinet will add a definition of “immediate family member” to Section 1 and add an exemption from the prohibition against being a contact person or legal representative only if a staff person is an “immediate family member” of the resident.

15. In response to the comments on dietary services, the cabinet agrees to amend the regulation so that social model ALCs will continue to be subject to the current requirements for dietary services as established by KRS 194A.705(1)(b) which requires only that three meals and snacks be made available each day.

    According to comments submitted by Kentucky’s three long-term care associations who brought SB 11 forward, the associations sought to “blend the two private-pay levels (assisted living and personal care) into one continuum of care.” Therefore, to ensure that apartment-style PCHs required by KRS 194A.704(1) to convert to ALCs adhere to the same dietary service standards as they do currently as well as require the same standards for ALCs-BH, the cabinet’s inclusion of a section on dietary services in 902 KAR 20:480 mirrors the same requirements established in the PCH regulation, 902 KAR 20:036, Section 4(3)(c).

16. See above response regarding dietary services.

17. The requirement proposed in 902 KAR 20:480 for retaining records only applies to regularly scheduled volunteers that provide services. The requirement would not apply to someone who volunteers occasionally.

18. According to KRS 194A.707(6), each ALC is not required but may elect to provide residents or their designated representatives with educational information or educational opportunities on influenza disease by September 1 of each year.

19. The cabinet does not expect ALCs to post a lengthy emergency disaster plan. Rather, a one-page plan that contains relevant information is acceptable including staff assignments in the event of a disaster or emergency (e.g., name(s) of staff responsible for directing an evacuation and person count),

temporary relocation site(s), location of equipment like fire extinguishers, and any other information the facility deems appropriate.

20. Because SB 11 did not include detailed standards related to resident records, the cabinet added Section 13 to the proposed ALC regulation. Section 13 of 902 KAR 20:480 is similar to Minnesota's rules for resident record content under Section 144G.43, Subd. 3: https://www.revisor.mn.gov/statutes/cite/144G.43.

    For residents who receive social model assisted living services, the cabinet agrees that some information would not be collected or included in the resident's record such as documentation of medication administration since that is not a service they would provide.

    In addition, for apartment-style PCHs that are required by KRS 194A.704(1) to convert to ALCs, it is important to note that 902 KAR 20:036, Section 3(6)(e) requires PCHs to maintain resident records so that if a resident transfers to another health facility, level of care within the same facility, or a community living setting, a copy of the resident's medical record must accompany the resident. Accordingly, Section 13 of the proposed ALC regulation assures that health information, at a minimum, is maintained for residents of ALCs-BH and ALCs-DC.

21. In response to the commenter's objection about requiring the resident's record to include "all records of communications *pertinent* to the resident's services", the cabinet expects facilities to document only relevant information that is exchanged about the resident's care needs such as a change in services.

22. The proposed requirement of Section 13(4)(j) for facilities to document in a resident's record "any incident or accident involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional" is a reasonable standard that increases transparency regarding the nature of the incident or accident. The requirement also helps ensure that the matter is properly addressed in accordance with the resident's needs, including any efforts to ensure preventive measures are implemented as appropriate to prevent future incidents or accidents. It will provide detail that will be useful in determining if a resident's needs have increased such that different services or a different level of care is required.

23. The proposed requirement of Section 13(4)(k) for facilities to document in a resident's record "services have been provided as identified in the service plan and according to any required orders received from the resident's health care practitioner" is a reasonable standard because it ensures the delivery of services as agreed upon in the service plan or otherwise ordered by the resident's health care practitioner are properly documented.

24. Contrary to the comments, the proposed regulation is clear regarding which standards apply to all ALC licensures level versus specific ALC categories. For example, Section 15(1)(a) on medication management states that “this section of this administrative regulation applies to facilities licensed to operate as an ALC-BH or ALC-DC.” Other sections of the regulation include exception clauses for social model ALCs that are not subject to a particular requirement.

    In addition, the regulation’s establishment of three ALC licensure levels provides clarity regarding which standards apply to all of the ALC licensure levels or just to ALCs that provide basic health services.

25. The proposed requirement of Section 13(4)(o) for facilities to document in a resident’s record “complaints received and any resolution” is a reasonable standard as it ensures facilities have followed through on attempts to resolve the resident’s complaint.

26. In response to the comment, many sections of the regulation require information to be provided to the resident, resident's legal representative, or resident's designated contact person. If required information has been provided to a dementia resident’s legal representative or designated contact person in lieu of the resident, the cabinet will not cite against the facility.

27. These background checks are already required of direct care staff but would now also be required for owners. 910 KAR 1:240, Section 7(3) requires a criminal background check initially and every two years thereafter plus an initial and annual CAN central registry, adult caregiver misconduct, and nurse aide abuse registry check. This is a reasonable requirement ensure resident safety and one that has been proposed in prior legislation. During prior legislative sessions, including as recently as 2022, Senator Danny Carroll sponsored such legislation.

    Additionally, each person with a “significant financial interest” in an ALC as listed on page 7 of the licensure application is considered an owner for purposes of meeting the background check requirements. Such background checks are a reasonable safety measure that enhance greater protections for ALCs residents and is similar to ALC laws in other states.

28. Please refer to the cabinet’s response to other commenters as it relates to replacing the requirement for a registered nurse in assisted living communities that provide basic health service with a licensed practical nurse.

29. In response to the comment, the cabinet will replace the requirement for a nurse or other licensed health professional in an ALC-BH or ALC-DC to document instructions for delegated tasks in the resident’s record with a requirement for the nurse or licensed health professional to document delegated tasks in the

resident's record.

30. Section 14(6)(a) requires periodic supervision of staff who provide social model assisted living services identified in KRS 194A.700(a)-(f), (i) or (n). Paragraph (c) of this subsection clarifies that "supervision" includes direct observation, but the regulation does not require direct observation at all times an unlicensed staff member provides services, just periodically.

31. Please refer to the cabinet's response to other commenters as it relates to replacing the requirement for a registered nurse in assisted living communities that provide basic health service with a licensed practical nurse.

32. See response to comment 31 above.

33. The proposed requirements for disposition of unused medications in 902 KAR 20:480, Section 15(20) are reasonable requirements to ensure that medication is not diverted or mis-used. It aligns with requirements in other states, including Minnesota's rules in Section 144G.71, Subd. 22: https://www.revisor.mn.gov/statutes/cite/144G.71

34. The proposed requirement in 902 KAR 20:480, Section 15(21)(c) align with the PCH regulation, 902 KAR 20:036, Section 4(1)(g).

35. The proposed requirement in 902 KAR 20:480, Section 15(21)(c)4.b. for supervised self-administration of a controlled substance if a resident is safely able to self-administer aligns with the requirements of the PCH regulation, 902 KAR 20:036, Section 4(g)3.d.

36. The proposed requirements in 902 KAR 20:480, Section 15(23) regarding loss or spillage of controlled substances are reasonable requirements similar to the requirements of the Minnesota rule, Section 144G.71, Subd. 23: https://www.revisor.mn.gov/statutes/cite/144G.71. Theft or misuse of a controlled substance is a criminal act. A significant loss can be either a pattern of small losses over time or one-time loss and is relative to the amount of controlled substance used by the registrant on average. The proposed requirement in the ALC regulation is intended to address any possible incidents of misuse or diversion.

37. In response to the comments regarding "temporary condition", 902 KAR 20:480, Section 1(20) cross-references the definition of this term in KRS 194A.700(26) which requires a plan to mitigate risks. Section 7(2)(d) of the regulation allows a facility to, "Permit a resident to arrange for additional services under direct contract or arrangement with an outside party pursuant to KRS 194A.705(3) if permitted by the policies of the ALC, ALC-BH, or ALC-DC."

    The regulation's cross-reference to KRS 194.705(3) assures that residents are

allowed to arrange for hospice or other end-of-life services if permitted by the facility's policies and the statutory definition addresses the requirement for mitigation plans.

38. In response to the comments regarding "move out notices", Section 13(4)(p) requires ALCs to include in a resident's record "Documentation of move-out or transfer to another setting, if applicable."

    Otherwise, requirements related to move out notices are covered under KRS 194A.705(5) and KRS 194A.713(8) and (9).

39. 902 KAR 20:480, Section 7(4)(a) requires all ALCs to maintain policies on "Reporting and recordkeeping of alleged or actual cases of abuse, neglect, or exploitation of an adult in accordance with KRS 194A.709."

    The cabinet will add clarifying language to require facilities that make reports of suspected or actual adult abuse, neglect, or exploitation to report to both the Department for Community Based Services and the OIG.

(16) Subject: Requirement for Residents to be Ambulatory

(a) Comment: Eric Evans, AARP, submitted the following comments: "Aging in Place is Imperative. AARP Kentucky does not support the express and implied prohibitions on aging in place that are contained in language that prohibits non-ambulatory residents, that outlines admissions exclusions, and that strictly prescribes limits on services that may be provided in each of the settings. We support residents' ability to age in place, and to not have to move as their needs change or increase."

(b) Response: KRS 194A.711 requires all ALC residents to be ambulatory, unless due to a temporary condition. This is a requirement of SB 11. However, it is important to note that a mobile nonambulatory individual may be a resident of an ALC because KRS 194A.700(2) defines "ambulatory" to include a resident's ability to walk, transfer, or move from place to place with an assistive device, including but not limited to a walker or wheelchair. The regulation does not change this definition. Moreover, KRS 194A.700(26) defines "temporary condition" so that a resident may stay in an ALC if the resident is nonambulatory but expected to regain ambulatory ability within six months of loss or ambulation or is nonambulatory but receiving hospice or other end-of-life services.

    In addition, ALCs-BH and ALCs-DC are restricted by SB 11 from providing services beyond basic health and health-related services. Individuals who do not meet the "temporary condition" criteria and whose needs exceed basic health and health-related services must receive care in a higher level long-term care setting.

(17) Subject: Civil Monetary Penalties

(a) Comment: Eric Evans, AARP, Submitted the following comments: “Enforcement Tools must be Impactful. AARP Kentucky does not support the statutory limitation on civil monetary penalties as only to be assessed if ‘imminent danger to a resident is present that creates substantial risk of death or serious mental or physical harm.

Civil monetary penalties are typically used as an escalating deterrent to discourage intentional or sloppy disregard for and non-compliance with state regulations. They are an important tool to intervene early and often, as needed. The statute’s significant limitation on the use of civil monetary penalties removed a powerful deterrent inspectors would have to stem violations before residents are put in imminent danger.”

(b) Response: SB 11 created a new statute, KRS 194A.722, that establishes limitations on civil penalties as stated in the title of the law. The cabinet therefore cannot establish any additional requirements that are outside of the parameters of the legislation.

(18) Subject: Person Centered Care

(a) Comment: Eric Evans, AARP, Submitted the following comments: “Regulations need to better ensure that services are person-centered and provided in accordance with service plans that have been developed through a person-centered service planning process. AARP Kentucky urges the Department to revise the regulations to require a person-centered service planning process with the resident as the focus and with the process resulting in a written service plan that specifies how the Assisted Living Community will meet the residents’ unique needs and preferences as identified through a comprehensive process. This service plan should be an attachment to the lease and the lease should expressly state that the ALC is required to provide the services outlined in the attached service plan.

States should require resident assessments and the development of regularly updated individual care plans. Assessments should be valid and reliable, and core Residents, their family members, or their representatives, as appropriate, should be fully involved in developing and updating care plans.”

(b) Response: SB 11 added a definition of “person-centered care” to KRS 194A.700(21). Section 7(2)(e) of the proposed regulation requires ALCs to “utilize a person-centered planning and service delivery process.” The service plan as defined by KRS 194A.700(24) is an agreement between the resident and the licensee about the services that will be provided to the resident. In accordance with KRS 194A.705(6)(b), the service plan must be designed to meet identified needs and provided to the resident immediately after move-in. Additionally, KRS 194A.717 requires ALCs to base their staffing levels in a number sufficient to meet the needs of residents in accordance with the resident’s lease agreement, functional needs assessment, and service plan.

Just as SB 11 allows ALCs to provide a range of basic health and health-related services, the cabinet's proposed ALC regulation also allows those services but establishes a new set of standards that will help ensure quality and safety for this level of care.

(19) Subject: Staffing, training, and qualifications provisions

(a) Comment: Eric Evans, AARP, submitted the following comments: "Regulations need better staffing, training, and qualifications provisions. AARP Kentucky recommends improving the regulations by:

Requiring all staff who are on site to have full criminal background checks, dementia training, and CPR/First Aid training, and to remove the current limitation on who receives these.

Prohibiting any direct care staff to have any unsupervised direct contact, resident contact or access to resident records or to facility records pending the outcome of their background checks.

Articulating both a minimum number of staff training hours as well as a requirement that individuals not just attend but actually demonstrate knowledge acquisition and, where appropriate, competency as part of the training."

(b) Response: The regulation aligns with SB 11's requirements for criminal background checks, dementia training, training in first aid and cardiopulmonary resuscitation, and other staff training requirements. However, the cabinet will add a definition of "volunteer" to Section 1 and require that regularly scheduled volunteers with duties equivalent to the duties of an employee providing direct care services and who have one-on-one contact with a resident are subject to the same background checks as employees.

The requirement for unlicensed staff who administer medications be certified medication aides ensures that such staff have passed a competency evaluation. Other sections of the proposed regulation require supervision to verify that tasks are being performed competently.

(20) Subject: Licensure Process

(a) Comment: Eric Evans, AARP, submitted the following comments: "Regulations need better vetting of potential licensees, including increased transparency.

Section 4 of the proposed regulations suggests that the Department will be reviewing the application for completeness in determining whether to grant a license. AARP Kentucky urges the Department to revise the regulations to articulate how the Department will be determining an applicant's fitness to have a license.

The Department must undertake steps to determine: Does the application and supporting documentation reflect the expertise, experience, finances, and overall ability of the applicant to provide high-quality, resident-centered services in

compliance with all state requirements? Coupled with this is the need for a more comprehensive licensure application form. We do not believe it is currently sufficient to gather needed information for determining the performance history and other critical information related to the applicant's appropriateness for getting a license.

As written, Section 3 of the regulations require disclosure of information related only to people or entities with a 'significant financial interest' (that own 25% or greater interest) in the facility. AARP Kentucky stresses how critical it is for the state to have full transparency into ownership, including clinical, experiential, financial, and compliance qualifications of all owners. The concept of 'significant financial interest' as used in the proposed regulations does not appear to be required or defined by statute. We urge the Department to revise this percentage, either by removing it or by reducing it to 5% or greater."

(b) Response: ALC applications will be subject to the same completeness review process the OIG applies to other applicants in accordance with 902 KAR 20:008, Section 2(4) and (5).

Additionally, the definition of "significant financial interest" in 902 KAR 20:480, Section 1(27) aligns closely with the definition of the same term in 902 KAR 20:008, Section 1(7).

(21) Subject: Life Safety Code

(a) Comment: Eric Evans, AARP, submitted the following comments: "AARP Kentucky strongly recommends that the regulations require Assisted Living Communities to comply with the National Fire Protection Association (NFPA) 101 Life Safety Code both in construction requirements and in fire safety (including 'shelter in place' or evacuation) rules and protocols. This would establish a nationally-adopted, minimum standard for ensuring physical plant health and safety for residents, also creating uniformity and a standard the Department could more easily confirm."

(b) Response: All ALCs must be currently approved by the State Fire Marshal's Office as a condition of initial licensure and annual renewal.

(22) Subject: Dementia Care Training

(a) Comment: Mackenzie Wallace, presented the following comments during the public hearing on January 23, 2023: "My name is Mackenzie Wallace. I represent the Alzheimer's Association of Greater Kentucky and Southern Indiana, and I'm the Director of Public Policy.

The Association is grateful to continue to be involved in this process. But we remain concerned that dementia specific training and education standards have not been laid out in the regulations for our ALC with basic health services or just the regular assisted living community.

So specifically our concerns continue to be with section 14, subsection 8, which revolve around orientation and annual training. We are appreciative that the annual in-service education must be included with Alzheimer's disease and other dementia. However, the lack of any specificity within the orientation and in-service education remains a problem.

As we stated during our testimony in the legislative session, the language of, quote, with emphasis on those most applicable to employee's assigned duties, end quote, continues to be an area of concern. It acknowledges that staff in an ALC or an ALC-BH will regularly interact with residents with Alzheimer's or other forms of dementia but it fails to articulate any criteria for the training. It could potentially lead to different communities providing different training programs.

Of particular concern are the many individuals living with dementia who for a variety of reasons will reside in an ALC or an ALC-BH but may not have access to care staff with sufficient dementia education. In rural and underserved areas of the Commonwealth, for example, there may only be one ALC or ALC-BH in an entire county without any dedicated dementia care options. Others may not be able to afford the additional cost of an ALC with dementia care but could still benefit immensely from an ALC or an ALC with basic health services.

And for many, their dementia may have not been formally diagnosed. We know that less than 45 percent of people living with Alzheimer's or another dementia actually receive a diagnosis and, therefore, may not know that they have this disease. Quality dementia training should exist across the entire spectrum of care, not only for assisted living communities with dementia care.

As proposed in the regulations, even a passing reference to Alzheimer's and dementia could satisfy the requirement. This is certainly against the intent of the policy and will have a grossly insufficient impact on the quality of care.

Outlining the specifics of the training that staff must receive, including the number of hours, the topic areas, and general content of the training and any required evaluation to address competency, can ensure that all Kentucky residents will be able to receive high quality, person-centered dementia care.

People with dementia reside in all care settings, not just assisted living communities with dementia care. Therefore, it is imperative that staff in all assisted living communities receive dementia specific training with articulated topic areas that address these -- with articulated topic areas to ensure high quality, person-centered dementia care. Nationally over 40 percent of all residents in residential care facilities, including assisted living communities and assisted living communities with basic health services, are struggling with Alzheimer's or other dementia. Establishing a uniform statewide standard of training around dementia, albeit less

than that required for an assisted living community with dementia care, is essential to providing appropriate care to this vulnerable population.

Across the country, states are continuing to articulate specific hours, content, and topic areas for dementia specific training in assisted living communities, including those with, quote, memory care, and those without. Minnesota, the state from which much of the provisions of Senate Bill 11 draw from, requires very specific topic areas and number of hours for staff in all assisted living settings, not just those with dementia care.

The Association is thereby officially requesting that section 14, subsection 8(a) and (b) are revised to include the following. And I will summarize here. Curriculum used for initial training of direct care workers should cover the following topic areas: Alzheimer's disease and dementia, person-centered care, assessment and care planning, activities of daily living, and dementia-related behaviors and communication.

We would also like to see a competency requirement. Participating in training sessions does not in and of itself translate to competency. To ensure competency, as in a demonstrated understanding and application of the training, it is necessary to observe the staff person implementing what they have learned.

We also believe that this should be portable. After completing dementia care training, care providers should receive a certificate as evidence of their training achievement and newly-obtained knowledge. To support portability, which is the ability to transfer skills or education from one setting to another, an individual should be issued a certificate upon completion of training, which would be portable between settings.

It is the recommendation of the Association, in order to ensure that the orientation, education, and in-service annual training are reflective of quality in dementia care, a minimum of six hours of initial dementia specific education should be required for staff in all assisted living communities, including assisted living communities with basic health services.

Also, I would be remiss if I didn't mention that several of the comments now have expressed concern over how providers are going to manage the transition into these different levels of licensure, specifically those communities that would be grandfathered in to an assisted living community with dementia care licensure.

I will remind many of you that this was a concern of the Association throughout the entire legislative process. And we were extremely worried for providers in how they would be able to manage this transition. We repeatedly asked for a solution for this via a transitioning period or a temporary licensure. This concern remained unaddressed in Senate Bill 11. It remains unaddressed in this regulation. And,

clearly, it would appear to be a concern for several of the providers, as we indicated it would be."

(b) Response: Please note that 910 KAR 4:010, Alzheimer's and dementia services curriculum review and approval, will remain in effect upon adoption of 902 KAR 20:480 so that all ALCs will continue to submit their proposed curriculum to the Department for Aging and Independent Living for approval, thereby helping to ensure appropriateness and effectiveness of the dementia care training.

The cabinet remains supportive of any legislative efforts that would help enhance and bring clarity to the ALC training requirements of KRS 194A.719 as it relates to training topic areas, minimum number of training hours annually, and competency evaluations for staff.

Although the cabinet will retain the language of Section 14(8) as written pursuant to the current requirements under KRS 194A.719, we are willing to continue discussions with stakeholders on this issue if additional legislation is sought.

(23) Subject: Testimony of Family Member of Assisted Living Community Resident

(a) Comment: Sean McElroy shared the following comments during the public hearing on January 23, 2023: "I am living in Lexington, Kentucky. I'm the co-POA of -- with my sister of my mother, who lives in assisted living, a medium-sized facility. I'm a trained chef. That's my profession. I am not a lawyer, so I don't know all of the in's and out's and how a regulation contradicts the law and these kinds of things.

I wish some of the folks who just recently spoke with all of the years of background and knowledge and experience could have been -- who each seem to have the same position, that they are against this regulation because, you know, it contradicts law or contradicts the Senate Bill or contradicts what the associations have decided is prudent, I wish they would have been a little more specific to get to the real details.

Bailee, the previous speaker, was able to elaborate on a few details about requirements for dining procedure and those kinds of things. What I'm concerned about, from my experience of visiting my mother three, four days a week during the daytime, nighttime, weekends, weekdays, observing over the past year and two months that she has been in assisted living, observing from my perspective as a chef, chefs are trained to observe large-scale situations, time concerns, employee/co-worker concerns, equipment functioning, details of what products you have in stock, juggling so many things at once. So I pay attention to details.

One comment that everyone has seemed to make is that this -- if this regulation passes, becomes law, it will endanger, and this is terminology that this facility where my mother lives has used to substantiate their rate increase. And the rate increase was installed in September of last year. So they have already taken advantage of

this pending law to increase their rates to between 14 and 20 percent.

So some people have said this could potentially cause us to increase our rates and put us out of business. Well, this company has already taken advantage and raised rates, has been collecting that money starting November 1st. There were two levels of rate increase: One was in healthcare services and one was in monthly rent. They have been collecting that money, and there has been nothing shown, no improvements, no seeming preparation to make changes that were promised. ‘We need to hire three new nurses because of this law, that's why we are increasing rates.’ Not a single new nurse has been hired just to get a foot, you know, in that direction.

So the regulations in this pending law have already been used by this company to increase rates drastically, 14 to 20 percent. My mother's rates increased 20 percent because she receives healthcare services, assisted living.

Many residents at this facility are very upset and they have been for several months and they get no credible kind of support from management. Management seems to dismiss them, minimize their concerns, just pat them on the shoulder and say, ‘Oh, it's okay, don't worry.’

And these folks, seniors, are scared, anxious, worried about their savings just going away. And within the few months that these rates have been increasing nothing has been done to really assuage their concerns. They are still -- at the resident council meetings, they still raise concerns. And they are still told, ‘Don't worry about it. We would go out of business if we didn't raise your rates.’ But what is being done, too, with that money, basically.

One other small detail that I wanted to mention. I was on a phone conversation Friday with Carrie Anglin and Terry, both from the DAIL. And there was one particular piece of information that I believe I was correct in bringing up and they told me that I was misinformed, and this is about assistance with self-administration of medication.

It was my understanding that --because I read it in literature and I wasn't clear because I didn't have the paper in front of me, whether I read it in the residency agreement of the company or if I read it in the regulations, state regulations. But I was certain that aides, KMA, CNAs, must be trained to observe the resident taking the medication to make sure it was taken properly. And if there were any problems, if the resident was combative or refused to take or didn't take the medication properly, the aide would then have to write a report. And that's the reason for the observation, making sure a resident doesn't throw the pills in the trash, drop a pill on the ground, choke on a pill.

I was told by Carrie and Terry that that is not the current statute or law or whatever, that aides are not required to observe. And I said, ‘How can that be?’ And it turns

out in reading both the residency agreement from this company and what I believe is the current law, and I'm sorry if I'm confusing law with statute with regulation, but currently I believe it is required that aides observe a resident taking medication.

The language in the residency agreement of the company is almost exact to what I read on the Kentucky Legislature website. And this residency agreement we signed in October 2021. So that language existed in this company's literature October 2021. If this law was just being -- or these regulations were just being developed and just signed by the Governor in March of 2022, it seems to me like that would be a super coincidence that that language would match almost exactly.

So the point is, how can the CHFS DAIL representatives not be clear about that detail and kind of tell me that, no, that's -- you're not correct there. I believe I'm correct in saying that. And the reason I think this is so important is because if a company is not clear on how to train their staff, and I've witnessed this, that's why I mention it, I visit my mom regularly and I -- this company has super turnover, this is just constant, management and aides.

And a comment that Carrie and Terry both made to me on Friday was, ‘Well, that's just how the -- this industry is. It is because of pay.’ I said, ‘No, it is not just because of pay. It is because of training and clarity and understanding of what are the rules, regulations, procedures, protocols and why.’

I've seen aides come in, take pills out of the locked drawer, which this company keeps medication in a locked drawer, take the pills out of their slips, put them in cups, set them on the table and walk out. Now, are they doing that because I'm there and they are just expecting that I am going to observe my mother take the pills? They don't make any comment. They just walk out. And these are typically new aides that do this. And sometimes we -- I will remind them, ‘Oh, wouldn't you mind staying here and watching her take her medication? I believe that's appropriate, whatever.’

Risk is introduced. If a company, an executive director, managers, the supervisory CNAs or the wellness director who trains the KMAs and CNAs, if they are not clear, if they all have different interpretations of should an aide watch or not or do they have to do this or that, it introduces risk, unnecessary risk into the lives of these residents, where if -- you might have a night shift aide who was just hired and who is one of two aides covering a building of 90 residents. Because this company allows -- you know, I mean, I guess you are allowed, you only need one waking staff member per building or per floor minimum.

And, so, you know, this particular -- I'm sure this is similar to other facilities. You might have a full staff during the day on a weekday, eight aides running around, every manager on your staff running around. You have to avoid people in the hallways there is so much activity on a weekday from eight -- you know, 9 to 5.

Evening shifts get much sparser. Weekend shifts get even more sparse, where you have two aides covering an entire building, no managers. And if they are not clear on the process and procedure and they are not staying to observe residents taking their medication and if they walk out and that resident chokes, drops a pill and following that is compromised somehow, becomes unsteady, becomes dizzy, you have got a big problem.

So, I just think that on these very particular kind of life -- these issues that affect life or death, I mean, I understand all kinds of specific parts of this regulation that refer to -- you know, that talk about how you handle lease agreements and how you handle all of these kinds of things, but there are certain ones, when you get down to the nitty-gritty, they affect life and death. And if the CHFS, if the company, if the executive director, if the managers, if the family members, the residents aren't all on the same page about assistance with self-administration medication, that seems to introduce unnecessary risk to the lives of these residents.

And, fortunately, my mother is not on medication that would cause immediate emergency. But this company was unable to assist with her self-administration dozens and dozens of times over months and months. And several -- my sister and I told them every time medication was missed. We informed them. They said they would remedy it. It just continued to happen months and months.

So my mother survived that. I can't -- you know, it seems to me like that one particular detail and also the consequences of that, of people not understanding is that mandated, is that regulated, is that current, is that past, it seems like everyone could be more careful and attentive to those particular details.

How these regulations contradict law and, you know, trying to supersede legislation by regulation, and that's all fancy talk, I'm talking about training, reducing turnover of staff that introduces risk, when you just have people come in constantly from other facilities, not being able to get comfortable in this facility because they are immediately docked if they do something wrong. That's where the turnover is perpetuated. It is in the pay but it is in clear understanding from management of what the value of our workers are and the value of training them properly."

(b) Response: The Office of Inspector General is willing to meet with Mr. McElroy over Zoom or via conference call to discuss issues one-on-one that he has observed related to his mother's care and respond to his questions.

To schedule a call or Zoom meeting with OIG staff, please email Laurie Robinson at laurie.robinson@ky.gov.

(a) Comment: Sean McElroy submitted the following written comments: "My Additional Comments per Zoom public forum on Senate Bill 11 and 902 KAR 20:480:

I have to admit ignorance to the process and procedures of these laws, statutes, and regulations. I have trouble differentiating between 'KAR's, 'KRS's, and laws. What I do know is that I have observed practices by the management of the AL facility where my mother lives that are questionable. I do not understand what the law requires them to do in certain cases, but I know that they have difficulty maintaining consistency and transparency in some of their daily operations.

First, the facility where my mother (I am her son and Co-POA) lives is Highgrove at Tates Creek in Lexington, KY. It is a medium-sized 'Social Model'/Certified AL facility with Memory Care. I do not know how that differs from an AL with 'Dementia Care'. I do not know how Highgrove is designated in regards to the KAR when it refers to an ALC, ALC-BH, or ALC-DC. Will Highgrove be required, if pursuing a license, to change its description of services from 'Memory Care' to 'Dementia Care'? This affects how I read the regulations since a large portion of the regs relate specifically to the issue of Dementia Care. If I do not know how Highgrove is categorized (as an ALC or as an ALC-DH), then I do not know how the regs change the requirements for Highgrove. I do not know how to assess their financial, administrative needs/requirements after the final implementation of Senate Bill 11 and the KARs. How do I know whether or not to believe what they say when they claim that rates need to be raised exponentially to cover new, imposed costs? How do I know they are not making inaccurate claims just to bolster their desire for more profit?

Second, regarding staffing levels, in Senate Bill 11, Section 19 (3), it states that 'Staffing levels shall be sufficient to meet the scheduled needs of residents. During nighttime hours, staffing levels shall be based on the sleep patterns and needs of residents.' Does this refer to the staffing level of the entire AL facility or just to the secured Dementia Care Unit of the building? Also, what are the criteria to determine what is 'sufficient'? It says in 902 KAR 20:480, Section 7, pg. 13, lines 9-21: '(j): Develop and implement a staffing plan for determining staffing levels that: 2. Ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' functional needs assessment and service plans on a twenty-four hour (24) per day basis; and… (k) Ensure that one (1) or more staff are available twenty-four hours (24) per day, seven (7) days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs:'… Does this regulation add anything to Senate Bill 11? Why are there no ratios stated in the regulation or bill? If a facility has a population of 90 residents, how can only one staff member reasonably fulfill the requirements of resident safety? How is it determined to keep one, two, or more staff on hand around the clock in a facility of this size? Why is there no distinction between facilities with small resident populations versus medium versus large resident populations? When staff levels vary at Highgrove from 6-8 aides present during the daytime (in the AL wing, not including the Memory Care Unit) down to only 2 aides, or 3 aides, or on rare occasion 4 aides (levels differ on any given night shift) present during 3rd

shift/overnight, how is that determined to be 'sufficient'? Is it left up to the ED of the facility to determine staffing levels or is it regulated by CHFS?

In my experience, staffing levels at Highgrove vary so wildly that it seems like care is often compromised. If 1 or 2 aides call in sick or do not show up for 3rd shift that leaves 2 aides to cover 2 floors of apartments. To the best of my knowledge, no substitutes are called in to cover for the absent aides, thus leaving only 2 aides on staff. When staffing levels fluctuate so unpredictably, who is responsible and who has the authority to rectify the situation? The management at Highgrove does not seem to be compelled or willing or able to self-correct when this happens. I believe they are acting recklessly when staffing drops down to minimum levels. I believe they are introducing unnecessary risk to their residents when staffing levels are allowed to drop so low (unless it is true that only 1 aide is required to be present in the entire building). Does the new law only require 1 aide to be present on an overnight shift? Does the regulation only require 1 aide to be present on an overnight shift? Also, if there is no such thing as a required ratio, then why is the company allowed to assert, on caring.com, that they maintain a 1:13 staff-to-resident ratio? Is the current law similar in its requirements and does Highgrove/Traditions Management, LLC misunderstand the current law? Are they misrepresenting their services? Are they making a false statement? Are they ignorant, careless, or intentionally misleading the public when they make this assertion? Whose responsibility is it to correct them? I know from direct observation that they do not maintain a 1:13 staff-to-resident ratio during the overnight/3rd shift. And, either way, if there is no such thing as a required ratio, they seem to be perpetuating two falsehoods/misunderstandings. This is wrong.

Third, regarding the posting of information/policies in the building, it states in Senate Bill 11, pg. 20, Section 36, (1) (c) 'The community or facility shall post a statement in its entrance or lobby as follows: Written information relating to this community's or facility's services and policies is available upon request.'" It states in the KAR, Section 7, pg. 16, lines 9-16: '(5) Resident grievances. (a) Each ALC, ALC-BH, and ALC-DC shall post in a conspicuous place: 1. Information about the facility's grievance procedures; and 2. The name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. (b) The notice shall also have: 1. Contact information for the long-term care ombudsman; and 2. Information for reporting suspected abuse, neglect, or exploitation of an adult.' Seeing as though both of these requirements are pending and not yet in force, can you tell me what the current rules/guidelines are? Because as of today, Highgrove does not have either of these requirements fulfilled. In other words, they do not currently have any of this information posted in the building. Residents only have the contact info for CHFS/DAIL available in their Residency Agreement. Otherwise, they are asked to speak directly with a member of management about any grievance. When management is not present in their offices, there is no other contact information posted for residents to refer to – no telephone number, no e-mail address. Is this appropriate?

I have many other concerns, namely about the financial behavior of the company. The management at Highgrove, as well as their parent company Traditions Management, LLC (based in Indianapolis, IN), seem to have already taken full advantage of the prospect of Senate Bill 11. They have largely substantiated their recent steep rate increase on the basis of the passage of the new law with the requirement for licensure that it entails. The ED has made statements that they will need to hire 3 more nurses and claims that pay scales are increasing for all staff positions. No one knows if his statements/promises were made in earnest/good faith or not. No one knows what Highgrove pays its staff. They may be lowering rather than increasing their wages/salaries for all we know. They have not hired a single new nurse since making that statement/promise 4 months ago. They also promised to improve the quality of food. That has not happened in the past 4 months either. The bottom line is that this facility is cashing in on the prospect of Senate Bill 11 without showing any improvements or making any changes whatsoever. They are gaining a large financial windfall. They seem to have made promises that are not being fulfilled, or else have not yet seen fit to put the extra revenue to use. The profit motive seems to be overshadowing the good faith, ethical behavior of this facility. What are the solutions to this dilemma? CHFS should be required to read any notifications sent to residents that include any rate changes or policy changes. Your office should be able to follow up on any information that is misleading and detrimental to the safety of residents (i.e. the implementation of consistent, appropriate staffing levels).

Thank you for your attention. I hope some part of this letter made sense and might help you to understand our expectations, experiences, and difficulties.

P.S. When the aides in a facility skip a resident's dose of medication (and the resident relies on the aides to unlock the medication drawer and then to remind them to take their medication), how can this be remedied? If a manager is notified yet the problem persists over many weeks' and months' time, is there any way to hold the facility accountable? Is there any punitive measure that can be taken to incentivize them to rectify this negligence? The way it stands currently, we have had to rely on the 'word'/promise of the aides, the Wellness Director, and the Executive Director to remedy the situation. Within this past year, there were so many occasions where this failure to remind and assist my mother with her medication happened that we lost our trust and faith in the staff to correct the problem. Lately they have been doing better, but we are not holding our breath for a permanent correction/solution. Can measures/regulations be put in place to create a system of accountability for facilities/companies in this circumstance? How can a facility continue to fail in its primary responsibility to ensure that residents actually receive assistance with their medication on a daily basis? How can they conceivably be allowed to miss reminders several times a month for months on end, therefore endangering the health (and lives) of their residents? This is a service that residents like my mother pay for, and in many cases do not receive regular, reliable return on their payment. In other words, they are not getting what they pay for. CHFS should

be required to audit these facilities to determine whether or not the facilities are fulfilling their duties and operating in good faith."

(b) Response: The Office of Inspector General is willing to meet with Mr. McElroy over Zoom or via conference call to discuss issues one-on-one that he has observed related to his mother's care and respond to his questions.

To schedule a call or Zoom meeting with OIG staff, please email Laurie Robinson at laurie.robinson@ky.gov.

Summary of Statement of Consideration and
Action Taken by Promulgating Administrative Body

The public hearing on this administrative regulation was held on January 23, 2023. In addition to the public hearing, written comments were received during the public comment period. The Cabinet for Health and Family Services, Office of Inspector General responded to the comments and amends the administrative regulation as follows:

Page 1
RELATES TO
Line 6
After "194A.700-194A.729,", insert "**209.030(2)-(4)**".

Line 8
After "218A.200(6),", insert "**314.011(3)**".

Page 2
NECESSITY, FUNCTION, AND CONFORMITY
Line 1
After "communities", insert "**(ALC)**".
Line 2
After "services", insert "**(ALC-BH)**".
After "unit", insert "**(ALC-DC)**".

Section 1(13)
Line 17
After "(13)", insert the following:
"Immediate family member" means a:
(a) Spouse:
(b) Child;
(c) Stepchild;
(d) Son-in-law;
(e) Daughter-in-law; or
(f) Grandchild.
(14)

Section 1(14)
Line 18
After “194A.700(13).”, insert “**(15)**”.
Delete “(14)”.

Section 1(15)
Line 20
After “communities.”, insert “**(16)**”.
Delete “(15)”.

Section 1(16)
Line 21
After “194A.700(15).”, insert “**(17)**”.
Delete “(16)”.
Section 1(17)
Line 23
After “affairs.”, insert the following:
(18) “Licensed health professional” means a person who:
(a) Possesses a current Kentucky license or multistate licensure privilege to practice in Kentucky; and
(b) Provides services to ALC-BH or ALC-DC residents, including the delegation of tasks pursuant to KRS 194A.700(7)(h) as authorized under the professional’s scope of practice.
(19)
Delete “(17)”.

Page 3
Section 1(18)
Line 1
After “194A.700(16).”, insert “**(20)**”.
Delete “(18)”.

Section 1(19)
Line 4
After “community”, insert “**(21)**”.
Delete “(19)”.

Section 1(20)
Line 5
After “194A.700(17).”, insert “**(22)**”.
Delete “(20)”.

Section 1(21)
Line 6
After “194A.700(18).”, insert “**(23)**”.

Delete “(21)”.

Section 1(22)
Line 10
After “provider.”, insert “**(24)**”.
Delete “(22)”.

Section 1(22)
Line 10, after “194A.700(19).”, insert the following:
(25) “Nurse” is defined by KRS 314.011(3).
(26) “Nursing task” is defined by 201 KAR 20:400, Section 1(11).
(27)
Delete “(23)”.

Section 1(24)
Line 12
After “194A.700(21)”, insert “**(28)**”.
Delete “(24)”.

Section 1(25)
Line 13
After “194A.700(22)”, insert “**(29)**”.
Delete “(25)”.

Section 1(26)
Line 14
After “194A.700(23)”, insert “**(30)**”.
Delete “(26)”.

Section 1(27)
Line 15
After “194A.700(24)”, insert “**(31)**”.
Delete “(27)”.

Section 1(28)
Line 20
After “entity.”, insert “**(32)**”.
Delete “(28)”.

Section 1(29)
Line 21
After “194A.700(26)”, insert “**(33)**”.
Delete “(29)”.

Section 1(29)
Line 21

After “194A.700(27)”, insert the following:

(34) “Volunteer” means a person who has duties that are equivalent to the duties of an employee providing direct care services and the duties involve, or may involve, one-on-one contact with a resident. A volunteer does not include a member of a community-based or faith-based organization or group that provides volunteer services that do not involve unsupervised interaction with a resident.

Page 12
Section 7(2)(e)
Line 17

After “person-centered”, insert “**care**”.

Page 14
Section 7(4)(a)
Line 22

After “194A.709”, insert the following:

and KRS 209.030(2) – (4) to the:
1. Office of Inspector General, Division of Health Care; and
2. Department for Community Based Services

Page 15
Section 7(4)(i)
Line 17

After “and”, delete “licensed”.

Section 7(4)(k)
Line 20

After “delegation of”, insert “**: a. Nursing**”.
After “tasks”, insert “**in accordance with 201 KAR 20:400;**”.
Delete “by registered nurses”.
After “or”, insert the following:

b. Therapeutic or other tasks assigned by

Section 7(4)(l)
Line 22

After “supervision of”, delete “registered”.

Page 16
Section 7(4)(m)
Line 2

After “tasks;”, insert the following:

, which shall include how the facility ensures compliance with the supervision requirements of 201 KAR 20:400, Section 4 if nursing tasks are delegated

Page 16
Section 7(5)(b)1.
Line 15
After “the”, insert “**state**”.

Page 17
Section 8(3)(b)
Line 14
After “representative”, insert the following:
unless the staff person is an immediate family member of the resident

Page 18
Section 9
Line 6
After “(1)”, insert “**(a)**”.
After “area.”, insert the following:
Access to central dining shall be provided
Delete the following:
A dining area shall be available
Line 7
After “ALC-DC”, insert the following;
in accordance with KRS 194A.703(2), including three (3) meals and snacks made available each day in accordance with KRS 194A.705(1)(b) with flexibility for residents in a secure dementia care unit.
(b) In addition to subsection (1) of this section, subsections (2) to (5) of this section of this administrative regulation shall apply to facilities licensed to operate as an ALC-BH or ALC-DC.

Section 9(3)(b)
Line 13
After “An”, delete “ALC,”.
After “ALC-BH”, delete “,”.
Page 19
Section 9(4)(c)
Line 1
After “a”, insert “**licensed health professional**”.
Delete “physician”.

Page 20
Section 10(1)
Line 4
After “(1)”, delete “Employee records.”

Section 10(1)(a)2.
Line 7
After “providing”, insert “**direct care**”.

Section 10(1)(b)
Line 8
After “record”, insert “**for each staff person**”.

Section 10(1)(b)6.
Line 19
After “902 KAR 20:205.”, insert the following:
(2) The record for each regularly scheduled volunteer shall include documentation of background checks in accordance with Section 14(1) of this administrative regulation.
(3)

Section 10(1)(c)1.
Line 20
After “902 KAR 20:205.”, delete “(c)1.”.
After “Each”, delete “employee”.

Section 10(1)(c)2.
Line 22
After “facility.”, insert “**(4)**”.
Delete “2.”.
After “operation,”, delete “employee”.

Page 23
Section 13(4)(i)
Line 9
After “or”, insert “**licensed**”.
After “health”, delete “care”.

Section 13(4)(j)
Line 12
After “or”, insert “**licensed**”.
After “health”, delete “care”.

Section 13(4)(m)
Line 19
After “health”, insert “**professional**”.
Delete “care practitioner”.

Page 25
Section 14(1)(a)
Line 15
After “owners”, insert “**,**”.
Delete “and”.
After “staff”, insert “**, and regularly scheduled volunteers**”.

Line 16
After “residents”, insert the following:
, which may include access to the belongings, funds, or personal information of residents

Page 26
Section 14(2)
Line 23
After “nurses.”, delete the following:
Except for a social model ACL,

Page 27
Section 14(2)
Line 2
After “license”, insert “**or multistate licensure privilege**”.
After “practice”, insert “**in Kentucky**”.

Section 14(4)(a)
Line 14
After “nurse.”, delete “(a)”.
After “a”, delete “registered”.
After “nurse”, insert “**readily**”.
Lines 15 - 16
After “available”, delete the following:
for consultation by staff performing delegated nursing tasks. (b) The registered nurse shall be readily available

Section 14(4)(b)
Line 17
After “means”, insert “**of live, two-way communication**”.
After “to”, insert “**unlicensed**”.
Delete “the”.
After “delegated”, insert “**nursing tasks**”.
Delete “services”.

Section 14(5)(a)
Line 18
After “(a)”, insert “**1.**”.
Delete the following:
Except for a social model ALC,
After “a”, insert the following:
nurse in an ALC-BH or ALC-DC

Lines 18 - 19
After “a”, delete the following:
registered nurse or licensed heath professional

Line 19
After “with”, insert the following:
201 KAR 20:400.
2. A licensed health professional in an ALC-BH or ALC-DC may delegate tasks in accordance with
Line 20
After “the”, insert “**professional’s**”.
Delete “practitioner’s”.

Section 14(5)(b)
Line 23
After “the”, delete “registered”.
After “or”, insert “**appropriate**”.

Page 28
Section 14(5)(b)
Line 1
After “the”, delete “registered”.

Section 14(5)(c)
Line 4
After “the”, delete “registered”.
Line 5
After “the”, delete “registered”.

Section 14(5)(d)
Line 10
After “the”, delete “registered”.

Section 14(5)(e)
Line 12
After “the”, delete “registered”.
After “document”, insert the following:
delegated nursing or other assigned tasks

Lines 12 – 13
After, “document”, delete “instructions for the delegated tasks”.

Page 29
Section 14(6)(c)
Line 2
After “Supervision”, insert “**may include**”.
Delete “includes”.

Section 14(7)(a)

Line 9
After “performs”, insert “**: 1.**”.
After “nursing”, insert the following:
tasks shall be supervised by a nurse pursuant to the requirements of 201 KAR 20:400, Section 4;
After “or”, insert “**2.**”.
Line 10
After “by”, delete “a registered nurse or”.

Section 14(7)(a)1.
Line 12
After “to:”, insert “**a.**”.
Delete “1.”.

Section 14(7)(a)2.
Line 13
After “and”, insert “**b.**”.
Delete “2.”.

Section 14(7)(b)
Line 16
After “administration”, delete “**shall**”.
Line 17
After “1.”, insert “**Shall**”.
After “a”, delete “**registered**”.
Line 19
After “2.”, insert “**May**”.

Page 30
Section 15(1)(c)
Line 17
After “a”, delete “registered”.
After “nurse,”, insert “**appropriate**”.

Page 32
Section 15(2)
Line 8
After “194A.708(1)(d)”, insert the following:
the facility shall have a
Delete “registered”.
After “or”, insert the following:
other licensed health professional
Delete “prescribing practitioner shall”.

Page 33
Section 15(4)

Line 10
After “management;”, delete “and”
Line 11
After “Discuss”, delete “with the resident”.
After “refusal”, insert the following:
with the:
1. Resident;
2. Resident’s designated contact person or legal representative; or
3. Both individuals identified by subparagraph 2. and 3. of this paragraph;
Line 12
After “and”, insert “**(c)**”.

Page 34
Section 15(5)(b)6.
Line 8
After “a”, delete “registered”.

Section 15(5)(c)
Line 15
After “a”, delete “registered”.
Line 16
After “health”, insert “**professional**”.
Delete “care practitioner”.
After “the”, insert “**professional’s**”.
Delete “practitioner’s”.

Section 15(6)
Line 18
After “health”, delete “care”.

Section 15(7)
Line 23
After “administration.”, insert “**(a)**”.
After “unlicensed personnel”, insert the following:
who meet the requirements of subparagraph 1. of this paragraph

Page 35
Section 15(7)
Line 1
After “medication”, insert “**, or preloaded injectable insulin**”.
After “a”, insert “**nurse or appropriate**”.
After “health”, delete “care”.
Line 2
After “medication”, insert “**administration**”.
Line 3
After “the”, delete “**registered**”.

After “health”, delete “care”.

Section 15(7)(a)
Line 4
After “has:”, insert “**1.**”.
Delete “(a)”.
After “who”, insert the following:
: a. Is a certified medication aide; or
b.
After “has”, delete “: 1.”.
Line 5
After “completed”, insert “**a: i**”.
Delete “the Kentucky”.
After “program”, insert the following:
accepted by the Kentucky Board of Nursing (KBN);
After “and”, insert the following:
ii. Skills competency evaluation;
Line 6
After “and”, delete the following:
Demonstrated the ability to competently follow the procedures;
(b) Instructed the unlicensed personnel in the proper methods to administer oral or topical medications;
(c)

Section 15(7)(d)
Line 11
After “and”, insert “**3.**”.
Delete “(d)”.
Line 12
After “resident.” insert the following:
(b) The ALC-BH or ALC-DC shall ensure that a nurse or licensed health professional is readily available during times the unlicensed staff administers medications in accordance with Section 14(4) of this administrative regulation.

Page 36
Section 15(8)
Line 3
After “health”, insert “**professional**”.
Delete “care practitioner”.

Section 15(10)(b)1.
Line 16
After “the”, delete “registered”.
After “health”, insert “professional”.
Delete “care practitioner”.

Section 15(10)(b)2.
Line 18
After “a”, delete “registered”.
After “health”, insert “professional”.
Delete “care practitioner”.

Page 38
Section 15(15)(a)
Line 2
After “the”, delete “registered”.

Section 15(16)
Line 7
After “the”, delete “registered”.

Page 40
Section 15(21)(c)4.b.
Line 3
After “from” insert “**an appropriately authorized**”.
Delete “a”.
After “health”, insert “**professional**”.
Delete “care practitioner”.

Section 15(21)(d)
Line 5
After “(d)”, “**An appropriately authorized**”.
Delete “A”.
After “licensed”, insert “**health professional**”.
Delete “practitioner”.

Page 46
Section 19(1)(b)
Line 11
After “Assessment”,”, insert “**March 2023**”.
Delete “November 2022”.

Material Incorporated by Reference
Functional Needs Assessment

Page 2
Exclusions
Question 7
After “falls”, insert “**with major injuries**”.

Question 9

After “the”, insert the following:

facility able to provide assistance to the

After “individual/resident”, insert “**to manage incontinence**”.

Delete the following:

incapable of self-managing with minimal assistance

Note under Question 9

After “an”, insert “**ALC-BH or**”.

Page 3

Dietary

Under the box “Special Diet Followed” and “Yes □ No □ Comments:” add the following new boxes:

“**Food Allergies**” and “**Yes □ No □ Comments:”.**

Page 4

Medication

After “Needs Medication”, insert “**administration**”.

Delete “management”.

Attestation Statement

After “your”, delete “professional”.

Signature Line

After “Date”, insert the following:

The FNA shall be completed by a staff person who meets the qualifications of 902 KAR 20:480, Section 7(1)(c)2.