

QUESTIONS AND ANSWERS ON ASSISTED LIVING RESIDENCES REGULATIONS
(updated October 20, 2008)

Acronyms

Adult Care Facility = ACF

Adult Home = AH

Enriched Housing Program = EHP

Assisted Living Residence = ALR

Enhanced Assisted Living Residence = EALR or EAL

Special Needs Assisted Living Residence = SNALR or SNAL

Individualized Service Plan = ISP

Continuing Care Retirement Community = CCRC

Licensed Home Care Services Agency = LHCSA

Certified Home Health Agency = CHHA

Long Term Home Health Care Program = LTHHCP

Registered Professional Nurse = RN

Licensed Practical Nurse = LPN

Home Health Aide = HHA

Certified Nurse Aide = CNA

Public Health Law = PHL

Social Services Law = SSL

A. Applicability

No current questions.

B. Definitions

No current questions.

C. Certificates of Incorporation; Articles of Organization

No current questions.

D. Operating Certificates; Additional Certifications; Authority Limited to Operator

No current questions.

E. Applications for Licensure as an ALR; Certification as EALR and SNALR

1. Some facilities currently have ALP residents in their Dementia units; can they have ALP beds in the SNALR?

Facility-specific situations such as the one described in this question, which is not the norm, will be reviewed by the Department on a case-by-case basis.

2. If a facility has been awarded ALP beds and consequently rescind their application for ALR certification, can they still call themselves “Assisted Living”?

If a facility has beds that are approved by the Department pursuant to Section 461-l of the Social Services Law, they may call themselves “Assisted Living Programs”, however, they may not refer to themselves as “Assisted Living Residences.”

3. Since a nurse is required in a SNALR, will the development of policies and procedures for nurses be required? If so, how long can the ALR/SNALR certification remain pending until these policies are developed and at what point would a facility need to officially withdraw the application and continue operating as an Adult Home without a dementia unit?

It is the intent of the department’s regulations that SNALR nursing services will require the same policies and procedures which are required under the EALR, even though there is no specific mention of policies and procedures for nurses for SNALRs in the ALR regulations. Pursuant to Sec.1001.10(m)(2) “If an EALR provides healthcare services that would ordinarily be provided by a home care service agency licensed pursuant to Article 36 of the public health law, then the operator of the EALR shall develop appropriate policies and procedures related to such health care services to include but not be limited to....” The same requirements apply to the SNALRs.

Policies and procedures may be requested of the facility at any point during the application process; applicants will have 60 days to respond to such a request pursuant to §1001.5 (h). Extensions may be granted as needed.

Section E of the Application for Licensure as an ALR, Certification as an EALR and Certification as a SNALR instructs applicants to provide copies of personnel policies and procedures. If the policies and procedures are not submitted with the application, the Department will request that they be submitted within 60 days. Pursuant to §1001.5 (h), extensions may not be for more than 60 days. Thus, if the Department is not in receipt of requested policies and procedures within 60 days of its request after initial application, or 120 days if the facility has been granted an extension, the Department **may** administratively withdraw the application due to a failure to respond.

ALR applications which include SNALR certification cannot be withdrawn by the applicant unless the dementia unit is closed under the NYS facility closure guidelines.

Failure to comply with the ALR/SNALR application requirements may result in the Department taking necessary actions to close the dementia unit.

4. Once we receive approval of the ALR/EALR application, what is the expected time frame for implementation? Will there be a pre-opening survey?

Yes, there will be a pre-opening survey. Once an approval of the ALR/EALR is granted, and the pre-opening survey has been successfully completed, the facility itself will be in control of the timeframes for implementation.

F. General Provisions

1. If a facility currently has a waiver approved (some of them are very old) and they apply for ALR, does the waiver stand or do they need to resubmit another waiver?

Waivers address individual circumstances and will be dealt with by the Department on a case-by-case basis. All current waivers will need to be resubmitted to the Department for review and new approvals.

G. Admission and Retention Standards

1. In a CCRC, there is frequently the movement of residents from independent living to adult home to skilled nursing facility, back to adult home back to independent living and so on. It seems that it would be an essential part of maintaining continuity of care for the CCRC contract holders to include direct admission from any other level of care to the EALR if the individual is in need of EALR services. Is this permissible?

CCRCs operating EALRs who wish to propose a scenario as described will need to submit such proposals in writing to the Department of Health via the established waiver process, to be addressed on a case-by-case basis. As stated above, it is not currently allowable to directly admit residents to the EALR from the community who exceed the retention standards of a “basic” ALR (the purpose of EALR certification is to permit “aging-in-place”). Further, any resident being admitted to an EALR must have the required pre-admission interview, screening, medical evaluation and an individualized service plan developed.

2. Can residents in a SNALR “age-in-place” like in an EALR?

No. SNALRs, in and of themselves do not have the ability to allow “aging-in-place”; only EALRs. Therefore, the facility must be dually-certified for SNALR and EALR for a resident to receive special needs and enhanced services simultaneously. Further, administratively, such resident would be occupying both an available EALR bed

and an available SNALR bed.

3. The DOH-3122 appears to require a mental health evaluation with the exception that "the resident does not evidence need for placement in a residential treatment facility licensed or operated pursuant to article 19, 23, 29 or 31 of the Mental Hygiene Law". Does the new DOH-3122 satisfy the requirements for a mental health evaluation upon admission?

No. The DOH-3122 provides for an assessment as to the need for a mental health evaluation. Pursuant to 10 NYCRR 1001.7(i): "Information collected through the required prospective resident interview, mental health evaluation if required, medical evaluation, the pre-admission evaluation including the Personnel Data and Resident Evaluation Form, and any other information as needed, on forms approved by the Department, must be used to determine whether the individual is appropriate for admission to the ALR." Furthermore, following 18 NYCRR 487.4(e)(3): "... in the event that a proposed resident has a known history of chronic mental disability, or the medical evaluation or resident interview suggests such disability, then a mental health evaluation must be conducted."

4. If a physician indicates on a Medical Evaluation that a resident needs a certain level of care that ultimately, after ALR resident interview and assessment, is determined not the best level of care for the resident, must the ALR go back to the physician for a new Medical Evaluation? An example may be if an individual is in the early stages of dementia but could function well in the basic ALR and doesn't need all the specialized services and environment of the SNALR. Would the ALR be cited in survey for not following the doctor's 'orders'?

Yes, in this situation, the ALR would be required to have a new Medical Evaluation; the ALR has no authority to over-ride clinical decisions made by the resident's physician. It is the responsibility of the facility to follow-up with the physician any concerns regarding the physician's determination of level of care for the resident, and to identify the appropriate level of care. If the level of care on the Medical Evaluation is changed or revised by the physician, a signed, dated revised Medical Evaluation must be provided.

If an ALR does not follow physician's orders on a Medical Evaluation, they will be cited on survey for that violation.

5. Can a resident enter an EALR from an ALR which does not have an EALR?

This question is currently under review by the Department, and may require a statutory change to resolve.

6. What if a facility has only enhanced level beds? Can they accept enhanced level residents, or do they too need to start with all 'basic' level residents?

All assisted living residences (ALR/EALR/SNALR) must be certified as an ALR. EALR services are provided in addition to the ALR services. Therefore, a facility cannot have only "enhanced level beds". All ALRs/EALRs have the ability to accept "basic" level residents. However, facilities cannot admit residents at the EALR level, all admissions must be at the ALR basic level of care.

H. Consumer and Resident Protections

1. Will EALR staff be allowed to take action in accordance with established "Do Not Resuscitate" (DNR) orders, or is it expected that they will continue to contact emergency personnel and provide a copy of the DNR to them?

The ALR regulations are silent on the issue of DNR. Therefore, procedures for ALRs and staff in response to a DNR will remain the same as is handled in ACFs. For all types of advance directives, the operator must document they exist, and the facility must send a copy of the advance directive with the resident when the resident is transferred to another facility. In the event emergency medical services transports the resident to another facility, the operator must give a copy of the advance directive to the emergency medical services responder.

I. Resident Funds and Valuables

No current questions.

J. Resident Services

1. Some of the services that require admission to the EALR are personal care related (i.e. assistance to walk and transfer). These are personal care tasks that ACF aides are currently trained to provide as part of the basic 40-hour training (albeit not on a "chronic" basis for any individual resident). Will ALR Resident Care Aides be able to provide this assistance for an EALR resident, or will you require only an HHA to provide it?

10 NYCRR 1001.10(j)(3) states: "Personal care service tasks shall be performed by staff, hereafter referred to as resident aides, appropriately trained to perform such tasks ...". The Department is finalizing curriculum to train Resident Care Aides, which will then be used by facilities to develop training for such aides in all ALRs, including EALRs. Resident Care Aides will be trained to the same level as home care personal care aides. As stated in 1001.10(m)(3): "Personal care tasks that exceed the approved

scope of tasks in which the resident aide is trained, shall be performed by home health aides trained in such tasks pursuant to section 700.2(b) of this Title.”

2. Can EALRs contract for HHA services?

Yes, EALRs may contract for the provision of HHA services. An EALR must arrange for any needed health care services to be provided by a home care services agency. An EALR is permitted to provide such services directly, if it so chooses. If it does not, however, then it must contract with an approved PHL Article 36 home care services agency to provide such necessary services.

3. Will EALR/SNALR nurses be able to administer and/or read tuberculosis (TB) tests?

Yes, TB testing procedures fall within the scope of practice for registered professional nurses (RNs), once they have received appropriate training in the administration and reading of TB tests.

4. What is the scope of practice for nursing in an EALR?

The scope of practice of nursing is defined in State Education Law Article 139, irrespective of the setting. The services allowable within an ALR, EALR and SNALR are dictated by the Assisted Living Reform Act (PHL Article 46-B). “Health care services” in an ALR are defined as including those which would be provided by a home care services agency licensed under PHL Article 36. Therefore, the range of services which could be provided by a nurse in an EALR are dictated by the resident’s health care needs, as described in the resident’s Individualized Service Plan (ISP), and what the EALR and RN are each authorized by law to provide.

5. What is the scope of practice for nursing in an SNALR?

See Question #4.

6. While nurses are allowed to provide services within their scope of practice in an EALR and SNALR, can a facility choose not to allow their nurses to do this?

An EALR and/or SNALR operator may choose to limit the range of services a nurse may provide residents to those minimally required in 10 NYCRR 1001.10, as long as the resident’s needs are otherwise met pursuant to his/her ISP. Further, at a minimum, the EALR/SNALR will need to have policies addressing the contracting of necessary services and oversight of contracted staff. If at a later point in time they decide to use their facility nurses to provide these services, they must have appropriate policies and procedures in place. Any limitations on the provision of nursing care by an

EALR as it affects resident admission/retention must be explained in the required disclosure information.

7. Is the expectation that EALR/SNALRs must eventually develop nursing policies and procedures, or can they go on indefinitely contracting for such services?

See Question #6. While an EALR/SNALR can simply choose to contract for nursing services with a home care services agency licensed or certified pursuant to PHL Article 36, it must still have policies and procedures which address the provision of services at the EALR/SNALR.

8. Would nurses be allowed to provide total assistance with feeding?

Yes, this is within the scope of nursing practice.

9. Would staff other than nurses be required to complete training prior to providing total assistance with feeding?

Currently, home health aides are also trained to provide total assistance with feeding. It is not expected that Resident Care Aides will be trained in such practice. Therefore, only a nurse or HHA will be professionally capable of serving residents in need of such assistance.

11. Can the RN of an EALR/SNALR make the determination to give a PRN medication either on- or off-site?

Yes. Pursuant to the NYS Scope of Practice of LPNs and RNs, "licensed practical nurses function by law in a dependent role at the direction of an RN Under such direction, LPNs may administer medications, provide nursing treatments, and gather patient measurements, signs and symptoms that can be used by the RN in making decisions about the nursing care of specific patients". Therefore, an LPN may report "signs and symptoms" that can be used by the RN to make the determination to give a PRN medication.

K. Personnel

1. 10 NYCRR 1001.11(c)(2)(i) refers to "40 hours of initial training as specified in the Department's training requirements and curriculum or an approved equivalent program" for resident aides. Has the Department's training requirements and curriculum been developed? What are the procedures are to obtain an approved equivalent program?

The Resident Care Aide Training Curriculum outline has been drafted and has been shared with the industry for review and comments, with additional information to

be provided by the Department in the near future. In the interim, ALRs should continue to use the existing training curricula currently used for ACF and home care aides.

2. Is the Resident Care Aide training plan that is currently under development by the Department going to be used to train the EALR aide staff?

The regulations do not refer to any special category of “EALR aide staff”. All Resident Care Aides in ALRs, EALRs and SNALRs will receive the same minimum personal care task training. Personal care tasks that exceed the approved scope of tasks in which the Resident Care Aide is trained must be performed by HHAs.

3. Can EALRs train their own HHAs?

In order to train HHAs, an entity must be approved to provide such training pursuant to current home care requirements. Basic training and curriculum content, including competency evaluation and training requirements for HHA training, are delineated in Part 484 of Title 42 of the Code of Federal Regulations and 10 NYCRR 700.2. Further, as of 10/1/06, any organization seeking initial approval of a HHA training program in NYS must comply with the requirements set forth in the DOH “Guide to Home Health Aide Training and Competency Evaluation”.

4. Can EALRs apply for approval as a HHA trainer?

Yes. See Question #3.

5. Must EALRs apply for approval as HHA trainers?

No. See Question #3.

6. Have the requirements for the on-call RN in EALRs/SNALRs been defined?

Pursuant to 10 NYCRR 1001.11(j)(2), an EALR or SNALR must have an RN on-call and *available* for consultation 24 hours a day, seven days a week, if not available on site. The EALR is required to provide or arrange for nursing services for its residents as necessary, including (but not limited to): assessment and evaluations of residents; supervision of aides; and nursing care and treatments. Therefore, when not on-site, the RN must be available to respond to any resident needs which may arise. If an incident arises, as in the nursing home or home care setting, the on-site LPN or HHA verbally conveys his/her observation of the resident’s condition to the RN, who then makes a professional determination of the steps to be taken. This may require the RN to physically go to the EALR and assess the resident in person.

7. If an operator has an approved EALR and skilled nursing facility adjacent to each other, such as with a CCRC, would it be acceptable for the SNF’s

RN Manager to meet the EALR’s requirement for on-site RN coverage? If so, how would such approval be obtained?

Pursuant to 10 NYCRR 1001.11(j)(1) an EALR or SNALR must have a registered professional nurse on duty and on site at the residence, for eight hours a day, seven days per week. In the described situation, only if the SNF’s RN Manager is physically at the residence would this requirement be met. Any requests for approval of a waiver of this requirement must be made in writing to the Department of Health’s Division of Home and Community Based Care. See Question #6. Such requests shall be addressed on a case-by-case basis, as submitted in writing via a waiver application to the Department of Health’s Division of Home and Community-Based Care. *(Revised)*

8. Can the RN be working somewhere else or have other responsibilities while (s)he is on-call?

This will be determined on a case-by-case basis, as submitted in writing to the Department of Health. The RN must be able to *simultaneously* fulfill his/her legal duties for the ALR, including being on-site if needed, and wherever “else” it is being proposed that (s)he be (e.g., nursing home).

9. Does the RN have to possess knowledge of the residents, programs, etc.?

Yes. 10 NYCRR 1001.11(c) requires an operator to “provide staff sufficient in number and qualified by training and experience to render, at a minimum, those services mandated by law or regulation”, including nursing in an EALR/SNALR.

10. 10 NYCRR 1001.11(n) states that at any time in which the RN is not on-duty and on-site at an EALR/SNALR, “sufficient home health aide staff” must be provided to meet the care needs of residents. Does this mean that all Resident Care Aides must be upgraded to HHAs if an EALR/SNALR does not have 24/7 RN coverage?

No. Resident Care Aides and HHAs are subject to different training requirements. Either an individual is trained to the Resident Care Aide standard or the HHA standard. It is anticipated that HHAs would supplement Resident Care Aides in those functions that Resident Care Aides are not qualified to perform.

11. Will LPN coverage be sufficient to fulfilling the “sufficient home health aide staff” requirement, in the absence of the on-site RN at an EALR/SNALR.

Yes, as LPNs are considered a higher level of staff to the HHA, this would be acceptable.

12. Adult home regulations (18 NYCRR 487.9(d)) allow for the administrator to be designated as case manager, in facilities with less than 50 beds. Likewise,

enriched housing program regulations (18 NYCRR 488.9(d)) state that case management may be carried out by the program coordinator. Do these same permissions apply to the ALR administrator?

Yes. Such permission is to be granted by the Department on a case-by-case basis, via submission and approval of a waiver application.

13. In an AH/ALR with 20 beds, the administrator could theoretically be providing 20 hours per week of case management, in addition to fulfilling his/her administrative responsibilities the remaining 20 hours per week (pursuant to 18 NYCRR 487.9(c)). As such, would this negate the need for the ALR to hire a separate case manager?

See question #12.

14. In an AH/ALR of 25 or more beds, 18 NYCRR 487.9(c) requires the administrator to perform 40 hours per week of administration. If qualified to be case manager, can the administrator also fulfill the required (10 NYCRR 1001.11(c)(1)(iii)) 20+ hours per week of case management responsibilities?

The ALR regulation states that, in ALRs of 25-44 beds, the ALR is required to provide 20 hours per week of case management “+ 1 hour per week for each bed over 24”. In a 25-bed AH/ALR, as an example, 21 hours of case management would then be required to be provided per week *in addition* to the 40 hours/week required for administration – creating a 61-hour work week. While an operator may request such permission, via submission of a waiver application, (s)he would need to demonstrate that the individual can adequately meet all administrative and case management needs of residents and the ALR.

15. If an administrator is doing case management for any of the required hours, must they meet the qualifications of a case manager? 10 NYCRR 1001.11(c)(1) suggests that a facility must use a qualified case manager regardless of the size of the facility.

Yes. Pursuant to 10 NYCRR 1001.11(c)(1), the operator must provide staff “sufficient in number and qualified by training and experience” to provide those services required by law and regulation. For ALRs with less than 25 beds, “a qualified case manager” must not only be on-site for at least 20 hour per week, but available to provide case management services.

16. Will the Department be prior-approving case managers for enriched housing programs approved for ALR, as it does for adult homes (18 NYCRR 487.9(d)(2)) or will it revert to EHP regulatory provisions?

There is no regulatory requirement for the Department to prior-approve an ALR case manager, regardless of whether the ALR is certified as an AH or EHP. Review of qualifications will take place on survey.

17. Nursing staff are allowed to carry out the ALR’s case management functions, pursuant to 10 NYCRR 1001.11(m). Are the nurses expected to meet case manager qualifications?

Yes. The operator must provide staff “qualified by training and experience” to provide those services required by law and regulation.

18. If an EALR and/or SNALR operator also operates a nursing home, may (s)he utilize the nursing home’s Medical Director (MD) on call after hours to meet the requirement for an on-call RN?

The Department will consider such requests on a case-by-case basis, via submission and approval of a waiver application. Such waiver application must explain how the MD would fulfill all the regulatory requirements of an on-call RN, including any necessary provision or arranging of nursing services for residents as necessary: assessment and evaluations; supervision of aides; and nursing care and treatments. As with the on-call RN, this may require the MD to physically go to the EALR/SNALR to assess a resident in person.

L. Records and Reports

No current questions.

M. Structural and Environmental Standards

1. With regard to building requirements, is it true that an existing ACF that is in compliance with all ACF building regulations may be granted exemption from all new ALR building standards (even for existing structures), such as width of corridors?

No. The Department believes the new standards in 10 NYCRR 1001.13 are necessary to modernize the building standards for ACFs/ALRs, to reflect the change in resident populations over time. What Section 1001.13(e) states is that an applicant may submit a request for Department approval of an alternative method of assuring resident welfare and safety (i.e., a waiver request), describing how the alternative would meet the intended purpose of the particular safety feature. Phase-in modifications may also be permitted.

N. Disaster and Emergency Planning

No current questions.

O. Inspection and Enforcement

No current questions.

P. Contracts

1. If an ALR/EALR/SNALR contracts for either nurses or HHAs, is the operator responsible for meeting the orientation and in-service training and requirements of 10 NYCRR 1001.11 or can the home care agency perform such functions if approved?

While the operator may opt to provide Resident Care Aide and/or HHA training, (s)he is not required to. This training could be contracted for or the facility could hire already trained staff. However, it is the operator's responsibility to ensure staff are indeed qualified. The operator is further required to provide orientation of all staff, either directly or through a contractor, to the policies and procedures related to the provision of ALR, EALR and/or SNALR services as applicable, including to general duties of staff, applicable facility and service delivery procedures, responsibility for responding to resident emergencies, emergency evacuation and disaster plan, and personal appearance of the employee (10 NYCRR 1001.11(f)). *(Revised)*