WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #3

Do Not Mark In This Box

FILED

AUG 6 2 49 PM '99

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

Division of Health
AGENCY: Department of Health and Human Resources TITLE NUMBER: 64

CITE AUTHORITY W. Va. Code §16-5D

AMENDMENT TO AN EXISTING RULE: YES ____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ____

TITLE OF RULE BEING AMENDED: ____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 14

TITLE OF RULE BEING PROPOSED: Personal Care Homes

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Joan E. Ohl, Secretary

$17.20

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: August 6, 1999

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: (Agency name, Address & Phone No.) Division of Health
Department of Health and Human Resources
State Capitol Complex, Building 3, Room 265, Charleston, WV 25305
Telephone: (304) 558-5598

LEGISLATIVE RULE TITLE: Personal Care Homes, 64CSR14

1. Authorizing statute(s) citation: WV Code §§ 16-5D-1

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

July 7, 1999

b. What other notice, including advertising, did you give of the hearing?

The Office of Health Facility Licensure and Certification will provide a written notice of the availability of this proposed rule, to personal care home providers; provider associations who may have an interest in distribution to their members, including, Personal Care Home Association, West Virginia Health Care Association; interested state agencies; and advocacy groups.

c. Date of Public Hearing(s) or Public Comment Period ended:

August 6, 1999

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached Yes ____ No comments received N/A

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing (be exact):

August 6, 1999

f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all written correspondence regarding this rule (please type):

John M. Wilkinson, Director, Office of Health Facility Licensure & Certification

Department of Health and Human Resources

Building 3, Room 550, Capitol Complex

Charleston, West Virginia 25305

(304) 558-0050 FAX: (304) 558-2515 jwilkinson@bph.wvdhhr.org

g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule (please type):

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place a hearing for the taking of evidence and a general description of the issues to be decided.

N/A

b. Date of hearing or comment period:

N/A

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefore?

N/A

d. Attach findings and determinations and reasons:

Attached N/A

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Personal Care Home Licensure Rule; 64CSR14

Type of Rule: _X_ Legislative _____ Interpretive _____Procedural

Agency: Division of Health
Department of Health and Human Resources

Address: Building 3, Capitol Complex
Charleston, WV 25305

SHOW OVER-ALL EFFECT IN ITEMS 1 AND 2 AND IN ITEM 3 GIVE EXPLANATION OF BREAKDOWN BY FISCAL YEAR INCLUDING LONG-RANGE EFFECT.

	ANNUAL		FISCAL YEAR		
EFFECT OF PROPOSAL	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
1. ESTIMATED TOTAL COST	$ -0-	$ -0-	$	$	$
PERSONAL SERVICES CURRENT EXPENSE REPAIRS AND ALTERATIONS EQUIPMENT OTHER					
2. ESTIMATED TOTAL REVENUES	$ -0-	$ -0-	$	$	$

3. EXPLANATION OF ABOVE ESTIMATES:

These proposed Personal Care Homes Licensure Rules constitute a re-writing of the current Personal Care Home Licensure Rules which contain references that are out of date or obsolete. Since these are a replacement of existing rules no additional costs will be incurred as a result of these changes. While the Office of Health Facility Licensure and Certification costs are increasing this is attributable to a growth in the number of providers surveyed and licensed and not to proposed changes in the rules.

4. Objectives of the rule:

The proposed rule, Personal Care Homes, is being revised to incorporate changes made to West Virginia Code § 16-5D-1 et seq. in 1997 and 1998 which eliminated ratings for these homes, decrease the amount of civil penalties, and altered the way initial surveys are billed. The rule is also being reorganized and revised.

5. Explanation of Overall Impact of Proposed Rule.

A. Economic Impact on State Government.

There is no economic impact on State Government directly as a result of this rule. This is a replacement of the current Personal Care Home Licensure Rule.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific Groups of Citizens.

This rule reduces the amount of Civil Monetary Penalties assessed providers in accordance with changes to West Virginia Code § 16-5D-1 in prior years.

C. Economic Impact on Citizens/Public at Large.

There is no economic impact on citizens or the public at large as a result of this rule.

DATE	AGENCY	AUTHORIZED REPRESENTATIVE
7/7/99	WV Dept. of Health & Human Resources	Joan E. Ohl Joan E. Ohl Secretary

Brief Summary of the Rule

PERSONAL CARE HOMES

64CSR14

The proposed rule, Personal Care Homes, establishes minimum standards for inspection and operation of these facilities in the areas of administrative policies; personnel; safety; sanitation; protective, personal, and health care services; dietary services; activity and social services; record keeping; physical facilities; limited and intermittent nursing and other items or considerations deemed necessary to ensure the health, safety and welfare of the residents, in accordance with West Virginia Code § 16-5D-1 et seq. The major changes in this proposed rule include deleting language relative to rating these homes, decreasing the dollar amounts of civil penalties in accordance with code changes, classing each requirement, and adding requirements for Alzheimer's and other demential units. In addition the rule is being reorganized and revised to clarify language and delete redundancies.

Statement of Circumstances Which Require the Proposed Rule

PERSONAL CARE HOMES

64CSR14

The proposed rule, Personal Care Homes, is being revised to incorporate changes made to West Virginia Code §§ 16-5D-1 et seq. in 1997 and 1998 which eliminated ratings for these homes, decrease the amount of civil penalties, and altered the way initial surveys are billed. The rule is also being reorganized and revised.

64CRS14

RULE TO BE REPLACED

The Division of Health's proposed legislative rule, "Personal Care Homes" 64CSR14 will repeal and replace the Division of Health's legislative rule "Personal Care Home Licensure Rule" 64CSR14, that has been effective since 1996 as the licensure standards for the operation of personal care homes.

PUBLIC COMMENTS AND DEPARTMENT RESPONSES

PERSONAL CARE HOMES, 64CSR14

A public comment period on the proposed rule, Personal Care Homes, 64CSR14, was held beginning July 7, 1999 and ending August 6, 1999. Eight individuals made comments. Comments are summarized below, and the Department's responses and changes to the rule are detailed.

General Comment: One comment addresses the general issue of the cost of providing care to medicaid residents and presents the need for reimbursement for costs in a less expensive setting that personal care homes provide. When the regulations changed to 80 square feet from 60 square feet per person in a bedroom some homes could not comply and lost residents. If homes are required to comply with physical facility requirements, why are they not able to receive additional money like nursing homes do when regulations change.

Response: While we appreciate the comment, reimbursement for individuals receiving supplemental income from the state is not within the scope of this rule. The square footage requirements were mandated by a federal court decision and went into effect July 1, 1997. No new space requirements are in this proposed rule.

General Comment: One comment addresses the cost of this rule to personal care home residents by being required to meet nursing home standards.

Response: This rule does not put nursing home requirements or additional significant requirements to the current personal care home rule, on personal care homes that would involve increasing costs to residents of the home.

§ 64-14-3. Comments: The term "personal care homes" should be defined in the rule to help give clarity to an often misunderstood term.

Response: We agree with the comment and think that providing the definition would be helpful to reading the rule. However, directions provided by the staff of the Legislative Rule Making Committee, are that the rule is to be read in conjunction with West Virginia Code §16-5D-1 et seq., and that definitions in the code, are not to be repeated in the rule, unless they expand on or clarify the definition in code.

3.23 Comment: Mental disorder is a defined as "a mental illness that affects the well-being or behavior of an individual to such an extent that for his or her own welfare or the welfare of others, he or she requires treatment". The term "welfare" is used instead of the phrase I am accustomed to, which is "a danger to self or others". I hope that by using the word "welfare" we will not be setting up a situation whereby people are required to obtain treatment when no such requirement is absolutely necessary.

Response: Agree. The language will be changed from "welfare" to "a danger to self or

others".

3.29 Comment: Definition of Physical Restraints - Federal State Operations Manual for Nursing Homes defines physical restraint as "any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body". Proposed definition in both PCH and RBC regs does not go far enough in establishing what constitutes a restraint. Suggest using language similar to that used for nursing homes.

Response: Disagree. We have found this language to be effective and easily understood by providers.

4.2.a.10. Comment: In addition to language ensuring provision of care for 30 days after notification of a pending closure the need to further spell out provider's responsibilities in helping residents find a new appropriate placement needs to be included.

Response: Disagree. Providers being closed by the department are already out of compliance with the rule.

4.6.a. Comment: I would advocate that a regular review of personal care homes be done on a regular basis such as once a year instead of "as is necessary".

Response: The language "as necessary" allows inspections to be conducted for a resurvey, for the required 120 and 210 day follow up on any uncorrected violation, and for complaint investigations as needed. We feel this language is appropriate.

4.6.e. Comment: 4.6.e. states the secretary shall prepare a written report of any inspection. As you know, the Ombudsman Program gets a copy of nursing home surveys. We seldom, if ever, get a copy of inspections or corrective action plans that deal with RB&C and personal care homes. Hopefully, we will begin to receive this information.

Response: Any dissemination of the report to individuals other than the licensee or administrator of a facility, would not be a requirement of the rule, but rather an informed decision by the department.

4.7.d. Comment: 4.7.d. of PCH regs states that the name of a complainant or resident shall be kept confidential "unless the resident gives written permission for the disclosure or there is clear and convincing evidence in a particular instance which requires disclosure of names". Who decides what is clear and convincing evidence and could this part of the regulation not be misinterpreted or abused?

Response: The criteria used limits this disclosure to situations involving immediate jeopardy to a resident's health, safety or welfare.

4.7.f. Comment: This presumption should also extend to a complainant. In particular, facility

staff who may have lost their jobs for making a complaint against a facility.

Response: This is covered in West Virginia Code §16-5D-8.

4.7.h. and 4.7.i. Comment: 4.7.h and 4.7.i. when notifying family, Social Security Administration, etc. could the Ombudsman Program not also be notified even if it meant deleting the resident's name?

Response: This would not be a requirement of the rule, but rather a decision by the department.

4.11.a.2. Comment: 4.11.a.2 states that no-issuance of initial or renewal of license can take place if "either the applicant or the administration has been arrested for, adjudicated, and convicted of any felony or misdemeanor relevant to the provision of care in a health care facility or operating a health care facility". How about placement on the CNA Registry?

Response: Agree. This will be added to this rule.

4.11.a.2. Comment: If a home is owner occupied, criminal behavior of all other family members living in the house should be taken into account before issuing or removing a license.

Response: Agree. However, prior to approval of the secretary for other individuals to reside in the home under 5.1.g., screening through the state police abuse registry can be required.

5.1.a. Comments: Under section 5.1.a. in addition to having policies and procedures for transfer and discharge, that there be added the requirement that there be written policies and procedures identified as to the provider's role in case of a closure. This will provide further protection for a resident in case of closure, including providing them a possible cause of action in a civil suit for breach of contract.

Response: Disagree. Policies and procedures for admission, transfer and discharge are already required. Failure of the facility to provide care in accordance with their admission agreement provides the resident with a possible cause of action in a civil law suit for breach of contract.

5.1.g. Comment: Does Section 5.1.g. exclude family occupied homes from operating if 4 or more residents are permitted to live at a home? I would hope this is not the case.

Response: No, this is not the case. However, the secretary has, with this requirement, the ability to impact on anyone residing in the home, who is creating a risk to residents of the home.

5.6.a. Comment: I suggest that abuse reporting be included in training that a new employee receives within their first 24 hours of being hired. I believe this for two reasons - first, in the event abuse is current even a new employee will know how to report it and second, it sends a message that reporting abuse is so important that a new employee is immediately trained on the

topic.

Response: We feel that this training is appropriately required within the first fifteen days of employment.

5.9.b Comment: 5.9.b. allows commingling of various residents' funds. Could this not be problematic?

Response: We have been able to monitor this by a review of facility accounting records on inspections.

6.2.a. Comment: 6.2.a. states the licensee shall provide a copy of residents' rights to the resident. I suggest also providing a copy to the residents' legal representative if such a representative is in place.

Response: Agree. Legal representative will be added.

6.3.d. Comment: 6.3.d. states "The licensee shall assure that all alleged violations involving abuse, exploitation, or neglect shall be immediately and thoroughly investigated and documented by the licensee or his or her designee or receipt of the allegation". My question is, investigated by whom? I assume by the RB&C home, but should it not also be pointed out that a report must be made to Adult Protective Services and OHFLAC? Certainly, APS needs to immediately investigate any allegations of abuse or neglect.

Response: 6.3.c. requires immediate reporting to Adult Protective Services. 6.3.f. requires reporting to OHFLAC and forwarding a report of the investigation within seventy-two hours of the date of the alleged abuse.

7.2.c. Comment: This violates a resident's right if they have capacity to reject medical treatment. (See Chapter 27 of the WV Code) What happens to the resident if they or their legal representative reject treatment after a referral is made? Also, I can see some rationale for a referral under a mental health disorder since the definition of mental disorder does speak to concerns to the welfare of the individual or others. However, the definition of a developmental disorder does not suggest a similar concern for individuals' safety. Therefore, under the proposed language, if for example a person exhibited a symptom such as being spastic, a referral would need to be made. This would appear to be excessive.

Response: Agree. The last two sentences will be deleted from this requirement.

7.3. Comment: Discharge and Transfer Procedures both PCH & RBC - There are many reasons other than the need for a higher level of care and danger to self or others, that have resulted in a transfer or discharge of a resident. Non-payment and breading house rules such as inappropriate smoking are two such examples. Recommend that language be added which requires that a discharge under these circumstances still requires a provider to make an effort to find an appropriate placement for that resident. (i.e. not just putting them out in the street).

Response: The language already requires a thirty day notice to residents for all discharges other than those listed in 7.3.d.. Therefore, residents who are being discharged for non-payment or for breaking house rules, will not just be put out on the street.

7.7. Comment: Pharmacists should be included in the rule as a health care professional who can provide oversight of medication administration because they can provide a review of the complete drug regimen of residents, point out potential drug interactions, adverse effects, and identify unnecessary drugs.

Response: 7.7.e currently lists a consulting pharmacist as one of the health care professionals who can provide the required review of a residents drug regimen annually. West Virginia Code §16-5O-1 et seq. requires a registered professional nurse to oversee medication administration by unlicensed personnel. This rule conforms with that law.

7.7.k.2.B. Comment: Could we, with the resident's permission, give returnable medications to Health Right instead of destroying them?

Response: Per discussion with the a representative of the Board of Pharmacy this is acceptable if drugs are still within their date of expiration and have been stored properly.

7.8.e. Comment: Reporting major incidents-Define falls/accidents. EX. Is a fall that results in a broken hip that requires surgery to be reported?

Response: 3.22. Defines a major incident as "an event or occurrence, the outcome of which places one (1) or more residents' health and well-being in jeopardy or imminent danger, as for example: a fall, accident or other event which seriously injures or threatens the life of the resident;.....". Yes, a fall resulting in a fractured hip would be a serious injury. Any injury that requires admission to a hospital to treat the injury is considered to be a serious injury.

9.1.d. Comment: Why weigh a resident monthly who doesn't require nursing care? We feel this would make them feel like a "patient". We feel yearly is enough unless their is a medical reason.

Response: Agree. This requirement will be changed to yearly weights.

10.2.d. Comment: Do we have to have the assistance of qualified fire safety and emergency response team and other appropriate experts to develop our emergency plans? Which experts document the plan?

Response: You need only one expert to document on the plan. The requirement will be altered to say "or" instead of "and".

11.2.c. Comment: There should be freedom of choice. Many people grew up near railroad tracks or near highways. If a provider wants to open a home in what might be seen to some as an undesirable location that should be a business decision. If you include dirty air or foul odors

most of Kanawha (Chemical) Valley should be excluded from consideration. If the intent is to protect resident's safety, then there should be a brief statement that if homes are to be opened close to railroad tracks or traffic patterns, precautions need to be taken to assure resident's safety.

Response: Agree. The language will be changed to require safety precautions if homes are located near to railroads, etc.

11.2.h. Comment: This is a possible violation of Federal Fair Housing Laws especially in homes which may only have 4, 5, or 6 residents. Federal Fair Housing Laws require that housing for people with disabilities should not be dealt with differently than for others in the community. So, for example, if local zoning allows a certain number of non-related individuals to live together without requiring parking spaces, then that needs to be equally applied to group homes as well. The intent is to have individuals live in communities with as much "normalcy" as anyone else. See attached information relating to Federal Fair Housing Laws. The parking space requirement would effectively eliminate personal care homes from operating in most urban areas, where on the street parking is the general rule.

Response: Disagree. We believe this is a misinterpretation of the case attached to the comment. This case centers on the illegality of municipalities in enacting zoning and other legislation to preclude group homes. We do not think local ordinances supercede the American's with Disabilities Act (ADA). We believe that our requirement conforms to ADA requirements and does not violate the Fair Housing Act. We do not agree that the requirement for parking space eliminates personal care homes from operating in urban areas, as these requirements have been in effect since 1997.

11.3.m. Comment: Section 11.3.k. has language requiring the maintaining a temperature of 72 F. Language for cooling devices should similarly state maintaining a temperature of no more than 80 F. Present language does not assure that the temperature could go above 80 F.

Response: Agree. The language will be changed to assure that temperature is maintained at no higher than 80 F.

11.12.c. Comment: RBC - Has language which is omitted from PCH regs. Recommend that it be included.

Response: The language in the proposed residential board and care rule was new language for those homes and therefore the provision for existing homes was added. This has been a requirement for personal care homes since 1997 and no need to provide the language for existing homes.

cc: KB
AS

STATE OF WEST VIRGINIA
BUREAU OF SENIOR SERVICES

Cecil H. Underwood
Governor

1900 Kanawha Boulevard, East
Holly Grove – Building 10
Charleston, West Virginia 25305-0160
Telephone (304) 558-3317
FAX (304) 558-0004

Gaylene A. Miller
Commissioner

August 5, 1999

John Wilkinson, Director
OHFLAC-DHHR
WV State Capitol Complex
Building 3, Room 550
Charleston, WV 25305

Dear John:

Roy Herzbach reviewed both the personal care and residental board and care regs. Due to time constraints I was only able to review the residential board and care regs but I did "look through" the personal care home regs and they appear to closely mirror the residential board and care regs. Therefore, in general, I believe any observations/concerns that I point out regarding the residentail board and care regs are also appropriate for the personal care home regs.

Please find the attached letter Roy has written to you. If you have any questions about our comments please feel free to contact either Roy or me. Please accept our gratitude for offering us the opportunity to supply you with our comments.

On page 4 3.23 mental disorder is defined as "a mental illness that affects the well-being or behavior of an individual to such an extent that for his or her own welfare or the welfare of others, he or she requires treatment". The term "welfare" is used instead of the phrase I am accustomed to, which is "a danger to self or others". I hope that by using the word "welfare" we will not be setting up a situation whereby people are required to obtain treatment when no such requirement is absolutely necessary.

Page 10 of RB&C regs item 4.6.a. dealing with inspections. I would advocate that a regular review of RB&C and personal care homes be done on a regular basis such as once a year instead of "as is necessary".

Page 11 item 4.6.f. states the secretary shall prepare a written report of any inspection. As you know, the Ombudsman Program gets a copy of nursing home surveys. We seldom, if ever, get a copy of inspections or corrective action plans that deal with RB&C and personal care homes. Hopefully, we will begin to receive this information.

Page II item 4.7.d. of RB&C regs states that the name of a complainant or resident shall be kept confidential "unless the resident gives written permission for the disclosure or there is clear and convincing evidence in a particular instance which requires disclosure of names". Who decides what is clear and convincing evidence and could this part of the regulation not be misintrepreted on abused?

Page 12 item 4.7.h and 4.7.i. when notifying family, Social Security Administration, etc. could the Ombudsman Program not also be notified even if it meant deleting the resident's name?

Page 14 item 4.11.a.2 states that non-issuance of initial or renewal of license can take place if "either the applicant or the administration has been arrested for, adjudicated, and convicted of any felony or misdemeanor relevant to the provision of care in a health care facility or operating a health care facility". How about placement on the CNA Registry?

Page 19 item 5.6.a. I suggest that abuse reporting be included in training that a new employee receives within their first 24 hours of being hired. I believe this for two reasons - first, in the event abuse is current even a new employee will know how to report it and second, it sends a message that reporting abuse is so important that a new employee is immediately trained on the topic.

Page 22 item 5.9.b allows commingling of various residents' funds. Could this not be problematic?

Page 23 item 6.2.a. states the licensee shall provide a copy of residents' rights to the resident. I suggest also providing a copy to the residents' legal representative if such a representative is in place.

Page 24 item 6.3.d. states "The licensee shall assure that all alleged violations involving abuse, exploitation, or neglect shall be immediately and thoroughly investigated and documented by the licensee or his or her designee on receipt of the allegation". My question is, investigated by whom? I assume by the RB&C home, but should it not also be pointed out that a report must be made to Adult Protective Services and OHFLAC? Certainly, APS needs to immediately investigate any allegations of abuse or neglect.

Sincerely,

Larry Medley
State Long Term Care Ombudsman

LM/db

Attachment

LEGAL AID SOCIETY OF CHARLESTON

LONG-TERM CARE OMBUDSMAN PROGRAM
922 Quarrier St., 4th Floor Charleston, WV 25301
(304) 343-4481 ext. 35 1-800-834-0598
FAX (304) 345-5934

July 28, 1999

☐ REGION I
YWCA
1100 Chapline Street
Wheeling, WV 26003
233-6331

☐ REGION I
P.O. Box 1865
Parkersburg, WV 26101
295-3339

☐ REGION II
Legal Aid Society of
Charleston
922 Quarrier St., 4th Floor
Charleston, WV 25301
343-4481 ext. 31

☐ REGION II
APPALRED
910 Fourth Ave., Suite 301
Huntington, WV 25701
522-1901

☐ REGION III
P.O. Box 546
Keyser, WV 26726
788-6770

☐ REGION III
1988 Listravia Avenue
Morgantown, WV 26505
296-0985

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P.O. Box 2985
Elkins, WV 26241
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1428 Main Street
Princeton, WV 24740
425-9138

Sponsored by: Bureau of
Senior Services

John Wilkinson, Director
OHFLAC - DHHR
WV State Capitol Complex
Building 3, Room 550
Charleston, WV 25305

Dear John:

Enclosed find comments as to proposed personal care and residential bd and care regs.

Section 3.29 - Definition of Physical Restraints - Federal State Operations Manual for Nursing Homes defines physical restraint as "any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body". Proposed definition in both PC Home and Residential Bd and Care Regs does not go far enough in establishing what constitutes a restraint. Suggest using language similar to that used for nursing homes.

Section 4.2.a.10 - Both PC and Board and Care Regs - In addition to language ensuring provision of care for 30 days after notification of a pending closure the need to further spell out provider's responsibilities in helping residents find a new appropriate placement needs to be included. I also suggest that under section 5.1.a of both sets of regulations that in addition to having policies and procedures for transfer and discharge, that there be added the requirement that there be written policies and procedures identified as to the provider's's role in case of a closure. This will provide further protection for a resident in case of closure, including providing them a possible cause of action in a civil suit for breach of contract.

Section 4.7.F (Both PC and Res. Bd and Care Regs) - This presumption should also extend to a complainant. In particular, facility staff who may have lost their jobs for making a complaint against a facility.

Section 4.11.a.2 - (Both Bd and Care and PC Home Regs) - If a home is owner occupied, criminal behavior of all other family members living in the house should be taken into account before issuing or removing a license. Does Section 5.1.g exclude family occupied homes from operating if 4 or more residents are permitted to live at a home? I would hope this is not the case.

Section 7.2.c - (Both PC and Res Bd and Care Regs) - This violates a resident's right if they have capacity to reject medical treatment. (See Chapter 27 of the WV Code) What happens to the resident if they or their legal representative reject treatment after a referral is made? Also, I can see some rationale for a referral under a mental health disorder since the definition of mental disorder does speak to concerns to the welfare of the individual or others. However, the definition of a developmental disorder does not suggest a similar concern for individuals' safety. Therefore, under the proposed language, if for example a person exhibited a symptom such as being spastic, a referral would need to be made. This would appear to be excessive.

Section 7.3 - Discharge and Transfer Procedures (Both PC and Res Bd and Care Regs) - There are many reasons other than the need for a higher level of care and danger to self or others, that have resulted in a transfer or discharge of a resident. Non-payment and breaking house rules such as inappropriate smoking are two such examples. Recommend that language be added which requires that a discharge under these circumstances still requires a provider to make an effort to find an appropriate placement for that resident. (i.e. not just putting them out in the street).

Section 11.2.F - Residential Bd and Care, 11.2.h - Personal Care Homes - This is a possible violation of Federal Fair Housing Laws especially in homes which may only have 4, 5, or 6 residents. Federal Fair Housing Laws require that housing for people with disabilities should not be dealt with differently than for others in the community. So, for example, if local zoning allows a certain number of non-related individuals to live together without requiring parking spaces, then that needs to be equally applied to group homes as well. The intent is to have individuals live in communities with as much "normalcy" as anyone else. See attached information relating to Federal Fair Housing Laws.

The parking space requirement would effectively eliminate personal care and Board and Care homes from operating in most urban areas, where on the street parking is the general rule.

Section 11.3.C - Residential Board and Care Home - Personal care home regs under section 11.3.(C) include the same language but add "and the license shall establish a program of preventive maintenance for all equipment". Recommend this language be added.

11.2.b - Residential Bd and Care) 11.2.C (Personal Care Homes) - There should be freedom of choice. Many people grew up near railroad tracks or near highways. If a provider wants to open a home in what might be seen to some as an undesirable location that should be a business decision. If you include dirty air or foul odors most of Kanawha (Chemical) Valley should be excluded from consideration. If the intent is to protect

resident's safety, then there should be a brief statement that if homes are to be opened close to railroad tracks or traffic patterns, precautions need to be taken to assure resident's safety.

11.3.M - (Residential Bd & Care and PC Home Regs) - Section 11.3.K has language requiring the maintaining a temperature of 72 F. Language for cooling devices should similarly state maintaining a temperature of no more than 80 F. Present language does not assure that the temperature could go above 80 F.

11.3.T - (Res Bd & Care) - Personal Care Regs have a section 11.3.t which is omitted in Res. Bd & Care Regs. Suggest this section be added to Res. Bd. & Care.

Section 11.5 - Personal care homes regs have a section 11.5 which speaks to the provision of bath towel bars. This is omitted from Residential Bd & Care Regs. Recommend that similar language be included in the Res. Bd and Care Regs.

Section 11.12(d) - Residential Bd & Care - Has language which is omitted from Personal Care Regs. Recommend that it be included.

In addition to the aforementioned comments, recommend that there be language included permitting married couples to share rooms.

Thank you for the opportunity to respond. If you have any questions concerning my comments, please contact me.

Very Truly Yours,

Roy Herzbach
Ombudsman Supervisor

RH/cjm

(district court may rely upon evidence presented at trial in sentencing). We hold the district court properly applied the Sentencing Guidelines in sentencing Campbell for his conviction under 21 U.S.C. § 843(b).

The judgment is AFFIRMED.

OXFORD HOUSE-C, an unincorporated association; Oxford House, Inc., a Delaware not-for-profit corporation; Oxford House-W, an unincorporated association; Missouri Department of Mental Health, Division of Alcohol & Drug Abuse; Missouri Department of Mental Health, Plaintiffs-Appellees,

v.

CITY OF ST. LOUIS, a Body Corporate, Defendant-Appellant.

Missouri Municipal League; City of Columbia, Missouri; City of Clayton, Missouri; The National Fair Housing Alliance; The Judge David L. Bazelon Center for Mental Health Law; United States of America; American Civil Liberties Union, of Eastern Missouri, Amicus Curiae.

OXFORD HOUSE-C, an unincorporated association; Oxford House, Inc., a Delaware not-for-profit corporation; Oxford House-W, an unincorporated association; Missouri Department of Mental Health, Division of Alcohol & Drug Abuse; Missouri Department of Mental Health, Plaintiffs-Appellees,

v.

CITY OF ST. LOUIS, a Body Corporate, Defendant-Appellant.

Nos. 94-1600, 94-3073.

United States Court of Appeals, Eighth Circuit.

Submitted Sept. 12, 1995.

Decided Feb. 23, 1996.

Groups homes brought handicap discrimination suit alleging that city violated federal Fair Housing Act and Rehabilitation Act by enforcing zoning ordinance limiting number of unrelated residents to eight. The United States District Court for the Eastern District of Missouri, Catherine D. Perry, J., 843 F.Supp. 1556, issued injunction prohibiting enforcement of zoning restriction, denied city's counterclaim, and awarded attorney fees and costs to group homes. City appealed. The Court of Appeals, Fagg, Circuit Judge, held that: (1) Congress had authority under commerce clause to enact provision of Fair Housing Act prohibiting handicap discrimination; (2) zoning restrictions were not exempt from Fair Housing Act; (3) eight-person restriction was valid under Fair Housing Act; (4) refusal of group homes to seek variance precluded claim for failure to accommodate; and (5) group homes failed to show Rehabilitation Act violation.

Reversed in part, vacated in part, and remanded.

1. Civil Rights ⇐109

Commerce ⇐82.20

Congress had authority under Commerce Clause to prohibit handicap discrimination in amendment to Fair Housing Act; rational basis existed for deciding that housing discrimination against handicapped has substantial effect on interstate commerce. U.S.C.A. Const. Art. 1, § 8, cl. 3; Civil Rights Act of 1968, §§ 801-901, as amended, 42 U.S.C.A. §§ 3601-3631.

2. Civil Rights ⇐131

Fair Housing Act applied to provision of city zoning code defining single-family dwelling to include group homes of eight or fewer unrelated handicapped individuals, given that limit was designed to promote family character of neighborhood; exemption applies only to total occupancy limits intended to prevent overcrowding in living quarters. Civil Rights Act of 1968, § 807(b)(1), as amended, 42 U.S.C.A. § 3607(b)(1).

3. Civil Rights ⇐131

Handicap discrimination prohibitions of Fair Housing Act prohibit municipality from

making dwelling unavailable to handicapped people on basis of handicap and requires municipality to make reasonable accommodations in zoning ordinance to give handicapped person equal opportunity to use and enjoy dwelling. Civil Rights Act of 1968, § 804(f)(1), (f)(3)(B), as amended, 42 U.S.C.A. § 3604(f)(1), (f)(3)(B).

4. Civil Rights ⇐131

Handicap discrimination prohibitions of Fair Housing Act prohibit municipalities from interfering with handicapped individuals' exercise of equal housing rights. Civil Rights Act of 1968, § 818, as amended, 42 U.S.C.A. § 3617.

5. Civil Rights ⇐131

City zoning restriction limiting group homes to more than eight unrelated residents was rational and did not violate Fair Housing Act's prohibitions on handicapped discrimination; city had legitimate interest in decreasing congestion, traffic, and noise in residential areas, and restricting number of unrelated persons who may occupy single-family residence was reasonably related to those legitimate goals. Civil Rights Act of 1968, § 804(f)(1), as amended, 42 U.S.C.A. § 3604(f)(1).

6. Civil Rights ⇐131

Finding that city discriminated against group homes by singling them out for zoning inspections and enforcement proceedings based on residents' handicapped status, allegedly in violation of Fair Housing Act, was clearly erroneous in absence of showing that city ignored zoning violations by nonhandicapped persons, regardless of whether city officials harbored prejudice or unfounded fears about residents. Civil Rights Act of 1968, § 804(f)(1), as amended, 42 U.S.C.A. § 3604(f)(1).

7. Civil Rights ⇐209

Group homes were required to apply to city board of adjustments for variance before claiming that city failed to accommodate homes as required by Fair Housing Act by enforcing zoning ordinance prohibiting group homes from having more than eight unrelated residents; group homes must give city a chance to accommodate them through established procedures for adjusting zoning code. Civil Rights Act of 1968, § 804(f)(3)(B), as amended, 42 U.S.C.A. § 3604(f)(3)(B).

8. Civil Rights ⇐131

Enforcing eight-person group home limit in zoning ordinance did not violate Rehabilitation Act, absent showing that number of group home residents was limited solely by reason of their disability and that residents requested exemption to eight-person limit. Rehabilitation Act of 1973, § 504(a), 29 U.S.C.A. § 794(a).

Appeals from the United States District Court for the Eastern District of Missouri; Catherine Perry, Judge.

James J. Wilson, St. Louis, Missouri, argued (Ronnie L. White, City Counselor, Julian L. Bush, Asso. City Counselor and Michael A. Garvin, Asst. City Counselor, on the brief), for appellant.

Ann B. Lever, St. Louis, Missouri, argued (Susan A. Alverson and Herbert A. Eastman, St. Louis, Missouri, and Barbara J. Wood and Jeremiah W. (Jay) Nixon, Attorney General of Missouri, Jefferson City, Missouri, on the brief), for appellees.

Marie K. McElderry, Washington, DC, argued (Edward L. Dowd, Jr., United States Attorney, Deval L. Patrick and David K. Flynn, Washington, DC, on the brief), for amicus curiae.

Before FAGG, HENLEY, and HANSEN, Circuit Judges.

FAGG, Circuit Judge.

In this handicap discrimination case, we consider whether the City of St. Louis violated the Federal Fair Housing Act and Rehabilitation Act by enforcing the City's zoning code to limit the number of residents in two group homes for recovering substance abusers. We conclude the City acted lawfully.

Oxford House-C and Oxford House-W are self-supporting, self-governing group homes for recovering alcoholics and drug addicts in the City of St. Louis. The Oxford Houses provide a family-like atmosphere in which

the residents support and encourage each other to remain clean and sober, and immediately expel any resident who uses drugs or alcohol. The Missouri Department of Mental Health, Division of Alcohol and Drug Abuse (DMH/ADA), helped establish the Oxford Houses and provides them with technical support. The houses also receive assistance from Oxford House, Inc., a national organization of Oxford Houses across the country.

Oxford House-C and Oxford House-W are located in St. Louis neighborhoods zoned for single family dwellings. The city zoning code's definition of single family dwelling includes group homes with eight or fewer unrelated handicapped residents. St. Louis, Mo., Rev.Code tit. 26, § 26.20.020(A)(1) (1994). After city inspections revealed that more than eight recovering men were living at each Oxford House, the City cited the houses for violating the eight-person limit.

Rather than applying for a variance excepting them from the eight-person rule, the Oxford Houses, the DMH/ADA, and Oxford House, Inc. (collectively Oxford House) brought this lawsuit against the City, contending the City's attempt to enforce the rule violated the Fair Housing Act, as amended, 42 U.S.C. §§ 3601-3631 (1988), section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a) (1994), and other federal laws. The City brought a counterclaim asking the district court to enjoin the Oxford Houses from violating the City's ordinances. Holding the City had violated the Fair Housing Act and the Rehabilitation Act by enforcing the eight-member limit against the Oxford Houses, the district court enjoined the City from using its zoning code to prevent the Oxford Houses from operating with their existing number of residents, ten in Oxford House-C and twelve in Oxford House-W. The district court also denied the City's counterclaim. *Oxford House-C v. City of St. Louis*, 843 F.Supp. 1580, 1584 (E.D.Mo.1994). The City appeals. We reverse the judgment for Oxford House, vacate the injunction, and remand the counterclaim for further consideration.

[1, 2] We first review the district court's decision that the City violated the Fair Housing Act. Attempting to avoid the Act's requirements altogether, the City contends Congress exceeded its authority under the Commerce Clause by prohibiting handicap discrimination in the 1988 amendments to the Act. We disagree. Congress had a rational basis for deciding that housing discrimination against the handicapped, like other forms of housing discrimination, has a substantial effect on interstate commerce. *See Morgan v. Secretary of Hous. & Urban Dev.*, 985 F.2d 1451, 1455 (10th Cir.1993). We also reject the City's contention that under 42 U.S.C. § 3607(b)(1), the City's limits on the number of unrelated people who can live together in a single family residential zone are exempt from the Act's requirements. The Supreme Court recently held § 3607(b)(1) only exempts total occupancy limits intended to prevent overcrowding in living quarters, not ordinances like the City's that are designed to promote the family character of a neighborhood. *City of Edmonds v. Oxford House, Inc.*, — U.S. —, —, 115 S.Ct. 1776, 1779, 131 L.Ed.2d 801 (1995). In short, the City must comply with the Act.

[3, 4] The Act prohibits the City from making a dwelling unavailable to handicapped people on the basis of their handicap. 42 U.S.C. § 3604(f)(1). In fact, the Act requires the City to make reasonable accommodations in its generally applicable zoning ordinances when necessary to give a handicapped person "equal opportunity to use and enjoy a dwelling." *Id.* § 3604(f)(3)(B); *Smith & Lee Assocs., Inc. v. City of Taylor*, 13 F.3d 920, 924 (6th Cir.1993). The Act also prohibits the City from interfering with handicapped individuals' exercise of their equal housing rights. 42 U.S.C. § 3617. The City does not contest the district court's conclusion that the Oxford House residents are handicapped within the meaning of the Fair Housing Act because they are recovering addicts. The issue is whether the City has unlawfully discriminated against, failed to accommodate, and interfered with the housing rights of these handicapped men.

[5] Rather than discriminating against Oxford House residents, the City's zoning code favors them on its face. The zoning code allows only three unrelated, nonhandicapped people to reside together in a single

family zone, but allows group homes to have up to eight handicapped residents. St. Louis, Mo., Rev.Code, tit. 26, §§ 26.08.160, 26.20.020(A)(1) (1994). Oxford House's own expert witness testified Oxford Houses with eight residents can provide significant therapeutic benefits for their members. The district court nevertheless found the City's zoning ordinances are discriminatory because the eight-person limit would destroy the financial viability of many Oxford Houses, and recovering addicts need this kind of group home. Even if the eight-person rule causes some financial hardship for Oxford Houses, however, the rule does not violate the Fair Housing Act if the City had a rational basis for enacting the rule. *Familystyle of St. Paul, Inc. v. City of St. Paul*, 923 F.2d 91, 94 (8th Cir.1991).

We conclude the eight-person rule is rational. Cities have a legitimate interest in decreasing congestion, traffic, and noise in residential areas, and ordinances restricting the number of unrelated people who may occupy a single family residence are reasonably related to these legitimate goals. *Village of Belle Terre v. Boraas*, 416 U.S. 1, 9, 94 S.Ct. 1536, 1541, 39 L.Ed.2d 797 (1974). The City does not need to assert a specific reason for choosing eight as the cut-off point, rather than ten or twelve. "[E]very line drawn by a legislature leaves some out that might well have been included. That exercise of discretion, however, is a legislative, not a judicial, function." *Id.* at 8, 94 S.Ct. at 1540. We conclude the City's eight-person restriction has a rational basis and thus is valid under the Fair Housing Act. *Familystyle*, 923 F.2d at 94.

[6] The district court found the City discriminated against the Oxford Houses by singling them out for zoning inspections and enforcement proceedings because of the residents' handicap. This finding is clearly erroneous because Oxford House did not show the City ignored zoning violations by nonhandicapped people. *See* Fed.R.Civ.P. 52(a). Although Oxford House presented evidence that the City did not take action against certain groups of more than three unrelated, nonhandicapped people residing together in single family zones, Oxford House did not show that these other groups were not entitled to reside in single family zones based on the zoning code's exception for valid preexisting uses. *See* St. Louis, Mo., Rev. Code tit. 26, §§ 26.16.050–.060 (1994). At any rate, Oxford House did not show anyone in the building inspector's office knew of the alleged zoning violations. The parties agree the City never received complaints about the groups Oxford House claims were violating the zoning code.

Having concluded Oxford House did not show the City treated the Oxford Houses differently from any other group, we believe the City's enforcement actions were lawful regardless of whether some City officials harbor prejudice or unfounded fears about recovering addicts. Because the district court found the City's actions were motivated by bias and stereotypes, however, we will briefly discuss the evidence of discriminatory intent. At trial, Oxford House presented testimony that one of the Mayor's assistants stated Oxford Houses might cause flight from the City. Also, when Oxford House's counsel asked the City's Zoning Administrator whether he would want to live next door to an Oxford House, the Zoning Administrator said no and expressed concern about transiency and property values. We do not believe these isolated comments reveal City officials enforced the zoning code against the Oxford Houses because of the residents' handicap, especially considering the Oxford Houses were plainly in violation of a valid zoning rule and City officials have a duty to ensure compliance. Oxford House also presented evidence that the inspectors who visited the Oxford Houses were aware of community opposition to the houses and hoped to discover zoning violations. Because the inspectors do not hold policymaking positions, their conduct and remarks tell us little about why City officials decided to take action against the Oxford Houses. Anyway, the district court took the inspectors' actions and comments out of context. Overall, we conclude the district court committed clear error in finding the City enforced the zoning code against the Oxford Houses because the residents are recovering addicts. We find no unlawful discrimination under the Fair Housing Act, either in the eight-person limit or in the City's enforcement activities.

[7] Also, the City did not fail to accommodate the Oxford Houses as the Act requires. *See* 42 U.S.C. § 3604(f)(3)(B). The Oxford Houses want the City to let them operate with more than eight residents. The City has consistently said it cannot make an exception to the zoning code unless the Oxford Houses apply to the City's Board of Adjustments for a variance, *see* St. Louis, Mo., Rev.Code tit. 26, § 26.84.060(D) (1994), and the Oxford Houses refuse to apply. Their refusal is fatal to their reasonable accommodation claim. The Oxford Houses must give the City a chance to accommodate them through the City's established procedures for adjusting the zoning code. *See United States v. Village of Palatine*, 37 F.3d 1230, 1233 (7th Cir.1994); *Oxford House, Inc. v. City of Virginia Beach*, 825 F.Supp. 1251, 1261 (E.D.Va.1993). The Fair Housing Act does not "insulate [the Oxford House residents] from legitimate inquiries designed to enable local authorities to make informed decisions on zoning issues." *City of Virginia Beach*, 825 F.Supp. at 1262. Congress did not intend for the Act to remove handicapped people from the "normal and usual incidents of citizenship, such as participation in the public components of zoning decisions, to the extent that participation is required of all citizens, whether or not they are handicapped." *Id.* In our view, Congress also did not intend the federal courts to act as zoning boards by deciding fact-intensive accommodation issues in the first instance. *Id.* at 1261.

The district court decided the Oxford Houses should not have to apply for variances because the City is certain to deny their applications. *See Village of Palatine*, 37 F.3d at 1234. Oxford House presented evidence that some neighbors of the Oxford Houses have concerns and complaints about the houses, and that the alderman representing the neighborhoods where the Oxford Houses are located does not want the houses to have more than eight residents. The record shows the Board of Adjustments has granted variances despite opposition from neighbors and aldermen, however. Having carefully reviewed the record, we conclude the district court committed clear error in finding it would be futile for the Oxford Houses to apply for variances. Thus, the Oxford Houses must apply if they want the City to accommodate them. We express no opinion about whether the Fair Housing Act would require the City to grant variances for the Oxford Houses if they apply.

[8] Because the City did not unlawfully discriminate against the Oxford House residents or refuse to accommodate them, the City did not interfere with the residents' equal housing rights by enforcing the eight-person rule against them, *see* 42 U.S.C. § 3617. Further, because the City did not limit the number of Oxford House residents "solely by reason of [their] disability" and the residents did not request an exception to the eight-person limit, the City did not violate the Rehabilitation Act. *See* 29 U.S.C. § 794(a); *Lua v. Moore*, 43 F.3d 1203, 1206 (8th Cir.1994). Having concluded the City acted lawfully, we remand the City's counterclaim seeking enforcement of its ordinances for further consideration.

In conclusion, we reverse the judgment in favor of Oxford House on the Fair Housing Act and Rehabilitation Act claims, vacate the injunction prohibiting the City from enforcing its eight-person zoning restriction against the Oxford Houses, and remand the City's counterclaim. Because Oxford House is no longer a prevailing party, we also reverse the award of fees and costs to Oxford House. 42 U.S.C. § 3613(c)(2).

KEY NUMBER SYSTEM

UNITED STATES of America, Plaintiff–Appellee,

v.

Walter REYNOLDS, Defendant–Appellant.

No. 95–3337.

United States Court of Appeals, Eighth Circuit.

Submitted Feb. 16, 1996.

Decided Feb. 26, 1996.

Defendant was convicted in the United States District Court for the District of

Consortium
for Citizens
With Disabilities

The Fair Housing Act: Essential Protection for People with Disabilities

- In the Fair Housing Amendments Act of 1988, Congress extended federal civil rights protections to people with disabilities in the sale and rental of private housing.

During the civil rights movement of the 1960s, people with disabilities began to demand more autonomy in their lives, starting an "independent living" movement and rejecting society's attitudes of pity, charity, and rehabilitation. Congress responded with the Fair Housing Amendments Act — "a national commitment to end the unnecessary exclusion of persons with [disabilities] from the American mainstream."

- The Fair Housing Act (FHA), like the Rehabilitation Act and the Americans with Disabilities Act, includes a broad, inclusive definition of disability — but there are exceptions.

The FHA covers individuals with a range of physical and mental impairments — including hearing or vision impairments, epilepsy, AIDS and HIV infection, cerebral palsy, and multiple sclerosis. The law does not, however, protect every individual who has a physical or mental impairment. For example, individuals currently addicted to drugs are not covered under the law. Moreover, the FHA has never granted anti-discrimination rights to convicted felons.

- The Fair Housing Act prohibits a range of discrimination against people with disabilities.

The law prohibits blatant discrimination, such as a landlord deciding not to rent a unit to a person with a wheelchair, or a person living with AIDS, because the landlord does not wish to be "bothered" with such individuals. The law also prohibits a landlord from refusing to allow a tenant to make reasonable modifications to a residence that will allow

the tenant access to the unit. Finally, the law requires a landlord to make reasonable accommodations to rules, policies, and practices that will ensure housing is made available to people with disabilities. For example, a landlord must make an exception to a "no pets" rule in order to accommodate a blind individual who needs a seeing-eye dog. Ensuring that reasonable accomodations and modifications are made is critical to achieving real equality and full access to housing for people with disabilities.

•The FHA also prohibits discrimination in the application of local zoning laws.

An important application of the FHA's anti-discrimination protection for people with disabilities occurs in the area of zoning. While the FHA does not preempt zoning laws, it does require that zoning laws not be applied in a discriminatory manner (e.g., a law that requires only group homes for people with disabilities to comply with a special hearing procedure). The law also requires that states and localities make reasonable accommodations to rules and procedures, such as granting variances to local zoning laws, in order to level the playing field so group homes for people with disabilities can locate in residential neighborhoods. Again, such accommodations are essential for real equality and access in housing for people with disabilities.

•The Fair Housing Act's protections do not strip localities of their power to regulate local land use.

Localities are not required to make accommodations that would impose an undue financial or administrative burden on the locality or that would undermine the essential purpose of a local zoning scheme. For example, a community need not grant a variance for an off-street parking places requirement for a group home if it can show the home would result in an unacceptable increase in traffic or noise in the neighborhood (See, e.g., Bryant Woods Inn, Inc. v. Howard County, 124 F.3d 597 (4th Cir. 1997)). Similarly, a city may refuse to grant a variance to a group home if members of the group home would pose a "direct threat" to the health or safety of others.

•The Fair Housing Act is a critical civil rights law that allows people

with disabilities to live independently in their communities.

Before 1988, prospective tenants and homeowners with disabilities were shut out of the housing market, and even excluded from certain neighborhoods, on the basis of ignorance, bias, and fear. With the protection of the Fair Housing Act, people with disabilities are guaranteed an equal opportunity to choose where to live, free from such invidious discrimination and harassment.

The FHA currently includes the right balance between protecting the rights of persons with disabilities and the rights of landlords, homeowners, states, and localities. The FHA needs to be supported, not diluted.

For more information contact: Katie Corrigan, Dana Singiser, or Dan Losen at (202) 662-9595 or via e-mail at corrigak@law.georgetown.edu.

CPEA Home Page / FHA as a Tool / Deficiencies in HR 3206
HR 589 versus HR 3206 / FHA's Protections Against Race Discrimination - Potential Impact of HR 3206 Against Certain Claims / HFA Helps Fight Drug Usage
Challenges to FHA's Protections for Children / Bazelon Center's Housing Page

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Coalition to Preserve the Fair Housing Act - MAllen47@aol.com

FEDERAL CASELAW ADDRESSING THE FAIR HOUSING RIGHTS OF PERSONS WITH DISABILITIES IN LAND USE AND ZONING ISSUES

California Land Use and Zoning Campaign
Protection and Advocacy, Inc.
Mental Health Advocates
Fair Housing Congress of Southern California

June, 1995

Document prepared by Protection & Advocacy, Inc. 449 - 15th Street, Oakland, CA 94612, 510/839-0811, pursuant to subcontract under HUD/FHIP Grant Agreement Number FH-70094-00097

More briefly surveyed in this memorandum are federal constitutional protections, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and the anti-NIMBY ("not in my backyard") statute, Govt. Code § 65008, et seq.[1]

II. FEDERAL FAIR HOUSING LAW

The FHAA extended the protections of the FHA to include, inter alia, persons with disabilities, or handicaps. The FHA, therefore, now protects persons from housing discrimination on the basis of race, color, religion, sex, national origin, familial status, and handicap. "Handicap" is defined as "a physical or mental impairment which substantially limits one or more . . . major life activities," or "a record . . . of such an impairment," or "one who is regarded by others as having such an impairment." 42 U.S.C. § 3602(h). Individuals who are disabled or who are perceived to be disabled, and those who associate with or seek to provide housing to persons with disabilities have standing to bring suit for discriminatory acts under the FHAA.

The FHAA recognizes that zoning and other land use restrictions and policies may illegally deny housing to disabled persons. Where such restrictions or other determinations have the effect of denying or interfering with the housing rights of disabled persons, they will be deemed illegal and discriminatory.

■ PLAINTIFF'S BURDEN OF PROOF

♦ Discriminatory Intent

To prove discriminatory intent under the FHAA, the plaintiff need only show that the plaintiff's disability was one factor considered by the defendant in making a land use or zoning decision. The plaintiff's handicap need not be the sole basis for the defendant's discriminatory actions. Further, a plaintiff need not demonstrate that the defendant harbors personal animosity, ill will, or a malicious desire to discriminate. Intentional discrimination includes actions motivated by stereotypes, prejudice, unfounded fears, misperceptions, paternalistic attitudes and a desire to respond to certain neighborhood and community concerns. Both circumstantial and direct evidence may be admitted to demonstrate discriminatory intent.

CASE AUTHORITIES

Casa Marie, Inc. v. Superior Court of Puerto Rico for Dist. of Arecibo, 988 F.2d 252 (1st Cir. 1993).

In ruling on a summary judgment motion, the court noted that although direct evidence of discriminatory intent was not required under the FHAA, plaintiff could bolster proof of such intent by offering direct evidence, such as statements made by the defendant

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[1]In California, AB 2244 amended the Fair Employment and Housing Act, Govt. Code §§ 12900, et seq., to include persons with disabilities. It explicitly prohibits public or private land use practices, decisions and authorization that have a discriminatory effect. § 12955(i). As court interpretations of this new law expand, so will its treatment in this memo. An expanded section on state laws and caselaw is being developed.

8 CAPITOL STREET, SUITE 700
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TELEPHONE (304) 346-4575
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West Virginia Health Care Association

August 5,1999

John Wilkinson, Director
Office of Health Facility Licensure & Certification
Department of Health and Human Resources
Building 3, Room 550, Capitol Complex
Charleston, WV 25305

Dear John:

Thank you for the opportunity to review the legislative rule for personal care homes, WV Code §§ 16-5D-1. In reviewing the rule, I found few changes to the current regulations. My only recommendation would be to define "personal care home" in the definitions section. It may help give clarity to an often misunderstood term.

Best wishes for passage in the 2000 legislature.

Sincerely,

John Alfano
CEO

c: Donna Gibeaut

August 5, 1999

John M. Wilkinson, Director
Office of Health Facility Licensure
and Certification
Capitol Complex, Building 3, Room 550
Charleston, West Virginia 25305

Dear Mr. Wilkinson:

Please accept this letter as my objection to the use of written comments in lieu of public hearings to provide opportunity for public debate on rule changes, economic impact, and the health care of elderly West Virginians in personal care homes.

Over the past thirty (30) years I have had more than ample exposure to the treatment and care of elderly parents and relatives. I have been in nursing homes were the stench from urine and fecal matter was so bad you needed a gas mask to stay inside.

The proposed rules in question give all the appearance of a concerted effort to reduce or eliminate the personal care homes in West Virginia or make it so costly that families will no longer have the financial means to support family members. If this should happen those individuals who can afford fifteen thousand dollars ($15,000.00) to twenty five thousand dollars ($25,000.00) out of their budgets will be forced to seek nursing home care at state and federal expense.

The proposed rules indicate that no economic impact will occur. This just is not true. The average cost of nursing home service is about twice the cost of personal care homes or about thirty five thousand dollars ($35,000.00) to forty thousand dollars ($40,000.00) per year.

If the personal care homes are required to meet nursing home standards, then we may as well transfer our relatives to nursing homes and let the state pay for this care. For the twenty plus (20+) families I know who have fathers, mothers, brothers, sisters, aunts, uncles, wives, and husbands in personal care homes, the economic impact will be devastating.

There are still people in this state who are actually involved in the care of elderly family members. My experience with nursing homes is that they are the armpit of the health care system.

The issue of personal care should be left with the family who pays the bills, not with an agency or organization who contributes nothing to the support or care of a family member.

These are issues that warrant public hearings so that honest, intelligent people can debate and evaluate these changes in the light of a free discussion. I am requesting that the implementation of these rules be suspended, hearings be held, and the economic impact be evaluated.

In summary let me state, for the record, that I have no investment in either nursing homes or personal care homes, nor do I receive a single dollar from any such facility. However, over the past three (3) years we have supported one of our family members at a cost of approximately fifty seven thousand dollars ($57,000.00) without one penny from the state or federal government.

I would be most happy to meet with you to discuss these issues if you believe my comments have merit. I can be reached at 343-8525 after 5:00 p.m..

Sincerely,

Gerald L. Tribble

GLT:plt

cc: Senator Brooks McCabe
Senator John R. Mitchell, Jr.
Senator Vic Sprouse
Senator Martha Yeager Walker
Delegate Jon Amores
Delegate Tim Armstead
Delegate Art Ashley
Delegate Shelly Moore Capito
Delegate Steve Harrison
Delegate Barbara Burruss Hatfield
Delegate Mark A. Hunt
Delegate Margaret "Peggy" Miller
Delegate Larry L. Rowe
Delegate Joe F. Smith
Delegate Sharon Spencer
Delegate Charles "Rusty" Webb

faxed 8/3

8/1/99

WOODRIDGE P.C.H.
3810 GRAND CENTRAL AVE.
VIENNA, WV 26105

Jon Wilkinson, Director

I would like to comment on the Personal Care Home Regulations. I do believe the regulations have caused an Economic Impact on Citizens/Public at Large. When new regulations are posed on business it always costs the consumer, in our business it has caused the price of care to increase, therefore causing the prospective clients to have to pay increased cost for their care. In my particular situation all of my residents are medicaid, therefore I have no way of increasing their monthly rates when new regulation are put into force. I believe when new regulations are placed on Personal Care Home Owners, there should be some reimbursement for costs given to the homeowners by the State and or Federal Government. After all Personal Care Homes are the wave of the future for individuals needing care. West Virginia should help the home owners take care of clients in the least expensive care available. The longer clients are able to stay in this kind of environment the less the State will have to pay for their care in a Nursing Home. The healthier Personal Care Home owners are able to keep their clients healthy, the longer they will remain in Personal Care Homes instead of Nursing Homes

Physical Facilities,

I believe several items in this category should pertain to new structures. Especially when you talking about square footage of rooms & leisure space. When regulations changed to 80 square ft. from 60 square feet per person in a bedroom, many homes cannot comply with this. We should not have to loose residents because of the new regulations. In my situation I have no where to make the rooms larger and if I did it puts a financial hardship on the home. All of my clients are medicaid & have no way of increasing revenue. The state isn't going to give me more money. As owners of Personal Care Homes we should not be put in the situation we are in as far as, what if we wanted to sell our business, it is almost impossible, no new owner would want to take on the responsibility of being strapped financially to start a business and then to continually be placed under new regulations.

Once again if many of the Physical facilities must comply who are we not able to receive additional money like Nursing Homes do when regulations are changed.

The economic impact is not on the state of WV. it is on the home owners, and their clients. A feasibility study should have been done as to what these regulations were going to cost the home owners, instead rules & regulations were put into effect with only what the impact was on the state not the people.

Sincerely
Sharon Vandevender

faxed 7/30 to KB

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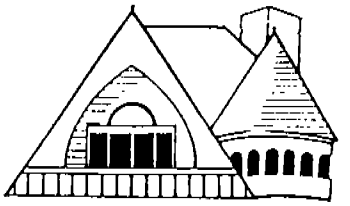

Elmhurst
The House Of Friendship

July 27, 1999

John Wilkinson
Office of Health Facility Licensure and Certification
Department of Health and Human Resources
Capitol Complex-Building 3, Room 550
Charleston, West-Virginia 25305

Dear Mr. Wilkinson,

The following are the comments from The Welty Home for the Aged, Altenheim, and Elmhurst, The House of Friendship, Inc. regarding the proposed rules for Personal Care Homes.

1. Question- Why are there no definitions for Personal Care Homes or Residential Board and Care Homes?

2. 7.8.e.- reporting major incidents- Define falls/accidents. EX. Is a fall that results in a broken hip that requires surgery to be reported?

3. 7.7.k.2.B.- Could we, with the resident's permission, give non-returnable medications to Health Right instead of destroying them?

4. 9.1.d.- Why weigh a resident monthly who doesn't require nursing care? We feel this would make them feel like a "patient". We feel yearly is enough unless their is a medical reason.

10.2.d.- Do we have to have the assistance of qualified fire safety **and** emergency response team **and** other appropriate experts to develop our emergency plans? Which expert documents the plan?

Thank you for letting us voice our comments regarding these changes. We were impressed with the condensation and organization of the regulations.

Sincerely,

Cheryl K. Jones

Cheryl K. Jones, RN
Executive Director

1228 National Road Wheeling, West Virginia 26003 (304) 242-0240 Fax (304) 242-0587

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Daniel W. Farley, Ph.D.-CNHA, ACSW
President/Chief Executive Officer
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July 15, 1999

Mr. John Wilkinson Director
Office of Health Facility Licensure
and Certification
Department of Health and Human Resources
Capitol Complex, Building 3, Room 550
Charleston, WV 25305

Dear Mr. Wilkinson:

This letter connects to proposed changes in 64CSR14, Title 64, Legislative Rules relating to personal care homes. For the moment, I have one suggestion for an amendment to the rules.

Under Article 64-14-3 Definitions, personal care home should be defined. In doing so, the definition will serve as an umbrella as one moves forward in the rules interpreting the various components and/or responsibilities of a personal care home.

If you have questions, please let me know.

Sincerely,

Daniel W. Farley

jm

Faxed KB
8-5-99

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August 2, 1999

John Wilkinson, Director
Office of Health Facility Licensure and Certification
Building 3, Room 550
State Capitol Complex
1900 Kanawha Blvd.
Charleston, WV 25305

Dear Mr. Wilkinson:

We are writing in regard to the rule requiring a registered nurse to oversee medication administration in residential care homes for the elderly.

A recent study published in the February issue of *Annals of Pharmacotherapy* suggests that there are many problems or potential problems with medication use in residential care facilities, especially with psychotropic drugs. The authors of this study, a copy of which is enclosed for your review, suggest that improved record keeping, periodic medication review, and education of staff, residents, and prescribers may help ensure appropriate medication use in these homes. A pharmacist would be the most qualified health care professional to provide such services. Pharmacists are experts in all aspects of the therapeutic use of drugs. They are uniquely qualified to identify actual or potential drug interactions and adverse effects, and to identify unnecessary drugs in a patient's therapeutic regimen.

There is already a long-standing precedence for the role of the pharmacist in the care of the institutionalized elderly. In nursing facilities, federal law mandates the review of each resident's drug therapy regimen at least monthly by a consultant pharmacist. These pharmacists ensure that all medications have a corresponding diagnosis, and that drugs are being dosed appropriately. They look for interacting drugs or foods, adverse effects, duplication in therapy, and continued use of medication that is no longer necessary. Pharmacists also recommend appropriate laboratory tests to monitor drug therapy. Educating patients and staff about all aspects of medication administration and use, monitoring patient medication compliance, and assisting with development of policies and procedures relating to medication administration are also routine activities offered by consultant pharmacists. In many cases, the consultant pharmacist is on-call twenty-four hours a day for any drug-related question that may arise. These services generally cost less than $10 per patient per month, and are not a major financial burden to patients or facility owners.

We hope that the legislature will consider the consultant pharmacist as an alternative to registered nurses for the provision of pharmaceutical care for residents of residential care facilities.

Sincerely,

Melanie Cupp

Melanie Cupp, Pharm.D., BCPS
Clinical Assistant Professor/Drug Information Specialist

Diane Casdorph

Diane Casdorph, R.Ph.
Clinical Instructor/Drug Information Specialist

Medication Use in Residential Care Facilities for the Elderly

Bradley R Williams, Michael B Nichol, Beverly Lowe, Peter S Yoon, Jeffrey S McCombs, and Jane Margolies

OBJECTIVE: To describe medication use by residents of residential care facilities for the elderly (RCFEs).

DESIGN: A cross-sectional survey of medication use.

SETTING: Licensed, private RCFEs recruited from a roster of all licensed RCFEs in the Los Angeles area.

SUBJECTS: Residents who were ≥60 years of age and whose medications were centrally stored in the facility.

MEASURES: Age, gender, race, health insurance coverage, dietary restrictions, ambulation status, medical diagnoses, and medication profile.

RESULTS: A total of 818 residents were surveyed. Residents were primarily white women who were >80 years. The average number of medications per resident was five; 94% of the sample took at least one medication. Cardiovascular drugs, central nervous system drugs, analgesics, diuretics, and potassium supplements were most commonly used. Use of multiple drugs within a therapeutic class was also common, with means ranging from 1.46 to 1.81 per resident for the most commonly prescribed classes. Diagnoses supporting the use of many medications were not documented in the residents' health records.

CONCLUSIONS: This RCFE sample was medically frail and took many medications. The frequent use of cardiovascular medication reflected the prevalence of cardiac disease in the elderly. The frequency of psychotropic drug use without a corresponding indication suggested prescribing for symptoms rather than documented medical conditions. Lack of recorded diagnoses limited the ability to evaluate drug therapy. Improved record keeping; periodic medication review; and resident, staff, and prescriber education are necessary to ensure appropriate medication use in this setting.

KEY WORDS: residential care, geriatrics.

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Many elderly people require some form of assisted living. One study[1] estimated that more than 1.6 million people of all ages require skilled nursing facility (SNF) or intermediate care facility services; 90% are >65 years. Another segment of the elderly population that is less frail yet unable to live independently is served by residential care facilities for the elderly (RCFEs), which are also referred to as rest homes or board-and-care homes. The US General Accounting Office[2] estimated that "as many as 75 000 board and care homes, licensed and unlicensed, serve over 1 million dependents, about half of whom are functionally disabled elderly persons." In contrast to nursing homes, RCFEs are social rather than medical environments in that they are designed to provide general supervision for relatively independent elderly residents and offer only minimal medical assistance.

Due to Medicare's prospective payment system and diagnosis-related group reimbursement policy, SNFs are caring for increasingly ill patients.[3,4] There is concern that the RCFE population is also becoming more frail as reimbursement policies tighten and SNF beds become less available. This is potentially troublesome because RCFEs are not medical facilities and staff are not trained to manage a largely frail elderly population. In particular, the staff do not possess the knowledge or skills required to review and monitor their residents' medication use.[2,5] Further-

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more, RCFEs vary widely, from the "mom and pop"–operated homes to the facilities that are being operated as part of large multiple-level-of-care complexes. The health and physical conditions of residents, the types of services being provided, the quality of care, and staff may differ according to available resources and staff background.

Since many older adults living in RCFEs are similar to custodial SNF residents, it is likely that drug use patterns are similar. Nursing home residents are among the most heavily medicated segments of the population.[6,7] Previous research has documented the incidence of polypharmacy,[8] excessive use of medications that are prescribed to be taken on an as-needed basis,[9,10] and high drug cost[11] in the long-term-care setting. Compounding these problems, the choice of suboptimal or inappropriate medications to treat SNF or RCFE residents places them at high risk for adverse drug reactions,[12] leading to complications such as cognitive impairment,[13] falls,[14,15] and hip fractures,[16] which will reduce their functional capacity and independence.

Problems with medication use in nursing homes have been recognized for more than 25 years.[17] A majority of problems have been encountered with the use of psychotropic medications (including antipsychotic and sedative–hypnotic agents) and cardiovascular agents. Less information has been published about medication use in RCFEs, but available data indicate similar problems with overall medication use,[18] psychotropics,[19-22] cardiovascular/diuretic agents,[23] and digitalis.[24] As SNF and RCFE resident populations become more similar, the less sophisticated staff and medication control procedures in RCFEs increase the risk for inappropriate or excessive medication use by the elderly residents in these facilities.[5]

To determine medication use patterns in RCFEs and to test the feasibility of programs to correct suboptimal medication use in this environment, a demonstration project was undertaken in 61 RCFEs in southern California. This report represents an analysis of baseline medication use and compares the findings with problems previously identified in the SNF environment.

Methods

SAMPLE SELECTION

A stratified random sample was drawn from a roster of all licensed RCFEs (n = 560) in Los Angeles County. Fifty-four facilities were randomly selected within three size ranges: small facilities of <10 beds, medium facilities of 10–49 beds, and large facilities of ≥50 beds. Small facilities were oversampled to ensure adequate representation. Initially, letters were sent to this sample only; however, due to a response rate <10%, letters were subsequently sent to the entire list of licensed facilities. Homes that did not respond received a follow-up telephone call. Concurrently, professional organizations such as the California Association of Services and Homes for the Aged and the California Association of Residential Care Homes assisted with recruitment efforts by informing their members of the study. The recruitment efforts resulted in the enrollment of 63 RCFEs. Two facilities withdrew, providing a final sample of 61 RCFEs, which lodged 818 residents ≥60 years. (Given the high refusal rate, it was important to know whether the participating RCFEs differed in any way from nonparticipating facilities. Comparison of the two groups according to license status indicated that participating facilities were more likely to be nonprofit [$\chi^2 = 18.51$; $p < 0.001$].) None of the facilities in the sample used the services of a consultant pharmacist or nurse to review medications.

All residents in small and medium facilities were eligible for inclusion in the study. In large facilities, only residents who were classified as requiring assisted living (i.e., needing help with some normal daily activities) were selected. These residents were chosen because their medications were centrally stored and prepared by the facility staff for resident self-administration, which was the system in use at all of the small and medium facilities. Several large facilities provided multiple levels of care, including both residential and skilled nursing services. Residents of these complexes frequently purchased life-care contracts on entry, under which the facility agreed to care for the person at whatever level of care was required for the remainder of their lives. Our study included only individuals who were living in the residential care portion of the facility.

DATA COLLECTION

During a three-month period (January–March) in 1990 a clinical pharmacist and trained assistants who were not healthcare providers collected data from the residents' health records, medication records and bottles, and through interviews with RCFE staff. Information for each resident included age, gender, ethnic background, known drug allergies, health insurance coverage, dietary restrictions, ambulation status, medical diagnoses, and medication profile (including dose and frequency of use for all medications). Medications used represented both prescription and nonprescription medications (including herbal products and nutritional supplements), whether they were routinely prescribed or used as needed. Data were collected for all medications on order on the date of the survey. Each drug was coded by therapeutic class according to the American Hospital Formulary Service,[25] although for analytical purposes, analgesic medications were defined as acetaminophen, opiates, and nonsteroidal antiinflammatory drugs and were evaluated separately from other central nervous system (CNS) agents. Diagnoses were coded using ICD-9-CM categories.[26] The prescriber and pharmacy from which the medications were obtained were also recorded.

ANALYSIS

Data obtained during the baseline period of the demonstration project were analyzed using χ^2 (two-tailed) statistic, paired Student's *t*-test with Bonferroni adjustment for differences in medication-related variables, and ANOVA to test for differences by facility size.

Results

RESIDENT CHARACTERISTICS

The sociodemographic characteristics and primary payer for the residents are presented in Table 1. As expected, the population was overwhelmingly female and white. Despite the advanced age of the population, >90% were able to ambulate without assistance. Residents of large facilities tended to be older but more ambulatory than those in small and medium facilities. Additionally, significantly more of the large facility residents were self-payers or had private insurance. This was partly because all life-care residents in the sample belonged to the large facility group.

RESIDENT MEDICATION USE AND RELATED FACTORS

Data describing the medication use rates are listed in Table 2. Medication use was common, as 94% of the overall sample took medications. The prevalence of medication use differed by facility size: 96.2% of residents in small, 86.7% in medium, and 98.2% in large facilities. Medications were commonly ordered without an associated diag-

nosis present in the resident's health record. This was less common in medium facilities as compared with large and small homes. Residents of small facilities used significantly more services of a greater number of physicians than did those of medium and large facilities. Residents of large facilities used significantly more pharmacies than did residents of small and medium facilities.

For this study, 16 major drug classes were targeted that included medications most commonly used in a geriatric population. Table 3 presents data for only those classes that were prescribed for at least 10% of the residents in the total sample. Since no consistent facility size effect related to drug class was noted, the data in Table 3 were not classified according to facility size.

Discussion

The residents studied in the sample were elderly, with approximately half the residents exhibiting impaired mobility and taking nearly the same number of medications as residents of nursing facilities. These factors place the RCFE resident at high risk for medication-related complications, yet no facility used a consultant pharmacist or nurse to monitor medication use in an effort to prevent such occurrences.

The residents in this sample were similar to those studied in other residential care settings with regard to age and

Table 1. Sociodemographic and Primary Payer Variables by Facility Size[a]

Characteristic[b]	Small	Medium	Large	p Value
Mean age (n = 818)	81.6 ± 8.7	80.8 ± 8.7	83.3 ± 7.88	<0.001
Female (n = 811) (%)	78.3	71.8	80.8	0.010
Race (n = 789) (%)				0.001
non-Hispanic white	84.3	87.5	96.3	
African-American	8.7	7.8	2.1	
Hispanic	3.9	2.2	0.7	
Asian	1.6	1.7	0.7	
other	1.6	0.8	0.2	
Ambulation status (n = 632) (%)				0.010
no limitations	50.8	52.9	54.6	
cane/walker independent	37.3	33.8	41.4	
cane/walker with assistance	7.9	8.3	3.0	
wheelchair bound	4.0	4.9	1.0	
First payment (n = 719) (%)				<0.001
private pay/insurance	4.8	2.9	15.2	
Medicare Part A	92.0	93.7	84.3	
other public insurance	3.2	3.4	0.5	

[a]Small facilities <10 beds, medium ≥10–49 beds, large ≥50 beds.
[b]ANOVA was completed for differences between facility sizes for mean age; χ^2 for all other between-variable analyses.

Table 3. Drug Use by Therapeutic Category

Therapeutic Category	Residents (no.)	Residents (%)	Mean Number of Drugs/Resident/ Category
Cardiovascular	440	53.8	1.66 ± 0.91
digitalis glycosides	212	25.9	
vasodilators	136	16.6	
calcium-channel blockers	103	12.6	
ACE inhibitors	83	10.1	
other antihypertensives	61	7.5	
β-blockers	42	5.1	
antiarrhythmics	40	4.9	
antilipemic agents	5	0.6	
Central nervous system	391	47.8	1.46 ± 0.73
anxiolytics	186	22.7	
antipsychotics	150	18.3	
antidepressants	131	16.0	
anticonvulsants	47	5.7	
Electrolyte/water balance[a]	349	42.7	1.81 ± 0.67
diuretics	288	35.2	
potassium supplements	165	20.2	
potassium-sparing diuretics	93	11.4	
Analgesics[b]	313	38.3	1.50 ± 0.73
Vitamins	220	26.9	1.40 ± 0.68
multiple vitamins	164	20.0	
Hormones	205	25.1	1.14 ± 0.38
thyroid supplements	116	14.2	
oral hypoglycemic agents	31	2.6	
estrogens	26	3.2	
corticosteroids	24	2.9	
insulin	21	2.6	
Autonomic nervous system	119	14.5	1.12 ± 0.44
anticholinergic agents	57	7.0	
adrenergic agonists	24	2.9	
α-adrenergic blockers	23	2.8	
cholinergic agonists	8	1.0	
Blood-forming agents[c]	85	10.4	1.01 ± 0.11
iron supplements	68	8.3	
anticoagulant/antiplatelet	11	1.3	

ACE = angiotensin-converting enzyme.
[a]Includes diuretics, electrolyte replacement products.
[b]Includes acetaminophen, aspirin, narcotic analgesics, and nonsteroidal antiinflammatory agents.
[c]Includes iron supplements, hematinics, and anticoagulants.

Table 2. Drug-Related Variables per Resident by Facility Size[a]

Variable (no.)	Small	Medium	Large	Small to Medium	Medium to Large	Small to Large
Drugs	4.59 ± 3.30	4.06 ± 3.10	5.59 ± 3.30	0.1285	<0.001	0.0025
Physicians	1.19 ± 0.70	1.04 ± 0.60	1.05 ± 0.20	0.0325	0.7471	<0.001
Pharmacies	1.37 ± 0.80	1.17 ± 0.70	1.78 ± 0.80	0.0138	<0.001	<0.001
Missing diagnoses	3.00 ± 2.93	2.36 ± 2.50	3.06 ± 2.62	0.0282	<0.001	0.8218

[a]Nominal a 0.05; Bonferroni adjusted a for 3 comparisons (pairwise) 0.017; Bonferroni adjusted a for 15 comparisons (experimentwise) 0.003.

gender.[5,18,22,27] They were largely ambulatory, which was not surprising given the semiindependent nature of the RCFE. Residents of large facilities were more likely to use private sources for healthcare payment, suggesting a more economically secure population.

Medication use within this sample was higher than has been reported in other residential facilities. In a British study of 1888 residents, the median number of medications was three.[27] The average of five medications per resident in our study was closer to the average of 4.6 prescriptions per resident[18] noted in a 10-state RCFE sample and six to eight or more medications per resident reported in reviews of the nursing facility literature.[6,7] Our data did not differentiate between medications ordered and medications taken. However, regulations governing RCFEs in California preclude the use of an as-needed designation for medications. Medications must be ordered on a scheduled basis or "per resident request"[28]; that is, the resident must request the medication for a specific problem (e.g., ask for a sedative for insomnia). As a result, as-needed medications were rarely ordered and the majority of medications ordered were taken by residents on a routine basis. Although residents of large facilities used more medications and visited more pharmacies than did residents of small and medium facilities, there was no clear reason for this finding. One possible explanation is the combination of greater financial resources and an effect of life-care contracts; residents who are more financially secure may use more healthcare services (e.g., visit physicians more frequently), purchase medications that less affluent individuals may be unable or unwilling to purchase, and can afford to live in life-care facilities that provide more skilled care when necessary. Regardless of the reason, this finding is troubling because it suggests fragmented health care with inadequate monitoring of medication use. This is an area in need of further exploration.

Another potentially disturbing observation was the frequency of missing diagnoses when medications were prescribed. This was less of a problem in medium-sized facilities, but no reason for this finding could be determined. Researchers in other studies discovered diagnoses missing in >50% of a large RCFE sample[27] and more than 60% when digitalis glycosides were prescribed.[24] A similar problem was reported for psychotropic medications in a review of the long-term-care facility literature.[29] In the RCFE environment, the attending physician must update the resident's health record at least annually. It was possible that the lack of diagnoses was due to an extended time period since the last update, poor record keeping, or inattention on the part of the prescriber. However, data from nursing facility research have indicated a strong association between adverse drug reactions and the lack of a definite diagnostic indication.[30] Whether this is true also for residents of RCFEs warrants further investigation. In any event, the absence of diagnoses in the health record made it very difficult, if not impossible, to evaluate the appropriateness of prescribing or medication use.

Hospital discharge data indicate that the most common primary diagnosis among the elderly is related to circulatory system disease.[31] It was not surprising, therefore, to find that the most commonly used medications in this sample were cardiac medications and electrolyte, caloric, and water-balance drugs (primarily diuretics and potassium supplements), as these two broad categories of medications are used to treat a multitude of cardiovascular diseases. As a result, the use of more than one agent by an individual in this sample was quite common. However, if use of these agents was similar to that in other long-term-care environments, many residents may not have required the continued use of these medications. Weedle et al.[24] reported that only one-third of their sample of 1888 RCFE residents using cardiovascular medications had an accompanying diagnosis. Several investigators have reported on the overuse of digitalis glycosides[32-34] and diuretics[35,36] in skilled nursing facilities. Similarly, the residents in our sample were typically taking only digoxin and had no recorded diagnosis to support its use. The potential for digoxin toxicity and several drug interactions makes periodic reevaluation necessary to determine if continued therapy is warranted[37] or if changing to an alternative therapy would offer equal or improved resident outcomes.

The infrequent use of cholesterol- and lipid-lowering agents in this sample is not surprising, given the advanced age of the sample. It is not clearly established that beginning treatment would significantly affect resident outcomes, particularly if the residents had not experienced previous cardiovascular events.[38]

Psychotropic drug use in this sample was quite common, as nearly half the population used at least one such medication. The mean number of medications per person within the class indicated that residents were frequently taking multiple agents. The mean number of medications used within each subgroup indicated that therapeutic duplication, while not typical, still remained a problem.

Data from this study were consistent with findings from both residential care and nursing facility settings. In a 10-state sample of RCFEs, Spore et al.[22] reported that 33% of the population used psychotropic medications, with prevalences ranging from 12.5% to 15.2% for anxiolytic, antidepressant, and antipsychotic use. Avorn et al.[21] found that 55% of Massachusetts rest home residents used at least one psychotropic agent and 39% used antipsychotic medications. Weedle et al.[27] noted CNS medication use among 34% of their RCFE sample, with 23% using hypnotic agents. Other studies[39,19] in RCFEs have reported hypnotic use in 33.5–59.7% of residents, with duration of therapy frequently exceeding one year. Studies from both intermediate and skilled care facilities reported use of psychotropic agents among residents, in the range of 38%[40]–54%.[41] As in our study, sedative–hypnotic agents and antipsychotics were the most often used psychotropic medications, with antidepressants being used much less frequently.[40-44] Use of these agents has been frequently associated with increased risk of falls,[14,15] use as chemical restraints,[44] and lack of facility resources,[40] indicating suboptimal pre-

scribing and use patterns. Intervention by a pharmacist in the nursing facility environment can reduce the rate of sedative–hypnotic use.[45]

Limitations of this study must be considered when evaluating the results. First, the group studied was a convenience sample. Although efforts were made to randomly select RCFEs, many declined to participate. Several expressed concern regarding potential licensing ramifications if problems were identified during the project. This may have reflected fears among operators that their facilities would not meet minimum standards regarding medication policies and procedures; thus, the sample may have self-selected those that represented the "higher quality" facilities. Unlicensed facilities were ineligible for participation because of concerns by operators regarding legal implications about their status with the state licensing agency. These factors suggest that the results might underestimate problems present in the RCFE population.

Second, only residents whose medications were centrally stored were eligible for evaluation. No information was collected from residents who were able to self-medicate. While the overwhelming majority of residents in small and medium facilities had medications centrally stored, many in large facilities did not. Therefore, the results of this study cannot be generalized to the entire RCFE population.

Finally, data were not complete for all subjects. Facility records were frequently incomplete, particularly regarding race, ambulation status, payment source, and diagnostic information. Attempts to fill in missing data were often unsuccessful because residents were no longer in the facility when the data collectors returned for follow-up. In many instances, residents or staff could not reliably supply diagnoses. This situation, however, illustrates a potentially significant problem in residential care. Lack of complete and reliable information may lead to therapeutic mistakes if a resident is sent to an emergency department or visits a new healthcare provider. Crucial data may be lacking that might affect decisions made by physicians or other prescribers.

Summary

Despite the limitations of this study, several points can be made. Many of these RCFE residents were frail and highly medicated, much as has been seen in nursing facilities. The prevalent use of cardiovascular medications reflected the frequency of cardiac illness common to older adults, but as in nursing facilities, it was possible that they were overused and inadequately monitored.

Most disturbing was the frequent use of psychotropic agents. The common use of psychotropic medications without supporting medical or psychiatric diagnoses suggests that they may have been used to treat symptoms rather than underlying medical conditions, and that older adults in any congregate living situation may be at excessive risk for adverse reactions. The RCFE environment provides an important residential alternative to older adults whose health is on a critical margin — too frail to live safely alone and unsupervised, yet sufficiently well to avoid nursing facility placement. While recognizing that RCFE residents are for the most part less frail than nursing facility residents, multiple medical problems, physical frailty, gait and balance problems, and impaired cognition are common findings.[46] There is concern, therefore, that it is a population declining in health status and living in residences without the healthcare services required in nursing homes. While it is essential to avoid the medicalization of this social environment, residents must be assured that they will not decline due to suboptimal management of drug therapy regimens.

These findings argue strongly for better monitoring of medication use in RCFEs. Strategies as simple as accurate record keeping would undoubtedly improve medication use. Periodic review of medication regimens by a pharmacist or other health professional familiar with geriatric pharmacology and therapeutics should help prevent ongoing overuse of medications as it has in other settings.[17] Providing education to residents, facility staff, and prescribers is important to enable all individuals involved in a resident's care to recognize the emergence of potential adverse drug events.

We acknowledge Loren G Lipson MD, Associate Professor, Medicine, and Chief, Division of Geriatrics, School of Medicine, University of Southern California, for his assistance with the study design and Fawn Takemoto and Debbie Shin, PharmD Students, School of Pharmacy, University of Southern California, for their assistance in data collection.

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EXTRACTO

OBJETIVO: Describir el uso de medicamentos por las personas que residen en residencias de ancianos (PRRA).

DISEÑO: Se envió inicialmente una carta a una muestra aleatoria estratificada obtenida de un registro de todos los PRRA con licencias (n = 560) en el área de Los Angeles, California. Se utilizaron varias estrategias para obtener la muestra debido a una respuesta inicial de menos de 10%.

ESCENARIO: Muestra final fue de 61 PRRA con licencias y privados.

PARTICIPANTES: Los residentes tenían que tener 60 años de edad o más y sus medicamentos estar custodiados por la instalación en un área centralizada.

MEDICIÓN DE RESULTADOS: Edad, género, raza, cobertura de seguro de salud, restricciones dietéticas, diagnósticos médicos, perfil de medicamentos, y grado de autonomía (e.g., asistencia necesaria en actividades del diario vivir).

RESULTADOS: Se completó un formulario a un total de 818 personas de 60 años de edad o más. Los residentes eran principalmente mujeres blancas de más de 80 años de edad. El número promedio de medicamentos utilizado por persona fue cinco; 94% de la muestra utilizaba por lo menos un medicamento. Los medicamentos más comúnmente utilizados eran los agentes cardiovasculares, medicamentos para el sistema nervioso central, analgésicos, diuréticos, y potasio como suplemento o en combinación con un diurético. También fue común el uso de más de un medicamento dentro de estas categorías terapéuticas con medias que fluctuaron entre 1.46 y 1.81 por persona. En el expediente médico de los pacientes no se encontró documentación de diagnósticos que apoyaran el uso de muchos de los medicamentos.

CONCLUSIONES: Esta muestra de PRRA fue de personas de edad avanzada con salud frágil y que utilizaban muchos medicamentos. El uso frecuente de medicación cardiovasculare es un reflejo de la prevalencia de enfermedades cardíacas en las personas de edad avanzada. La frecuencia con que se usaban los medicamentos sicotrópicos sin indicación clara sugiere el que estos se prescribían para tratar síntomas en vez de problemas documentados. La ausencia de documentación de diagnósticos limitó la habilidad para evaluar la farmacoterapia. Se necesita mejorar la documentación, una revisión periódica de las medicinas y la educación de médicos, personal de apoyo y residentes para asegurar el que los medicamentos se utilicen apropiadamente en estas residencias de ancianos.

LUZ M GUTIÉRREZ

RÉSUMÉ

OBJECTIF: Décrire les médicaments utilisés par les résidents de centres d'accueil pour personnes âgées (CAPA).

DEVIS EXPÉRIMENTAL: Un sondage en section croisée concernant l'utilisation des médicaments.

LIEU DE L'ÉTUDE: CAPA privés, recrutés à l'aide d'une liste de tous les CAPA autorisés de la région de Los Angeles, California.

PARTICIPANTS: Résidents âgés de 60 ans ou plus, dont la médication était entreposée dans un endroit central du centre d'accueil.

MESURES DE L'EFFET: Âge, sexe, race, plan d'assurance santé, restrictions alimentaires, état ambulatoire, diagnostics médicaux, et profil de consommation médicamenteuse.

TITLE 64
LEGISLATIVE RULES
DIVISION OF HEALTH
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 14
PERSONAL CARE HOMES

§64-14-1. General.

1.1. Scope. -- This legislative rule prescribes specific standards and procedures to provide for the health, safety, and the protection of the rights and dignity of residents of personal care homes. This rule must be read in conjunction with W. Va. Code §16-5D-1 et seq. to determine the complete requirements for licensing, regulating, and investigating complaints concerning personal care homes.

1.2. Authority. -- W. Va. Code §16-5D-5 and 16-1-7.

1.3. Filing Date. --

1.4. Effective Date. --

1.5. Repeal of Former Rule. -- This rule repeals and replaces W. Va. Division of Health Administrative Rules, Personal Care Home Licensure Rule, 64CSR14, 1996.

§64-14-2. Application and Enforcement.

2.1. Application. This rule applies to any individual person, and every form of organization, whether incorporated or unincorporated, including any partnership, corporation, trust, association or political subdivision of the State establishing, maintaining or operating a personal care home as defined in W. Va. Code §16-5D-2 and this rule: Provided, That this rule does not apply to homes or asylums operated by fraternal orders pursuant to W. Va. Code §35-3-1 et seq. A facility which provides extensive or ongoing nursing care, other specialized therapeutic care, or behavioral health services to four (4) or more individuals concurrently is subject to other applicable licensure rules.

2.2. Enforcement. This rule is enforced by the secretary of the department of health and human resources or his or her designee.

§64-14-3. Definitions.

3.1. Abuse -- Mistreatment of residents, including physical bodily harm, misuse of physical or chemical restraints, verbal abuse, and infliction of emotional suffering.

3.2. Activities of daily living -- The activities that individuals generally perform regularly in the course of maintaining their physical selves, such as eating, dressing, oral hygiene, toileting, personal grooming, and moving themselves from one location to another, as for example, in moving from a bed to a chair, or from one (1) room to another.

3.3. Administration of medications -- Opening a container of medication and giving the medication to the person for whom it is prescribed, including giving injections and administering eye drops.

3.4. Administrator -- The owner or individual selected by the licensee to be responsible for the day-to-day operation of the personal care home.

3.5. Adult day care. -- An alternative to twenty-four (24) hour institutional care for elderly or disabled adults who need care and supervision not to exceed fourteen (14) hours a day.

3.6. Bed capacity -- The number of residents for which a personal care home is licensed to provide care.

3.7. Behavioral health services -- Those services intended to help individuals with emotional or mental disorders, substance abuse problems, or mental retardation or other developmental disabilities to gain or regain the capacity to function adaptively in their environment, to care for themselves and their families, and to be accepted by society.

3.8. Boarding home -- An establishment which is held forth to the public as providing, or which is operated to provide, only room and board to persons not in need of personal supervision or residential, medical or nursing treatment. A boarding home does not provide personal assistance in eating, dressing, ambulation, bathing, taking medication, or any other daily living activities, any type of medical or nursing care, or any degree of personal supervision.

3.9. Chemical restraint -- A psychoactive drug that is used for discipline or convenience and is not required to treat medical symptoms.

3.10. Communicable disease -- An illness due to an infectious agent or its toxic product which is transmitted, directly or indirectly, to a susceptible host from an infected person or animal, or through the agency of an intermediate host or a vector or through the inanimate environment.

3.11. Developmental disorder -- A group of disorders in which the predominant disturbance is in the acquisition of cognitive, language, motor, or social skills. The disturbance may involve a general delay, as in mental retardation, or a delay or failure to progress in a specific area of skill acquisition or multiple areas in which there are qualitative distortions of normal development. The course of developmental disorders tends to be chronic, with some of the signs of the disorder persisting in a stable form, without periods of remission or exacerbation, into adult life.

3.12. Disability. -- Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of the usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability.

3.13. Exploitation. -- The act or process of taking unjust advantage of another for one's own benefit.

3.14. Extensive nursing care -- The nursing care required when there is a major deviation from normal in a body system or multiple body systems of such magnitude that the deviations are life-threatening and the individual's condition is unstable and unpredictable.

3.15. Functional needs assessment -- Any measurement tool that identifies for the resident and the home those services that the home will need to obtain or provide for the resident in order to promote the resident's health, comfort, dignity and independence.

3.16. Immediate and serious threat -- A situation that present a high probability of serious harm or injury to one (1) or more residents. An immediate or serious threat need not result in actual harm to any resident.

3.17. Imminent danger -- As applied to a violation of this rule, a danger which could reasonably be expected to immediately cause or contribute to death, serious physical harm or illness to residents, household members or staff before the threat can be eliminated through the plan of correction process found at Section 4.8 of this rule.

3.18. Legal representative[1] --

3.18.a. A conservator, limited conservator or temporary conservator appointed pursuant to the West Virginia Guardianship and Conservatorship Act, W. Va. Code §44A-1-1 et seq., within the limits set by the order;

3.18.b. A guardian, limited guardian or temporary guardian appointed pursuant to the West Virginia Guardianship and Conservatorship Act, W. Va. Code §44A-1-1 et seq., within the limits set by the order;

3.18.c. An individual appointed as committee or guardian prior to June 9, 1994, within the limits set by the appointing order and W. Va. Code § 44A-1-2(d); or

3.18.d. An individual having a medical power of attorney pursuant to the West Virginia medical power of attorney act, W. Va. Code §16-30A-1 et seq., within the limits set by law and the appointment;

3.18.e. An individual named as a representative payee under the U.S. Social Security Act, title 42 U.S.C. § 301 et seq., within the payee's legal authority;

3.18.f. A surrogate decision-maker appointed pursuant to the West Virginia health care surrogate act, W. Va. Code §16-30B-1 et seq., or the West Virginia do not resuscitate act, §16-30C-1 et seq., within the limits set by the appointment;

3.18.g. An attorney in fact appointed with power of attorney under common law or pursuant

[1] Owners and administrators should note that the various types of legal representatives do not necessarily have the lawful authority to act on behalf of the resident in all matters which may require action by a legal representative. For example, a conservator may have responsibility for financial affairs, but not personal affairs, such as medical care.

to uniform durable power of attorney, W. Va. Code §39-4-1 et seq., within the limits set by the appointment; or

3.18.h. An individual lawfully appointed in a similar or like relationship of responsibility for a resident under the laws of this state, or another state or legal jurisdiction, within the limits of the applicable statute and appointing authority; and

3.18.i. Who has no financial ties to the personal care home.

3.19. Licensed health care professional - A health care professional currently licensed in West Virginia such as, but not limited to a: social worker, dentist, practical nurse, occupational therapist, pharmacist, physical therapist, physician, physician assistant, psychologist, registered professional nurse, or speech-language pathologist.

3.20. Life Care Contract -- A contract between the licensee and an individual in which the licensee agrees to provide long-term residential care for the individual for the remainder of the individual's life, regardless of the level of care needed by the individual.

3.21. Limited and Intermittent Nursing Care -- Direct hands-on nursing care of individuals who need no more than two (2) hours of nursing care per day for a period of time no longer than ninety (90) consecutive days per episode.

3.22. Major Incident -- An event or occurrence, the outcome of which places one (1) or more residents' health and well-being in jeopardy or imminent danger, as for example: a fall, accident or other event which seriously injures or threatens the life of the resident; a resident death occurring from other than natural causes; a missing resident who is likely to injure himself or herself or who needs medication or treatment on a regular basis and who is likely to have difficulty returning to the home on his or her own; assaults on a resident resulting in injury; or events which cause the disruption of normal personal care home activity, such as threats or occurrences of extreme violence, explosions, fire or natural disasters.

3.23. Mental Disorder. -- A mental illness that affects the well-being or behavior of an individual to the extent that he or she present a danger to self or others, and for which he or she requires treatment.

3.24. Neglect -- Failure to provide for the necessities of daily living or the lack of care for significant medical problems.

3.25. Nursing support staff -- Registered professional nurses, practical nurses, and nursing assistants employed by the licensee to provide direct hands-on nursing services to residents.

3.26. Nursing care and nursing services -- Those procedures commonly employed in providing for the physical, emotional and rehabilitation needs of the ill or otherwise incapacitated which require technical skills and knowledge beyond that which the untrained person possesses, including, but not limited to, procedures such as irrigations, catheterizations, special procedures contributing to rehabilitation and administration of medication by a method which involves a level of complexity

and skill in administration not possessed by the untrained person.

3.27. On-going nursing care --The nursing care required when a deviation in health is expected to continue over a lengthy period of time, i.e., in excess of ninety (90) days, with minimal or no improvement.

3.28. Personal assistance -- Personal services, including, but not limited to the following: help in walking, bathing, dressing, eating, or getting in or out of bed, or supervision required because of the age or mental impairment of the resident.

3.29. Physical restraint -- A device which physically limits, restricts, or deprives an individual of movement or mobility.

3.30. Registered long term care nursing assistant. -- Any individual who has met the requirements for entry in the long term care nursing assistant registry, established under the requirements of 42 CFR §§ 483.150, 483.152 through 483.154, related to nurse aide training.

3.31. Resident -- An individual living in a personal care home for the purpose of receiving personal assistance and services.

3.32. Restorative care -- Care directed toward assisting a resident to achieve and maintain an optimal level of self-care and independence and providing assistance to residents in learning or relearning skills needed in everyday activities.

3.33. Secretary -- The secretary of the state department of health and human resources or his or her lawful designee.

3.34. Self-administration of medications. -- The act of a resident, who is independently capable of reading and understanding the labels of drugs ordered by a physician, in opening and accessing prepackaged drug containers, accurately identifying and taking the correct dosage of the drugs as ordered by the physician, at the correct time and under the correct circumstances.

3.35. Service Plan. -- A written description of the services being provided to the resident to meet all of the needs identified in his or her functional needs assessment.

3.36. Supervision -- The assumption of varying degrees of responsibility for the safety and well-being of residents including, but not limited to: being aware of the resident's whereabouts, to the extent identified as a need by the resident assessment; monitoring through observation the activities of the resident while on the premises of the home to ensure his or her health, safety and well-being; reminding the resident of any important activities of daily living and prescribed medication; purchasing of food and other supplies, and meeting nutritional and food needs; arranging for or providing transportation as necessary; and other similar activities.

3.37. Supervision of self- administered medications -- A personal service which includes reminding residents to take medication, opening bottle caps for residents, reading the medication label to residents, observing residents while they take medication, checking the self-administered

dosage against the label on the container, and reassuring residents that they have obtained and are taking the dosage as prescribed.

§64-14-4. State Administrative Procedures.

4.1. General Licensing Provisions

4.1.a. A person establishing, maintaining, offering, operating or advertising a personal care home shall obtain from the secretary a license authorizing the operation, which license remains unsuspended, unrevoked and unexpired.

4.1.b. A license is valid only for the licensee and for the structure named in the application and identified on the license. Separate buildings on the same premises operated as personal care homes require separate licenses. The license is not transferable or assignable. The license shall be surrendered to the secretary upon written demand, or immediately, when the personal care home ceases provision of services.

4.1.c. The words "clinic", "hospital", "nursing home", "residential care community" or any other words which suggest a type of facility other than a personal care home shall not be used in the name of the personal care home nor in the personal care home's advertising. If the licensee owns more than one (1) personal care home, each personal care home shall have a separate identification. The licensee shall notify the secretary of any change in the name of the personal care home.

4.1.d. Personal care homes which have residents who need limited and intermittent nursing care shall comply with Section 12 of this rule in addition to all other requirements of this rule.

4.1.e. The licensee is responsible for compliance with this rule, the terms of the personal care home's license; W. Va. Code § 16-5D-1 et seq., titled Personal Care Homes; other relevant federal, state or local laws and regulations and rules; and with the personal care home's policies.

4.1.f. A licensee shall not rent, lease or use the premises for any purpose that disrupts the activities of the residents.

4.1.g. A personal care home that intends to provide adult day care shall notify the secretary of the number of individuals it plans to serve in addition to the personal care home census. The secretary shall approve the provision of day care for the number of individuals identified based on space, accommodations and staffing before day care residents are accepted. Individuals being provided this service shall have health screening as required for personal care home residents and shall not have extensive or ongoing nursing care needs.

4.1.h. A licensee shall not advertise, assert, represent or otherwise imply in any manner that it may render care or services other than those specifically identified within the scope of its license.

4.1.i. The secretary may issue an initial or a renewal license for a period not to exceed one (1) year: Provided, That if an applicant timely submits, in conformance with this rule and W. Va. Code § 16-5D-1 *et seq.*, an application for renewal of a license currently in effect, together with

payment of the proper fee, the license shall continue in effect until;

4.1.i.1. One (1) year following the expiration date of the license;

4.1.i.2. The date of the revocation or suspension of the license pursuant to this rule and W. Va. Code § 16-5D-1 *et seq.*, or

4.1.i.3. The date of issuance of a new license, whichever date occurs first.

4.2. Initial License.

4.2.a. Applicants for initial licensure as a personal care home shall submit their applications to the office of health facility licensure and certification of the West Virginia department of health and human resources. Pursuant to W. Va. Code § 16-5D-6(a), the application shall include the following information:

4.2.a.1 The name and address of the applicant;

4.2.a.2. The name, address and principal occupation:

4.2.a.2.A. Of each person who, as a stockholder or otherwise, has a proprietary interest of ten percent (10%) or more in the applicant;

4.2.a.2.B. Of each officer and director of a corporate applicant; and

4.2.a.2.C. Of each trustee and beneficiary of an applicant which is a trust; and where a corporation has a proprietary interest of twenty-five percent (25%) or more in an applicant, the name, address and principal occupation of each officer and director of the corporation;

4.2.a.3. The name and address of the owner of the premises of the personal care home or proposed personal care home, if he or she is a different person from the applicant, and in that case, the name and address:

4.2.a.3.A. Of each person who, as a stockholder or otherwise, has a proprietary interest of ten percent (10%) or more in the owner of the premises of the personal care home or proposed personal care home;

4.2.a.3.B. Of each officer and director of a corporate applicant; and

4.2.a.3.C. Of each trustee and beneficiary of the owner of the premises of the personal care home or proposed personal care home if he or she is a trust; and, where a corporation has a proprietary interest of twenty-five percent (25%) or more in the owner of the premises of the personal care home or proposed personal care home, the name and address of each officer and director of the corporation;

4.2.a.4. Where the applicant is the lessee or the assignee of the personal care home

or the premises of the proposed personal care home, a signed copy of the lease and any assignment of the lease;

4.2.a.5. The name and address of the personal care home or the premises of the proposed personal care home;

4.2.a.6. The proposed bed quota of the personal care home and the proposed bed quota of each unit;

4.2.a.7. A list of the personal care home's employee positions and the duties of each position;

4.2.a.8. The name and address of the individual who is to serve as administrator;

4.2.a.9. Evidence of compliance with applicable laws and rules governing zoning, buildings, safety, fire prevention and sanitation as required by this rule; and

4.2.a.10. Documentation that the licensee has made provisions in policy to ensure the continuing care of all residents for the thirty (30) day period after notification of a pending closure. Any expenses incurred by the department to provide continuing resident care (i.e., food, staff, etc.) during this thirty (30) day period, are the responsibility of the owner.

4.2.b. The application shall be on forms provided by the secretary, and shall bear the notarized signature of the applicant. The signature on the application and accompanying forms serves as a release for obtaining references, credit and other background information. The application shall be accompanied by a non-refundable license fee in the amount shown on the form as established pursuant to W. Va. Code § 16-5D-6(e). The fee shall be in the form of a check or money order payable to the West Virginia office of health facility licensure and certification. The secretary shall not review incomplete forms; they shall be returned to the applicant. The applicant shall provide to the secretary a balance sheet showing all expenses and all income on forms provided by the secretary, including but not limited to, reimbursement of the owners, lease payment, and monthly rates charged. As mandated by W. Va. Code § 16-5D-6(e), the applicant bears the cost of the initial licensure inspections. An applicant shall pay the fee to the West Virginia office of health facility licensure and certification before the issuance of an initial or amended license.

4.2.c. Applicants for initial licensure shall provide to the secretary a preliminary operating plan which shall include a proposed budget that projects monthly income, lease payment and reimbursement of the owners.

4.2.d. The applicant shall submit the application and fee at least ninety (90) days prior to the date proposed for commencement of operations.

4.2.e. Except as specified in subsection 4.11 of this rule, the secretary shall, after inspection, issue an initial license, if the applicant complies with this rule.

4.2.f. If any residents of a personal care home are to be moved to another location owned or

operated by the same licensee, the licensee shall apply for a license for the new location at least ninety (90) days in advance of the move.

4.3 Waivers.

4.3.a. The secretary may waive a requirement of this rule if after a thorough investigation, the secretary determines that the waiver will not adversely affect the health, safety, welfare or rights of the residents.

4.3.b. In order to request a waiver, the licensee or resident shall submit a written request for the waiver at least thirty (30) days in advance of the date on which the waiver is requested to begin. The request shall:

4.3.b.1. Specify the specific requirement in this rule for which the waiver is requested;

4.3.b.2. Specify the time period for which the waiver is requested;

4.3.b.3. Include specific and detailed reasons for the request;

4.3.b.4. Explain why the specific requirement cannot be complied with; and

4.3.b.5. Document that there will be no adverse effect on resident health, safety, welfare, or rights if the waiver is granted.

4.4. License Renewal.

4.4.a. Applications for renewal of a license shall be postmarked or hand-delivered to the secretary a minimum of ninety (90) days prior to the expiration date appearing on the currently held license.

4.4.b. Except as specified in subsection 4.11 of this rule, the secretary shall issue a renewal license when the following conditions are met:

4.4.b.1. The personal care home is found to be in substantial compliance with this rule;

4.4.b.2. The applicant has submitted a complete application and all requested documentation regarding financial capability and management of the personal care home; and

4.4.b.3. The personal care home has met all Class I standards as set forth in subsection 4.10 of this rule.

4.5. Provisional License

4.5.a. The secretary may issue a provisional license when:

4.5.a.1. The personal care home has failed to meet all the requirements of W. Va. Code

§16-5D-1 et seq., provided that care given in the personal care home is adequate for the residents' needs and the personal care home has demonstrated improvement and evidences potential for substantial compliance during the term or the provisional license; or

4.5.a.2. All requirements for renewal of a license are not met prior to the expiration of the previously issued license.

4.5.b. The secretary shall not issue a provisional license when the personal care home:

4.5.b.1. Is in violation of any Class I standard; or

4.5.b.2. Has a record of noncompliance with this rule.

4.5.c. The secretary shall not renew a provisional license.

4.5.d. The secretary shall determine the period of time for which a provisional license is issued. However, in no instance shall this period exceed one (1) year.

4.5.e. If the owner of a personal care home is denied a provisional license or a provisional license expires, the secretary shall treat a subsequent application for a license as an application for initial license and the owner shall meet the requirements for an initial license including the cost of an initial application fee and inspections as determined by the secretary.

4.6. Inspections

4.6.a. The secretary shall inspect, or authorize a representative to inspect a personal care home as is necessary to carry out the intent of W. Va. Code § 16-5D-1 et seq. and this rule.

4.6.b. The secretary has the right to enter, without prior notice, the premises of a personal care home or any building for which there is reason to believe is being operated or maintained as a personal care home without license, to conduct inspections. If the owner or person in charge of the personal care home refuses entry, the secretary may apply to the circuit court in which the personal care home is located or the circuit court of Kanawha County for a warrant to authorize an inspection or to compel admittance to the premises of an unlicensed personal care home.

4.6.c. The secretary shall conduct at least one (1) inspection of a personal care home prior to issuance of an initial license. Inspections shall be conducted after the following conditions have been met:

4.6.c.1. The application and fee have been received and been determined to be complete;

4.6.c.2. All requested documentation verifies the readiness of the personal care home for an inspection;

4.6.c.3. Fees for the cost of inspections have been received by the secretary; and

4.6.c.4. Necessary inspections can be scheduled.

4.6.d. The secretary shall conduct periodic unannounced inspections to determine the personal care home's continued compliance with applicable statutes and rules.

4.6.e. The secretary shall prepare a written report of any inspection made pursuant to this rule within fifteen (15) days of the completion of the inspection and shall mail a copy to the licensee or administrator, as applicable, specifically listing any violation of this rule.

4.7. Complaint Investigation

4.7.a. Any person may register a complaint with the secretary alleging a violation or violations of this rule by a personal care home or a facility alleged to be operating unlawfully as a personal care home. The complainant shall state the substance of the complaint and identify the personal care home by name and/or address.

4.7.b. The secretary may conduct investigations as necessary to determine the validity of the complaint and shall notify the licensee of the personal care home or the operator of a facility alleged to be operating unlawfully as a personal care home of the substance of the complaint at the time of the completion of any investigation.

4.7.c. The secretary shall notify the licensee of any corrective action required, the time frame for completion of the corrective action and any disciplinary action to be taken by the secretary.

4.7.d. The secretary shall keep the names of a complainant and of any resident named in the complaint confidential and shall not disclose the names to the public without written permission of the complainant and the resident and his or her legal representative, if any. The secretary shall delete the name of a complainant or resident named in a complaint or information contained in the report of an investigation which could reasonably identify the complainant or any resident, unless the resident gives written permission for the disclosure or there is clear and convincing evidence in a particular instance which requires disclosure of names.

4.7.e. If a complaint becomes the subject of a judicial proceeding, nothing in this rule shall be construed to prohibit the disclosure of information that would otherwise be disclosed in judicial proceedings.

4.7.f. Any type of discriminatory treatment of a resident by whom, or upon whose behalf, a complaint has been submitted to the secretary, within one hundred twenty (120) days of the filing of the complaint or the institution of such action, raises a rebuttable presumption that the discriminatory treatment action was taken by the licensee in retaliation for the complaint or action.

4.7.g. If, after an investigation, the secretary determines that the complaint has merit, he or she shall advise any injured party of the possibility of a civil remedy. In addition, residents, residents' families or legal representatives or ombudsmen may also independently pursue civil remedies for violations of this rule.

4.7.h. If a personal care home which is found to have violated one (1) or more requirements of this rule during a routine inspection, or a complaint or other investigation fails to correct the violations within one hundred twenty (120) days of the completion of the inspection or investigation, the secretary shall give written notice of the uncorrected violations and of the amount of time until the secretary will report[2] the personal care home's lack of compliance with the rule to the Social Security Administration and to all residents, their families and any legal representatives. The secretary shall also provide all residents with a list[3] of approved facilities and agencies to assist them in moving.

4.7.i. If a personal care home which is found to have violated one (1) or more requirements of this rule during a routine inspection or a complaint or other investigation fails to correct the violations within two hundred ten (210) days of the completion of the inspection or investigation, the secretary shall report[4] the personal care home's lack of compliance with this rule to the Social Security Administration. The secretary shall also provide all residents, their families and any legal representatives with a list[5] of approved facilities and agencies to assist them with moving.

4.8. Plans of Correction

4.8.a. The licensee of a personal care home found on the basis of inspection or other investigation to have violations of requirements in this rule shall develop a plan of correction which shall be signed and dated by the licensee and submitted to the secretary within fifteen (15) working days of receipt of the report of the inspection or other investigation.

4.8.b. The secretary shall require immediate correction of an identified violation constituting immediate and serious threats to the health or safety of a resident or employee.

4.8.c. The plan of correction shall specify:

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[2] Under the provisions of 42 U.S.C. 1616(e) and 45 CFR, Part 1397--Standard Setting Requirements for Medical and Nonmedical Facilities Where Social Security Income (SSI) Recipients Reside, all states are required to "establish, maintain, and ensure the enforcement of standards for any category [emphasis added] of institutions, foster homes, or group living arrangements, in which, as determined by the state, a significant number of recipients of Supplemental Social Security Income (SSI) benefits resides or is likely to reside. SSI residents who live in relevant facilities which violate any of the standards will be subject to a reduction in their SSI payments ... in an amount equal to any state supplementary benefit or other payment made by the state for any medical or remedial care provided them by the facility." As part of their responsibilities under the federal regulations, states are required to make certain reports to the residents of deficient facilities and to the appropriate regional office of the United States Social Security Administration.

[3] See also footnote #2. The purpose of the notification is to inform residents that they do not have the protection of the violated requirement; the list is intended to provide assistance to residents in moving if the lack of compliance by the personal care home endangers them or causes a reduction in their benefits.

[4] See footnote #2.

[5] See footnote #3.

4.8.c.1. The violations to be corrected;

4.8.c.2. Action taken or proposed to correct the violations and procedures to prevent their recurrence; and

4.8.c.3. A calendar date by which each violation shall be corrected, which shall allow the shortest possible time in which the personal care home may reasonably be expected to correct each specific violation. A personal care home shall ordinarily be expected to comply with the rule within sixty (60) days of the inspection; however, the secretary may allow more time for certain types of deficiencies.

4.8.d. The plan of correction shall be approved, modified or rejected in whole or in part by the secretary in writing.

4.8.e. In modifying or rejecting a proposed plan of correction, the secretary shall state the reasons for the modification or rejection.

4.8.f. When the secretary rejects a plan of correction, the licensee has a reasonable amount of time, but no more than fifteen (15) working days, to submit a revised plan.

4.8.g. The secretary may conduct reasonable and necessary procedures, including a follow-up on-site inspection, to verify the correction of any violations identified during an inspection or any other investigation.

4.9. Reports and Records

4.9.a. The secretary shall, from the time of receipt, make available for public inspection and shall, upon request, provide copies of the following at a reasonable cost:

4.9.a.1. Information concerning and actual applications and exhibits;

4.9.a.2. Inspection reports;

4.9.a.3. Reports of the results of investigations conducted in response to complaints;

4.9.a.4. A current list of the names and addresses of personal care homes found to be in violation of this rule, including the details of each violation; and

4.9.a.5. Any other reports filed with or issued by the secretary pertaining to the compliance of a personal care home with applicable laws and rules.

4.9.b. The names of residents shall be kept confidential and shall not be disclosed without the resident's written permission or by order of court of record. Nothing contained in this rule shall be construed to require or permit the public disclosure of confidential medical, social, personal or financial records of any resident. Before releasing a report or record judged public information, the secretary shall delete any confidential information regarding a resident which would reasonably

permit identification of the resident.

4.10. Classification of Standards

4.10.a. In accordance with W. Va. Code §16-5D-5(c), the classification for each standard indicates the most serious classification that may be assigned to that standard and is established according to the following:

4.10.a.1. Class I standards are those the violation of which would present either an imminent danger to the health, safety or welfare of any resident or substantial probability that death or serious physical harm would result;

4.10.a.2. Class II standards are those the violation of which would have a direct or immediate relationship to the health, safety or welfare of any resident but which would not create imminent danger; and

4.10.a.3. Class III standards are those the violation of which would have an indirect or potential impact on the health, safety or welfare of any resident.

4.11. Non-Issuance of Initial or Renewal License.

4.11.a. The secretary may refuse to issue either an initial or a renewal license if he or she finds evidence of the following:

4.11.a.1. Lack of financial stability to operate, such as insufficient capital, delinquent accounts, checks returned because of insufficient funds, and nonpayment of taxes, utility expenses and other essential services;

4.11.a.2. Either the applicant or the administrator has been arrested for, adjudicated, and convicted of any felony or misdemeanor relevant to the provision of care in a health care facility or operating a health care facility or is listed on the long term care nursing assistant abuse registry maintained by the department;

4.11.a.3. The applicant has been denied or has had a license to operate a health care facility revoked in West Virginia or any other jurisdiction during the previous five (5) years;

4.11.a.4. The applicant has a record of noncompliance with lawful orders of the department or other licensing or certification agency for any jurisdiction in which the applicant has operated, directed or participated in the operation of a health care facility;

4.11.a.5. The owner or person in charge of the personal care home has refused entry to the secretary's duly authorized representative for an inspection or survey;

4.11.a.6. The licensee has inappropriately converted for its own use the property of a resident;

4.11.a.7. The licensee has secured property, or a bequest of property, from a resident by undue influence;

4.11.a.8. The licensee has submitted false information either on the licensure or renewal application forms or during the course of an inspection or survey of the personal care home; or

4.11.a.9. In the instance of an application for a renewal license, the licensee has failed to correct a violation of any Class I standard or has failed to be in substantial compliance with the requirements of this rule.

4.11.b. The secretary shall consider all available evidence at the time of the determination, including the history of the personal care home and the applicant in complying with this rule, notices of violations which have been issued to the personal care home and the applicant, findings of surveys and inspections, and any evidence provided by the licensee, residents, law enforcement officials, and other interested individuals.

§ 64-14-5. Personal Care Home Administrative Requirements.

5.1. General Administrative Requirements.

5.1.a. The licensee shall, in consultation with a licensed health care professional, establish and adopt written policies and procedures, which are consistent with this rule and specific to the personal care home, governing the care and safety of residents (i.e., notification of a resident's family, legal representative and physician regarding any apparent significant deviations from the resident's normal condition; administration of medications and treatments, disposal of outdated or discontinued medications in accordance with applicable State and federal laws, assistance with activities of daily living, the provision of limited and intermittent nursing care if applicable, infection control, admission, discharge and transfer of residents, and release of information from resident records). Policies and procedures shall be developed governing the protection of residents' personal property (i.e,. periodic inventories of each resident's personal possessions) and rights, the operation of the personal care home, the services provided by the personal care home, emergency procedures and disaster plan, complaint procedures, and all other policies and procedures required by this rule. (Class III)

5.1.b. Policies and procedures shall be in writing, signed and dated by the administrator at the time of adoption and kept current with changes indicated by a dated signature of the administrator. (Class III)

5.1.c. A copy of each policy and procedure shall be available for inspection on request by employees, residents and the general public. (Class III)

5.1.d. The personal care home shall have written rules governing resident behavior and responsibilities as follows: smoking; alcohol consumption; visitation; recreational activities (including television); laundry; and the use and storage of personal belongings such as furnishings and clothing. House rules shall not be inconsistent with this rule. (Class III)

5.1.e. Those personal care homes that provide limited and intermittent nursing care shall comply with the requirements established in Section 12 of this rule. (Class I)

5.1.f. A personal care home is prohibited from renting, leasing or using its premises for any purpose that disrupts the activities of the residents. (Class III)

5.1.g. Residence in a personal care home is restricted to residents, unless otherwise approved in writing by the secretary. (Class III)

5.1.h. A personal care home is prohibited from advertising, asserting, representing or otherwise implying in any manner that it may render care or services other than those within the scope of its license. (Class III)

5.2. The Licensee.

5.2.a. The licensee is responsible for compliance with this rule; the terms of the personal care home's license; W. Va. Code §§ 16-5D-1 et seq.; other relevant federal, state or local laws and regulations; and with the personal care home's policies. (Class II)

5.2.b. The licensee shall:

5.2.b.1. Give evidence of financial responsibility; (Class III)

5.2.b.2. Protect the physical and mental well-being of the residents; (Class II)

5.2.b.3. Keep the records and make the reports required by this rule; (Class III) and

5.2.b.4. Meet the qualifications of the administrator if he or she assumes those duties. (Class III)

5.2.c. The licensee shall maintain fiscal records which accurately identify, summarize, and classify funds received and disbursed for the operation of the personal care home. A recognized system of accounting shall be used to accurately reflect details of the business. The personal care home shall be administered on a sound financial basis consistent with good business practices. Evidence of issuance of bad checks or accumulation of delinquent bills shall constitute prima facie evidence that the ownership lacks satisfactory proof of financial ability to operate the personal care home in accordance with the requirements of W. Va. Code § 16-5D-6. (Class III)

5.2.d. The licensee shall maintain a liability insurance policy in an amount that will cover all injuries to any residents. (Class III)

5.2.e. The licensee shall notify the secretary in writing within ten (10) days of any permanent change in the administrator, consultant registered professional nurse, or supervising registered professional nurse of the personal care home. A licensee shall not operate a personal care home more than thirty (30) days without a qualified administrator or supervising registered professional nurse, unless the secretary grants an extension, based on a determination that a reasonable attempt

has been made to find a suitable replacement. (Class III)

5.3. Administrator.

5.3.a. A personal care home shall have an administrator who is at least twenty-one (21) years of age and has an associate degree, or its equivalent in a related field: Provided, That individuals who are personal care home administrators prior to the effective date of this rule are not required to have an associate degree, but shall have at least a high school education or its equivalent approved by the State department of education. (Class III)

5.3.b. The administrator of a personal care home shall have a personal history which does not contain the following: evidence of abuse, fraud, or substantial and repeated violations of applicable laws and rules in the operation of any health or social care facility or service organization, or in the care of dependent persons; and conviction of crimes relevant for the provision of care to a dependent population as evidenced by a criminal investigative background check by the West Virginia state police through the central abuse registry. (Class II)

5.3.c. The administrator shall participate in ten (10) hours of training related to the administration and operation of a personal care home annually. Attendance records shall be maintained on file at the personal care home. (Class III)

5.3.d. The administrator is responsible and accountable for the development and execution of all policies and procedures required by this rule and shall be able to conform to applicable statutes, rules and regulations; know the requirements of the rule for personal care homes; and ensure the adequacy and appropriateness of services delivered to the residents. (Class II)

5.3.e. The administrator or a responsible employee, designated in writing, shall be available and in charge of the personal care home at all times. (Class III)

5.4. Employment Standards.

5.4.a. The personal care home shall have written personnel policies and procedures which appropriately meet the needs of the personal care home. (Class III)

5.4.b. The administrator shall assure that all staff of the personal care home meet the age requirements of applicable state and federal law, rules and regulations. (Class III)

5.5. Staffing Requirements.

5.5.a. Each personal care home shall have a minimum of one (1) residential staff twenty-four (24) hours per day (i.e., one per eight (8) hour shift) and shall have a sufficient number of qualified employees on duty to provide the residents with all of the care and services they require. At a minimum, an additional personal care staff will be available on the day shift for each seven (7) residents identified on their functional needs assessment to have two (2) or more of the following care needs: dependence on staff for eating, toileting, ambulating, repositioning, special skin care, or one (1) or more inappropriate behaviors that reasonably requires additional staff to control

behavior (e.g., sexual acting out, stripping in public settings, refuses basic care, such as bathing, destroys property) or self injurious or injurious behavior directed at staff or other residents. At a minimum, an additional personal care staff will be available on the evening shift for each twelve (12) residents identified on their functional needs assessment to have two (2) or more of the above care needs. An additional personal care staff shall be staffed on the night shift for each fifteen (15) residents identified with two (2) or more of the care needs set forth in this subdivision. (Class I)

5.5.b. Awake staff shall be present in the personal care home during normal resident sleeping hours when residents require supervision during sleeping hours or are in need of limited and intermittent nursing services unless all residents are certified by a physician or psychologist as not being in need of sleep time supervision and they are not in need of limited and intermittent nursing services. (Class I)

5.5.c. A multi story personal care home shall maintain at least one (1) awake staff per story while residents are sleeping, except that the secretary shall permit one (1) awake staff in a multi story facility if:

5.5.c.1. The residents of the personal care home are certified by a physician or psychologist as not being in need of supervision during sleeping hours; (Class I)

5.5.c.2. The personal care home has no residents who are in need of limited and intermittent nursing services; (Class I) and

5.5.c.3. The personal care home has an immediate emergency call system from the residents to the awake staff person. (Class I)

5.5.d. The personal care home shall have staff, in addition to the direct care staff, to meet the laundry, food service, housekeeping, and maintenance requirements of this rule. (Class II)

5.5.e. When regular staff and supervisory staff are absent due to illness and vacations, there shall be coverage by substitute personnel with comparable qualifications. (Class I)

5.5.f. The licensee of the personal care home shall maintain and furnish to the secretary upon request, information setting forth the number (in full-time equivalents) and types of employees on duty in the personal care home at any given time. (Class III)

5.5.g. If a resident experiences a poor outcome related to a lack of supervision or unmet care needs, the secretary may require the licensee to add staff. (Class I)

5.5.h. All personal care homes shall make arrangements for a registered nurse to manage and oversee the provision of nursing services for all residents of the personal care home. The frequency with which a registered professional nurse shall provide services to the personal care home not providing limited and intermittent nursing services shall be based upon the needs of the residents, but not less than weekly. Arrangements for nursing services may be made by contract with an individual, or a nursing service with a management entity, or the personal care home may employ a registered nurse, or the administrator of the personal care home may act in this capacity, if licensed

as a professional registered nurse. Arrangements with a home care agency providing only individualized direct care does not satisfy requirements for nursing management over-sight of all residents as specified in this rule. Homes whose administrator or supervisor-in-charge is a registered professional nurse are not required to employ another individual to meet the responsibilities of the registered professional nurse if there are sufficient numbers of nursing support staff to meet the needs of residents. (Class I)

5.5.i. The registered professional nurse shall provide the personal care home with a system that provides for twenty-four (24) hour accessibility between the personal care home, the registered professional nurse, and other emergency personnel. (Class II)

5.5.j. The responsibilities of the supervising nurse shall include:

5.5.j.1. Liaison between the personal care home resident, the resident's physician, and the administrator (if applicable) on an as needed basis; (Class II)

5.5.j.2. Supervision and monitoring as identified in this rule, by physician orders, by the resident's individualized functional needs assessment, and as specified within the resident's individualized service plan; (Class II)

5.5.j.3. Recording a progress note in the resident's record, as indicated by the needs of the resident, to document the status of the resident and any changes in his or her health or welfare; (Class III)

5.5.j.4. In-service training, as applicable, of personal care staff related to the implementation of care procedures or personal assistance services provided to the resident's in the home; (Class III)

5.5.j.5. Supervision of supervised or assisted administration of medication; (Class I)

5.5.j.6. Supervision of medication storage, dispensing systems and disposition; and (Class II)

5.5.j.7. Admission and discharge planning as it relates to the medical component of resident care. (Class III)

5.6. Employee Orientation and Training.

5.6.a. The licensee shall provide training to new employees within the first twenty-four (24) hours of association with the personal care home in emergency procedures and disaster plans, including the following: evacuation procedures, procedures to report a missing resident, medical emergencies, accidents, fire, natural disasters or other emergencies. (Class II)

5.6.b. The licensee shall maintain a written plan of orientation and training for employees that addresses facility policies and procedures, resident rights, confidentiality, abuse prevention and reporting requirements, ombudsman role, complaint procedures, specialty care based on

individualized resident needs and service plans, cardiopulmonary resuscitation (CPR) as applicable, first aid and infection control. (Class II)

5.6.c. The licensee shall provide this orientation and training within the first fifteen (15) days of employment. (Class II)

5.6.d. The licensee may modify the initial orientation and training for individual employees if the individual is a registered long term care nursing assistant and maintained as such on the nursing assistant registry maintained by the secretary. This registration satisfies the requirement for training in the areas of personal grooming, hygiene, assistance in feeding and activities of daily living. All other topics required by this rule shall be addressed in the employee's initial orientation/training program. (Class III)

5.6.e. The licensee shall provide in-service training annually on the topics of resident rights, confidentiality, abuse and procedures to prevent the occurrence of those incidents, emergency care of residents (first aid and as applicable, CPR), fire safety and evacuation plans, responsibilities of the residential staff for assisting residents (i.e., individualized service plans, activity programs, etc.), and infection control. (Class II)

5.7. Personnel Records.

5.7.a. The licensee shall maintain a confidential personnel record for each employee, including the administrator, and for volunteers who provide direct services to residents. Each record shall contain at least the following:

5.7.a.1. An employment application which includes at least the individual's current home address and telephone number, emergency contacts, and social security number; (Class III)

5.7.a.2. Documentation of the results of a screening through the West Virginia state police central abuse registry regarding previous convictions involving abuse, mistreatment or neglect of dependent populations or theft of the property of those populations within thirty (30) days of employment, documented verification of past employment or personal references, and a check of the nurse aide abuse registry established by the state; (Class III)

5.7.a.3. A record of orientation, annual and/or additional training, education and credentials; (Class II)

5.7.a.4. The date of employment and a position title and description; (Class III) and

5.7.a.5. A health record containing the results of an employment physical examination and annual screens for tuberculosis (tine test not acceptable) and other communicable diseases as indicated by exposure, prevalence or currently accepted medical practice in congregate living situations as indicated by the secretary, which is obtained in the first week of employment and annually thereafter. (Class II)

5.7.b. The licensee shall maintain personnel records on file at the personal care home for

at least three (3) years following termination of employment. Documentation of the date and reason for termination of employment shall be noted in the record. (Class III)

5.8. Administrative Admission Procedures.

5.8.a. The licensee shall not discriminate against residents or a prospective resident on the basis of race, national origin, religion, age, gender, sexual orientation or disability. The admissions policy shall state the resident population that the personal care home is licensed to serve and shall not discriminate within the confines of that definition. (Class III)

5.8.b. The relationship of a resident to the personal care home shall be covered by a written contract entered into at the time of or prior to the individual's admission. The contract shall specify the following information:

5.8.b.1. The personal care home's admission, retention and discharge criteria; (Class III)

5.8.b.2. Written assurance of the services that the personal care home will provide to meet the individual's needs; (Class III)

5.8.b.3. Full disclosure of all costs, an annual or monthly contract price, refund policy and an assurance that residents shall not be held liable for any cost that was not disclosed; (Class III)

5.8.b.4. How health care will be arranged or provided; (Class III)

5.8.b.5. The complaint process; (Class III) and

5.8.b.6. How prescribed medications are obtained, and who is responsible for payment. (Class III)

5.8.c. The licensee shall provide each party to the contract with a copy of the contract. If the existing contract does not meet the requirements of this rule, the licensee shall provide current residents with new or updated contracts within fourteen (14) days of the effective date of this rule. (Class III)

5.8.d. Thirty (30) days prior to any increases, additions, or other modifications of the rates, the licensee shall give written notice of the proposed changes to residents. (Class III)

5.8.e. The licensee shall inform and document notifying the resident of how to access the following information at the time of the agreement:

5.8.e.1. Information and referral services regarding the resident's utilization of social, recreational, and vocational activities within the community; (Class III)

5.8.e.2. How the resident's personal property will be protected from loss and theft; (Class III)

5.8.e.3. How the resident will be assisted in making appointments for medical, dental, nursing or mental health services, and how transportation to and from these services will be arranged; (Class III)

5.8.e.4. Policies and procedures for emergency situations that affect the well-being of residents, including, but not limited to the following: life-threatening medical emergencies (including whether CPR will be provided), fires, natural disasters, severely inclement weather, industrial accidents, major incidents, a missing resident and immediate or serious threats; (Class III)

5.8.e.5. The responsibility for required medical examinations and treatment orders; policies regarding room changes, retention during temporary illness or a significant change in resident status, transfers and discharges, and the resident's and the licensee's transfer and discharge notification responsibilities; (Class III)

5.8.e.6. House rules governing resident behavior and responsibilities; (Class III)

5.8.e.7. A resident's bill of rights which is consistent with this rule; (Class III) and

5.8.e.8. The storage, administration and disposal of medications. (Class III)

5.8.f. A personal care home is prohibited from entering into a life care contract without prior permission of the secretary. In making a determination of whether to grant permission, the secretary shall consider the ability of the provider to demonstrate the depth of their financial worth which shall include, but not be limited to, producing financial statements for a minimum of three (3) years. The proposed licensee shall also demonstrate successful experience in the management of a life care community and in the ability to manage the potential impact of catastrophic illness or disease. (Class III)

5.9. Management and Control of Resident Funds.

5.9.a. The licensee shall manage a resident's funds, only on the written request of the resident, in the manner directed by the resident, and in accordance with this rule, utilizing generally acceptable accounting principles to manage the funds in the resident's best interests. (Class III)

5.9.b. The licensee shall assure that the accounting system does not commingle resident funds with the home's funds or with the funds of any person other than another resident. (Class III)

5.9.c. A resident's personal funds exceeding two-hundred dollars ($200) shall be deposited in an interest bearing account at a local bank. (Class III)

5.9.d. If the licensee handles resident monies in excess of twenty-five dollars ($25) per resident and in excess of five-hundred dollars ($500) for all residents in any month, he or she shall give a bond in an amount and with such surety as the secretary approves, sufficient to cover all resident accounts at all times. The licensee shall file a bond in the sum to be fixed by the secretary based upon the magnitude of the operations of the applicant but the sum may not be less than two-thousand five-hundred dollars ($2,500) as shown in Table 64-14 A, found at the end of this rule.

Whenever the amount of any bond which is filed pursuant to this subsection is insufficient to adequately protect the money of residents being handled, or whenever the amount of the bond is impaired, the licensee shall file an additional bond in an amount necessary to adequately protect the money of residents being handled. (Class III)

5.9.e. The licensee shall assure that the resident account record shows in detail, with supporting documentation, all monies received on behalf of the resident and the disposition of all funds received. Persons shopping for residents shall provide a list showing a description and price of items purchased if the purchase exceeds ten ($10) dollars, along with payment receipts for these items. (Class III)

5.9.f. The licensee shall render a true and complete accounting of the management and disposition of resident funds upon request to the depositor and the secretary and at least quarterly to the resident. Information shall be given to the resident upon request. (Class III)

5.9.g. Upon termination of the deposit, the licensee shall account to the depositor for all funds received, expended and held on hand. (Class III)

§ 64-14-6. Resident Rights.

6.1 Posting of Information and General Rights.

6.1.a. The licensee shall post the following information, easily readable, in a conspicuous place:

6.1.a.1. Residents' rights; (Class III)

6.1.a.2. Phone numbers of the abuse hotline; the office of the licensing agency; the state ombudsman; and the regional ombudsman; (Class III)

6.1.a.3. The name, address and telephone number of the designated long-term care ombudsman program serving the region in which the personal care home is located, with a brief description of the services provided by the long-term care ombudsman program, and a statement as to the penalties for willful interference and retaliation; (Class III) and

6.1.a.4. The personal care home's current license. (Class III)

6.1.b. The licensee shall promptly notify the resident and the resident's legal representative or designated family member whenever there is a change in residents rights. (Class III)

6.1.c. If a legal representative has been appointed for or designated by any resident as having the authority to exercise on behalf of the resident one (1) or more of the resident's rights under this rule, the licensee shall afford the legal representative full opportunity to exercise the authority. If an appointed or designated legal representative exercises this authority, he or she shall exercise his or her authority in a manner consistent with all applicable state and federal laws, rules and regulation. (Class III)

6.1.d. Nothing in this rule shall in any way be construed to diminish or deprive any individual of rights recognized and established under other laws of the State of West Virginia or of the United States. (Class III)

6.1.e. A resident shall be encouraged and assisted throughout the duration of his or her stay to exercise his or her rights as a resident and as a citizen, such as voting in governmental elections. (Class III)

6.1.f. A resident has the right to be free from restraint, interference, coercion, discrimination, or reprisal from the licensee in exercising his or her rights. (Class II)

6.2. Notice of Rights.

6.2.a. The licensee shall provide a copy of residents' rights to the resident or the resident's legal representative with duplicates on request. The date the rights are distributed shall be recorded. (Class III)

6.2.b. The resident has the right to inspect all records pertaining to him or her and to purchase photocopies at a reasonable cost. (Class III)

6.2.c. Residents have the right, if they choose, to view the results of inspections and complaint investigations conducted by the licensing agency. Deficiencies cited during the most recent survey and any complaint investigations conducted within the preceding twelve (12) months, and the personal care home's plan of correction shall be located in a place accessible to residents. (Class III)

6.2.d. The licensee shall notify the resident and the resident's legal representative or designated family member at least seventy-two (72) hours prior to a change in room or roommate assignment unless an emergency situation occurs. (Class III)

6.3. Treatment.

6.3.a. The resident has the right to participate in planning his or her overall care, to utilize the physician or pharmacist of his or her choice, to be fully informed in advance about care and treatment that may affect him or her, to make advanced directives about his or her medical care and to refuse treatment. (Class II)

6.3.b. No resident shall be abused, exploited, neglected, mistreated, or restrained by physical or chemical means. Physical restraints shall only be used in an emergency under physician's order not to exceed twenty-four (24) hours for the safety of the resident or others in the community until professional help arrives on the premises. Restraints utilized during emergencies shall be limited to cloth vest or soft belt restraints only and their application shall be by trained staff only. Restraints shall be released every two (2) hours for at least ten (10) minutes. These procedures shall be documented and available for review by the secretary. Half length side rails are permissible, only if used to assist the resident in turning or getting out of bed (Class I)

6.3.c. Any medical, dental or mental health professional, ordained minister, christian science practitioner, religious healer, social service worker, peace officer, or law enforcement officer is required under the adult protective services law, W. Va. Code § 9-6-9 to report any incident in which an incapacitated adult is neglected, abused, or in an emergency situation, subject to conditions likely to result in neglect, abuse or emergency, or has died as a result of abuse or neglect. Reports of neglect, abuse or emergency situations shall be made immediately to the local adult protective services office of the department or by calling the adult protective services hotline number, as required by law and to the community's licensing agency. The secretary may report alleged failures by a licensed health care professional to report alleged incidents of neglect or abuse or emergency situations to the individual's licensing board. (Class I)

6.3.d. The licensee shall assure that all alleged violations involving abuse, exploitation or neglect shall be immediately and thoroughly investigated and documented by the licensee or his or her designee on receipt of the allegation. While the investigation is in progress, measures shall be taken to ensure that further abuse does not occur. (Class I)

6.3.e. If the allegation is substantiated, the licensee shall assure that appropriate sanctions are invoked or actions are taken to prevent a recurrence of alleged abuse, exploitation or neglect. (Class I)

6.3.f. The licensee shall assure that the licensing agency is notified within seventy-two (72) hours of the date of the allegation of abuse, exploitation, or neglect. The licensee shall concurrently, forwarded to the licensing agency documentation of the investigation, the results of the investigation and the response to the investigation. (Class III)

6.3.g. The resident has the right to refuse to participate in experimental research. A resident shall participate in experimental research only on the basis of prior written informed consent. Any informed consent procedures shall be in conformance with applicable state and federal laws, rules and regulations. (Class I)

6.4. Self Determination.

6.4.a A resident has the right to meet with and participate in the activities of social, religious, and community groups, at his or her discretion. (Class III)

6.4.b. Residents have the right to assemble and organize themselves as a group to solicit and recommend improvements in the personal care home's services and to resolve problems that may arise between the residents and the licensee. (Class III)

6.4.c. A resident shall not be compelled to retire at night or arise in the morning at the same set time. (Class III)

6.4.d. Residents have the right to be free to leave the personal care home and grounds, however, this right does not absolve the licensee of the responsibility to supervise residents. (Class II)

6.5. Privacy and Confidentiality.

6.5.a. The resident has the right to personal privacy and confidentiality of his or her personal and permanent resident record. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal assistance, visits and meetings of family and resident groups. (Class II)

6.5.b. The resident has the right to associate and communicate privately with persons of his or her choice. (Class III)

6.5.c. No person shall enter a resident's room without identifying him or herself to the resident and receiving the resident's permission to enter. (Class III)

6.6. Complaints.

6.6.a. The resident has the right to voice grievances with respect to treatment or care furnished without discrimination or reprisal for voicing the grievance. (Class II)

6.6.b. The resident has the right to prompt action by the licensee to resolve grievances the residents might have, including those with respect to the behavior of other residents. The licensee shall respond to the complainant in writing within twenty-four (24) hours for serious complaints, such as abuse, neglect, or injuries of unknown origin. For complaints of a less serious nature, the licensee shall respond to the complainant in writing no later than four (4) days after the complaint is filed. (Class III)

6.6.c. Nothing in this rule shall be construed to limit in any way the lawful authority of the department to administer and implement W. Va. Code § 9-6-1 et seq. relating to adult protective services. (Class II)

6.7. Work.

6.7.a. The resident has the right to be employed outside the personal care home. (Class III)

6.7.b. The resident has the right to refuse to perform services for the personal care home. (Class III)

6.7.c. The resident has the right to perform services for the personal care home when:

6.7.c.1. The licensee has documented the resident's need or desire for work in the service plan in the resident's record; (Class III)

6.7.c.2. The agreement specifies duties, hours of work and compensation; (Class III)

6.7.c.3. The agreement is not a condition for admission or continued residence; (Class III) and

6.7.c.4. The resident enters into the agreement voluntarily. (Class III)

6.7.d. Any resident who performs any staff duties shall meet the personnel and health requirements for that position. (Class II)

6.7.e. A licensee shall not permit residents to perform work which creates conditions potentially hazardous for themselves or others. (Class I)

6.8. Mail and Communication.

6.8.a. The resident has the right to send and promptly receive unopened mail. A staff member shall only open and read correspondence on the direct written request of the resident. (Class III)

6.8.b. The resident has the right to have access to stationary, postage and writing implements. (Class III)

6.8.c. The resident has the right to have access to a telephone. Privacy shall be afforded the resident during telephone use. (Class III)

6.9. Access and Visitation Rights.

6.9.a. The resident has the right to receive visitors. Relatives and members of the clergy shall be permitted to visit at any time. Any entity or individual that provides health, social, legal, or other services to a resident, shall be permitted access to the resident. All visitation is subject to the resident's right to deny or withdraw consent at any time. (Class I)

6.9.b. The resident has the right to receive information from agencies acting as client advocates such as the state's long term care ombudsman program, and to be afforded the opportunity to contact these agencies. (Class II)

6.10. Personal Property.

6.10.a. The resident has the right to retain and use personal possessions including furnishings, and clothing as space permits, unless to do so would infringe upon the rights, health or safety of other residents. (Class III)

6.11. Civil Rights.

6.11.a. Individuals have the right to be free from discriminatory practices related to admission or services on the grounds of race, religion, national origin, age, gender, sexual orientation or disability. (Class II)

6.12. Protection of Resident Funds

6.12.1. The resident has the right to manage his or her financial affairs. The licensee shall

not require a resident to deposit their personal funds with the personal care home. (Class III)

§64-14-7. Health Care Standards

7.1. Admission

7.1.a. Individuals requiring ongoing or extensive nursing services shall not be admitted to the personal care home. (Class II)

7.1.b. Individuals requiring a level of service for which the personal care home is not licensed or does not provide shall not be admitted. (Class I)

7.2. Retention of Residents Whose Condition Declines After Admission.

7.2.a. A resident who's condition declines after admission, and qualifies for or is receiving services coordinated by a licensed hospice, may receive these services in a personal care home. A backup power generator shall be provided for services utilizing equipment which requires auxiliary electrical power in the event of a power failure, such as suction apparatus, and intravenous or tube feeding pumps. In the event that a resident is receiving limited and intermittent nursing care or hospice services, the licensee shall assure that the resident has privacy in care and the ability to evacuate in an emergency. The provision of services to the resident receiving limited and intermittent nursing care or hospice care shall not interfere with the provision of services to other residents. (Class I)

7.2.b. The licensee shall assure that a resident who requires ongoing or extensive nursing care is provided the care and services necessary to meet their needs and that the requirements of Section 12 of this rule are met, pending the resident's discharge from the personal care home. (Class I)

7.2.c. If a resident exhibits symptoms of a mental or developmental disorder, and the resident is not receiving services to meet his or her current needs, is not a client of a behavioral health center, and does not have a case manager, the licensee shall advise the resident or his or her legal representative of his or her behavioral health service options within the community. (Class II)

7.2.d. The licensee shall seek immediate treatment for a resident or refuse to admit a prospective resident if the licensee has reason to believe that the resident may suffer serious harm or is likely to cause serious harm to himself or herself or to others if appropriate interventions are not provided in a timely manner. (Class I)

7.3. Discharge and Transfer Procedures.

7.3.a. The licensee of a personal care home with a resident who needs more than limited and intermittent nursing care shall inform the resident or his or her legal representative of the need to move the resident to a health care facility with the capability of providing the needed level of nursing care. (Class III)

7.3.b. The licensee shall assist the resident and his or her legal representative to attempt on a weekly basis to secure placement in alternative care facilities. (Class III)

7.3.c. The licensee shall thoroughly document in the resident's record efforts made to obtain placement in alternative care facilities and refusals from the facilities in the event that the resident is unable to secure alternative placement and remains in the personal care home. (Class III)

7.3.d. The licensee shall give the resident a thirty (30) day notice prior to discharge unless an emergency situation which requires transfer to a hospital or other higher level of care exists or if the resident is a danger to himself or herself or others. A copy of the written discharge notice shall be filed in the resident's record. (Class III)

7.3.e. Prior to transfer or discharge the licensee shall prepare a summary to accompany the resident which shall include the residents functional needs assessment, individualized service plans, current physician's orders, any advanced directives, any allergies and pertinent progress notes. (Class II)

7.4. Records.

7.4.a. All resident records containing the information required by this rule shall be retained at the personal care home in a secure area and shall be made available for inspection by the secretary's duly authorized representative. (Class III)

7.4.b. The licensee shall begin at admission, maintain, and keep current, a record for each resident. (Class II)

7.4.c. The resident's record shall include:

7.4.c.1. The resident's name; social security number; birth date; sex; marital status; religious preference and affiliation, if any; (Class III)

7.4.c.2. The names, addresses and telephone numbers for the following relevant persons: physician; dentist; legal representative, if applicable; person, organization or agency responsible for payments for support of the resident, if applicable; next of kin or other interested relatives; persons to be notified in case of an emergency or death; any case management agency or organization; and any day care or other programs in which the resident regularly participates; (Class III)

7.4.c.3. All agreements or contracts entered into between the resident and the licensee; (Class III)

7.4.c.4. Advanced directives, allergies; the dates of physician, dentist and other health and behavioral health care providers and other professional appointments and visits (including those for accidents and illness requiring medical attention, coordinated by the licensee); all contact with the resident's physician by the personal care home staff; and observations by personnel, licensed nurses, physician, or others authorized to care for the resident; (Class II)

7.4.c.5. A list of clothing and personal possessions of the resident; (Class III) and

7.4.c.6. Any other records as required by this rule. (Class III)

7.4.d. The licensee shall keep resident records in safe storage for at least five (5) years from the date of the death, discharge or transfer of the resident. If the personal care home ceases to operate, the licensee shall procure a holding area for the resident records that will ensure the confidentiality and safety of the records from loss, destruction or unauthorized use. (Class III)

7.4.e. Each licensee shall maintain a permanent resident register in a bound notebook in chronological order according to the date of the resident's admission. The register shall include the date of the resident's admission, his or her name, the date of his or her last day in the personal care home and the name and address of the residence, health care facility or other place to which the resident (if living) has been discharged. (Class III)

7.5. Assessments and Service Plans

7.5.a. The licensee shall assure that each resident has a written, signed and dated health assessment by a licensed physician or other licensed health care professional authorized to perform such assessments by applicable State laws and rules not more than sixty (60) days prior to those resident's admission, or no more than five (5) working days following admission, and at least annually thereafter. The admission and annual health assessment shall include screening for tuberculosis and other communicable diseases if indicated by exposure, prevalence or risk according to current medical practice in congregate living situations as indicated by the secretary and shall be maintained in the resident's medical record. (Class II)

7.5.b. Within thirty (30) days of admission, every resident shall have an individualized functional needs assessment completed in writing by a licensed health care professional. At a minimum, the resident's assessment shall include a review of health status and functional, psycho social, activity and dietary needs and shall be maintained in the resident's medical record. (Class II)

7.5.c. Each resident shall have a service plan, based upon his or her functional needs assessment, developed within forty-five (45) days of admission. The service plan shall be developed in response to the individual resident's needs and shall be maintained in the resident's medical record. (Class II)

7.5.d. The assessment and service plan shall reflect the resident's current needs and therefore shall be updated annually and as indicated by a significant change in the resident's condition. (Class II)

7.6. Services.

7.6.a. The licensee shall provide assistance to the resident and the resident's family in the resident's adjustment to the personal care home setting and to transfer when other levels of care become necessary. (Class II)

7.6.b. The licensee shall encourage and assist all residents in developing and maintaining independence, self-determination and the highest level of functioning possible. (Class II)

7.6.c. The licensee shall provide the resident with personal assistance to meet the needs identified on his or her functional needs assessment. Resident needs may include, but are not limited to, assistance from staff to supervise self-administration of medically prescribed drugs and treatments, to follow any planned diet, rest or activity regimen, to utilize functional equipment (i.e. hearing aides, glasses, canes, etc.), and to perform activities of daily living. (Class II)

7.6.d. The licensee shall assist the resident in making appointments for appropriate medical, dental, nursing or mental health services as needed by the resident. (Class II)

7.6.e. The licensee shall provide or arrange for appropriate transportation of the resident to receive medical appointments and social services. (Class III)

7.7. Medications and Treatments.

7.7.a. The licensee shall ensure that resident care is provided by appropriately licensed health care professionals when required by state law and rules, and that medications and treatments given to residents are administered as required by state and federal law, rules and regulations, including. W. Va. Code § 16-5O-1 et seq. and Division of Health rule "Medication Administration by Unlicensed Personnel," 64CSR60. (Class I)

7.7.b. The written order or prescription of an individual authorized by law to prescribe drugs in this State is required for obtaining, altering, discontinuing and administering or self-administering prescription and over-the counter medications, treatments, therapies, etc. Copies of the prescriptions or written orders shall be retained in the resident's record. (Class I)

7.7.c. The prescribing health care professional shall determine whether or not the resident can self-administer such medications in a safe manner and shall document this in the residents medical record. (Class I)

7.7.d. Verbal orders of the prescribing health care professional shall be reviewed and signed by the individual responsible for the order within ten (10) working days from the original order date. (Class II)

7.7.e. The attending physician, prescribing health care professional, or a consulting pharmacist shall review the medication regimen of each resident as needed, but at least annually. The resident's record shall contain documentation of this review. (Class II)

7.7.f. The licensee shall keep a record of all drugs given to each resident indicating each dose given. The record shall include the resident's name; the name of the medication; the dosage to be administered and route of administration; the time or intervals at which the medication is to be administered; the date the medication is to begin and cease; the printed name, initials and signature of the individual who administered the medication; and any special instructions for handling or

administering the medication, including instructions for maintaining aseptic conditions and appropriate storage. (Class I)

7.7.g. Medications shall be kept in a locked room, cabinet or other storage receptacle and accessible only to the staff responsible for medications unless residents are determined to be capable of self-medication. In those cases, the licensee shall provide the self-medicating resident with resources to store medications to be inaccessible to other residents. (Class I)

7.7.h. The container label of each prescription drug shall be legible, legally dispensed and labeled for the resident for whom it has been prescribed. When the prescriber's directions change, the container shall be relabeled only by a licensed pharmacist or there shall be a written document signed and dated by the physician to verify the change in a medication prescription which is stored in the resident record. All medications shall be kept in their original labeled containers and shall be labeled in accordance with the rules of the West Virginia board of pharmacy and in a manner that the name and strength of medication, manufacturer name, lot number, and expiration date can be readily identified by the home. (Class I)

7.7.i. If refrigeration of medication is required, the licensee shall provide: a refrigerator in a locked room; a locked refrigerator; or a locked box within the refrigerator for storage. A thermometer is required in a refrigerator storing medications. The temperature within the refrigerator storing medications shall be maintained within the recommended temperature range on the medication package. (Class I)

7.7.j. If Schedule II drugs of the Uniform Controlled Substances Act W. Va. Code § 60 A -1-101 et seq. are administered, a copy of the written prescription signed by the physician shall be in the resident's record and a proof of use record shall be maintained. Schedule II drugs shall be stored in a manner so that they are securely protected by two (2) locks. The key to the separately locked Schedule II drugs shall not be the same key that is used to gain access to non-scheduled drugs. (Class II)

7.7.k. The disposition of unused medications due to situations such as a change in drug therapy, the death of the resident, the resident leaving the facility, or the resident's inability to take the medication, shall be in accordance with the following:

7.7.k.1. Individual resident drugs supplied in unit dose or the manufacturer's originally sealed container shall be returned, if unopened, unless otherwise prohibited under applicable federal or state laws, to the issuing pharmacy, Provided, That:

7.7.k.1.A. No drug covered under the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 21 U.S.C. § 801 et seq. shall be returned (Schedule II, III, IV, V); (Class III)

7.7.k.1.B. All returned drugs shall be identified as to lot or control number; (Class III) and

7.7.k.1.C. The signatures of the receiving pharmacist and the registered nurse shall

be recorded in a separate log which lists the name of the patient, the name and strength of the drug with National Drug Code, the prescription number (if applicable), the amount of the drug returned and the date of return. The log shall be retained for at least two (2) years; (Class III) and

7.7.k.2. Resident drugs which are outdated, adulterated, deteriorated, or non-returnable shall be destroyed in the following manner:

7.7.k.2.A. Drugs listed in Schedules II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 21 U.S.C. § 801 et seq. shall be destroyed in the presence of a pharmacist and the registered nurse. The following shall be retained for at least two (2) years: the name of the resident, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above; (Class III) and

7.7.k.2.B. All other non-scheduled legend drugs not in unit dose packaging or not in the manufacturer's originally sealed container shall be destroyed in the presence of a pharmacist or licensed nurse and one other witness. The patient's health record or a separate log shall contain the name of the resident, the name and strength of the drug, the prescription number, if applicable, the amount destroyed, the date of destruction and the signatures of the witnesses. The log shall be retained for at least two (2) years. (Class III)

7.7.l. When oxygen therapy is required, the personal care home shall have a portable source available for resident use for out-of-room activities and in the event of power failure. The licensee shall maintain any equipment electrically safe and shall arrange for service as needed; store the oxygen tubing in a sanitary manner when not in use and replace it as indicated by accepted infection control measures; prohibit smoking in any location when oxygen is in use; post no smoking signs conspicuously; and enforce the smoking prohibition. (Class I)

7.8. Accident, Illness and Major Incident Procedures.

7.8.a. A standard American Red Cross first-aid kit, or the equivalent, shall be readily available at all times to provide emergency aid for commonly occurring household injuries. (Class III)

7.8.b. When a resident experiences an illness or an incident that results in injury or resident complaint, the licensee shall arrange for an appropriately licensed health care professional to:

7.8.b.1. Assess the severity and cause of the accident or illness; (Class I)

7.8.b.2. Advise the staff as to the need to seek emergency assistance related to the accident or illness; (Class I) and

7.8.b.3. Record actions taken in the resident's record, and, recommend to the licensee, in writing, actions, if any, to take to avoid similar accidents or illnesses. The licensee shall keep a written documentation of the recommendations. (Class II)

7.8.c. If the resident has an obvious need for emergency assistance, the person on duty should first obtain emergency assistance, and then call the licensed health care professional. (Class I)

7.8.d. The staff of the personal care home shall monitor and document the resident's condition for a period of twenty-four (24) hours following the accident or the onset of the illness or as specified by the licensed health care professional. (Class II)

7.8.e. The licensee shall report major incidents to the West Virginia office of health facility licensure and certification as soon as possible, but no later than the next business day. (Class III)

7.8.f. The personal care home staff shall promptly notify the resident's physician, responsible party and/or next of kin, when there is a major incident or any significant change in the resident's condition. (Class I)

7.8.g. The licensee shall take reasonable precautions to comply with recommendations by the local public health authority should an epidemic occur. (Class I)

7.9. Resident Death.

7.9.a. The personal care home shall immediately report the suspected death of a resident to the attending physician and report death to the resident's family or legal representative, as applicable. (Class III)

7.9.b. Upon the death of a resident, the following information shall be entered in the resident's record:

7.9.b.1. A record of the notification of the resident's physician, the designated individual for emergencies, and legal representative, if any; (Class III)

7.9.b.2. The date, time and circumstance of death, including the name of person to whom the body was released and any other details specific to the death; (Class III) and

7.9.b.3. A record of the disposition of the resident's personal belongings that were released, including funds. The resident's legal representative or next of kin shall sign a detailed receipt for these items. (Class III)

7.9.c. In the event of the death of a resident, a licensee shall deliver all property held in trust to the resident's estate administrator or executor. (Class III)

64-14-8. Activities

8.1. The licensee shall provide an activity program designed to meet the needs of each resident. The program shall:

8.1.a Provide information and referral services and opportunities for utilization of social,

recreational, vocational activities within the community; (Class III)

8.1.b. Provide a monthly calendar of varied events which lists all social and recreational activities for the residents; (Class III) and

8.1.c. Provide at least seven (7) hours of scheduled activities available to the residents each week for no less than one (1) hour each day. (Class III)

§64-14-9. Dietetic Services.

9.1. General.

9.1.a. The licensee shall ensure that each resident is offered at least three (3) freshly prepared meals daily, seven (7) days a week and special diets and snacks which meet resident needs and choices, as identified in his or her needs assessment. Residents' meals shall be in substantial compliance with current Recommended Dietary Allowances of the Food and Nutrition Board of National Academy of Sciences, National Research Council, or as specified in this rule, except as ordered by a physician. (Class II)

9.1.b. When therapeutic or modified diet services are provided by the personal care home, a physician's order for each diet and the meal pattern, including types and amounts of food to be served, shall be on file. Therapeutic or modified diets, as recommended by the physician, shall be prepared according to written instructions obtained from the resident's physician or dietitian. At no time shall a resident be offered less than one thousand four hundred (1,400) calories daily, unless specifically ordered by a physician. (Class I)

9.1.c. The residents shall be offered a variety of foods at meals as follows:

9.1.c.1. At breakfast: fruit or juice; cereal, whole grain or enriched bread product; and Grade A vitamin D milk; (Class III) and

9.1.c.2. At noon and evening meals: protein sources, such as meat, poultry, fish, eggs, cooked dried legumes, cheese or peanut butter; vegetable or fruit; whole grain or enriched grain food products; and Grade A vitamin D milk. (Class III)

9.1.d. Each resident shall be weighed upon admission and yearly and provided with the amount of food and fluid on a daily basis necessary to maintain his or her appropriate minimum average weight. Documentation of these weights shall be maintained in the resident's record. (Class III)

9.1.e. The licensee shall encourage resident participation in menu planning and shall serve meals at times mutually agreed upon by residents in the home with consideration of individual resident preferences. (Class III)

9.1.f. The licensee shall accommodate residents who are unable to eat at the planned mealtime and provide for a meal substitution if the resident does not tolerate the foods planned for

the meal. (Class II)

9.2. Administrative Requirements.

9.2.a. The licensee shall maintain a daily record of actual foods served for each meal. Menu content shall be varied. (Class III)

9.2.b. The licensee shall keep grocery receipts and records of actual food served on file in the personal care home for at least thirty (30) days. (Class III)

9.3. Food Service Sanitation.

9.3.a. The food service facilities shall comply with Division of Health rule, "Food Service Sanitation," 64CSR17. (Class II)

9.3.b. When required by the local health department having jurisdiction over the county in which the center is located, all persons engaged in food service activities shall have valid food service worker permits. (Class II)

§64-14-10. Fire Safety, Disaster and Emergency Preparedness and Training.

10.1. Fire Safety

10.1.a. The licensee shall provide evidence of compliance with applicable rules of the state fire commission. The state fire marshal's written approval is required for any variation to compliance with the fire code, and the variation shall be coordinated with the secretary. (Class I)

10.2. Disaster and Emergency Preparedness Plan

10.2.a. The personal care home shall have a written disaster and emergency preparedness plan which states procedures to be followed in the event of an internal or external disaster or emergency which could severely affect the operation of the personal care home. (Class I)

10.2.b. The disaster and emergency preparedness plan shall have procedures for the following situations at minimum and shall identify specific tasks and responsibilities for all employees in the event of the following: missing residents; high winds; tornadoes; floods; bomb threats; utility failure; and severe winter weather. (Class I)

10.2.c. The disaster and emergency preparedness plan shall include at least an emergency water agreement; an alternate shelter agreement; an emergency transportation policy; and an emergency food supply list and menu which will provide nutrition for all persons residing in the community for a minimum of seventy-two (72) hours. (Class I)

10.2.d. The licensee shall obtain the assistance of qualified fire safety, emergency response teams or other appropriate experts in developing and maintaining the disaster and emergency preparedness plan. Documentation by the expert shall be maintained in the personal care home.

(Class I)

10.2.e. The licensee shall provided the local fire department with a floor plan and with the opportunity to become familiar with the personal care home. (Class I)

10.2.f. The personal care home shall have written plans and procedures for transferring casualties and uninjured residents. These procedures shall include the transfer of pertinent resident records including identification information, diagnoses, allergies, advanced directives, medications and treatments, and any other records needed to ensure continuity of care. (Class I)

10.2.g. There shall be copies of the disaster and emergency preparedness plan at all staff stations or emergency control stations. The disaster and emergency preparedness plan shall be located in an area that allows visual contact at all times. Staff shall know the location at all times. (Class I)

10.2.h. The disaster and emergency preparedness plan shall be reviewed and updated by the administrator or his or her designee on an annual basis and signed and dated to verify review. (Class III)

10.2.i. Emergency call information shall be conspicuously posted near each telephone in the personal care home, exclusive of telephones in resident rooms. This information shall include at least the following:

10.2.i.1. The telephone numbers of the fire department, the police, an ambulance service and other appropriate emergency services; (Class I)

10.2.i.2. Key personnel telephone numbers, including at least the following: the administrator; physician (if applicable); or the nurse on call (if applicable); (Class I) and

10.2.i.3. The names and telephone numbers of all other personnel to be called in case of fire or emergency. (Class I)

10.3. Disaster Training and Rehearsal.

10.3.a. Within twenty-four (24) hours of admission, the disaster and emergency preparedness plan procedures shall be clearly communicated by the staff to the resident and documented. (Class I)

10.3.b. The disaster and emergency preparedness plan shall be rehearsed by all personnel from all shifts once yearly, and the rehearsals shall be documented in the personal care home's records. (Class I)

§64-14-11. Physical Facilities.

11.1. Applicability; Construction; Additions; Renovations; Alterations; Other Standards.

11.1.a. The provisions of this Section apply to physical facilities, operations, maintenance and equipment for all personal care homes, renovations or additions. (Class I)

11.1.b. A complete set of drawings and specifications for the architectural, structural, and mechanical work shall be submitted to and approved by the secretary before construction begins. This requirement applies to new construction, additions, renovations, or alterations to existing personal care homes. (Class I)

11.1.c. The submitted set of construction documents (drawings and specifications) shall be prepared, signed and sealed by an individual registered to practice architecture in the State of West Virginia. One (1) set of these documents shall be submitted to the State Fire Marshal for review. The new personal care homes or addition shall be inspected during the construction phase by a registered professional architect, preferably the designing architect. (Class I)

11.1.d. During the construction phase an as built set of drawings shall be kept by the general contractor on which all changes (from all trades) to the project are noted. Each change shall be noted in red and dated. The architect shall present this as built set of drawings to the owner when the project is completed. (Class I)

11.1.e. All construction, new additions, renovations or alterations shall be inspected and approved by the secretary prior to admitting new or additional residents. When construction is substantially complete, the architect shall submit to the secretary a substantial completion form signed by all the parties involved and a completed inspection request form. (Class I)

11.1.f. Unless substantial construction is started within one (1) year of the date of approval of final drawings, the owner or architect shall secure written notification from the secretary that the plan approval for construction is still valid and in compliance with this rule. (Class I)

11.1.g. Plans for addition, removal or modification of equipment which is permanently affixed to the building or which may otherwise involve or necessitate new construction, alterations, or additions to the personal care homes shall be submitted to and approved by the secretary. (Class I)

11.1.h. Other changes involving equipment, which may or may not require physical changes in the personal care homes, but which may relate to other standards and requirements of this rule may require the secretary's approval. Personal care homes may request approval in advance from the secretary regarding a particular change or rearrangement. Areas in which changes are likely to require approval include, but are not limited to, the kitchen, the laundry, and heating equipment. (Class I)

11.1.i. All fees specified in Division of Health rule, "Fees for Services," 64CSR51 for site inspections of new construction or major renovations, architect reviews of drawings and specifications, and inspections of new projects prior to openings are the responsibility of the licensee. (Class III)

11.1.j. A licensee shall obtain approval from the secretary of the licensee's plan of operation,

and the secretary shall determine the licensed bed capacity. An increase in capacity can occur only with permission of the secretary. (Class II)

11.1.k. The Americans with Disabilities Act (ADA) and the American National Standards Institute (ANSI) codes shall be followed when they apply. (Class II)

11.1.l. The personal care home shall comply with the State Fire Commission rule, "State Building Code," 87CSR4[6]. (Class I)

11.1.m. Where local codes or regulations require standards higher than those required by this rule, local building codes and zoning restrictions shall be observed. (Class I)

11.1.n. Evidence of compliance signed by local fire, building and zoning officials shall be available on-site for review. (Class I)

11.2. Site Characteristics and Accessibility

11.2.a. Sites for all new personal care homes and sites of additions to existing personal care homes shall be inspected by the secretary prior to the architect beginning work on final drawings and specifications. (Class I)

11.2.b. Personal care homes shall be located in a residential setting as convenient as possible for necessary services and access to the personal care home, if local zoning laws allow. (Class III)

11.2.c. If a personal care home site is located near railroads, freight yards, traffic arteries or airports, precautions shall be taken to assure resident safety. This requirement applies to new construction only. (Class I)

11.2.d. There shall be adequate drainage to divert surface water from the personal care home. (Class II)

11.2.e. The personal care home's hard surface access road shall connect directly to a hard surface highway which provides access to hospitals and allows medical and fire personnel access. (Class I)

11.2.f. Any questionable soil conditions shall be reviewed by a qualified soils engineer and if conditions require, earth core borings shall be conducted. The secretary shall be supplied with copies of soil test reports if engineered soil is installed or other soil tests conducted. (Class I)

11.2.g. The site shall have accessibility to electric power. Water shall be supplied with

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[6] Available from the State Fire Commission or the Secretary of State. Section 4 of the above referenced Building Code rule incorporates by reference the BOCA National Building Code; BOCA National Plumbing Code; BOCA National Mechanical Code; BOCA National Existing Structures Code ; BOCA National Energy Conservation and CABO One- and Two-Family Dwelling Code. You may purchase these books, collectively or separately, from Building Officials and Code Administrators International, 4051 West Flossmoor Road, Contra Club Hills, Illinois 60477-5795, 1-312-700-2300 or BOCA International Regional Offices, 3592 Corporate Drive, Suite 107, Columbus, Ohio 43229, 1-614-890-1064 or view a set at the Secretary of State's Office.

sufficient pressure to operate the fire sprinkler system adequately. (Class I)

11.2.h. Parking areas shall be constructed using clean, solid earth bed, a compacted stone base and a hard surface all weather finish coat with a slope which permits good drainage. There shall be parking spaces for all staff on duty, and a minimum of one (1) parking space for each five (5) beds. A minimum of (2) two handicapped parking spaces shall be located at the main entrance. All parking areas shall be free of broken, gaped or uneven paving. (Class II)

11.2.i. Hard surface concrete walks, a minimum of forty-eight inches (48") wide with light broom top surface texture shall be provided at all exits and connect into the main walk or parking area. (Class II)

11.3. Physical Facilities and Equipment

11.3.a. Maintenance and housekeeping shall be provided to maintain safe, sanitary and accident free living conditions. (Class I)

11.3.b. Low windows, open porches, changes in floor level and similar accident hazards shall be designed so that the danger of accident is minimized. Danger areas on the property outside the building shall be safeguarded. (Class I)

11.3.c. All equipment shall be maintained as recommended by the manufacturer and the licensee shall establish a program of preventive maintenance for all equipment. (Class III)

11.3.d. The personal care home shall be kept free of insects, rodents and vermin. (Class III)

11.3.e. Pesticides shall be applied only by an applicator certified by the United States Department of Agriculture. (Class I)

11.3.f. Each room occupied or used by residents shall have level floors which are slip resistant. Floor covering shall be maintained in a clean and odor-free condition, free from protrusions and lie flat and even. (Class II)

11.3.g. Ceilings and walls shall be in good repair, free from unfilled cracks, and finished to allow for satisfactory cleaning. (Class II)

11.3.h. All doors and windows shall be operable and shall be constructed and maintained to fit snugly, yet be opened and closed easily without requiring the use of special tools. All doors shall be provided with positive latches suitable for keeping the doors closed. (Class II)

11.3.i. Minimum door widths for new construction shall be thirty-six inches (36") for exterior exits and resident rooms. Minimum door widths for new construction shall be thirty-four inches (34") for bathroom doors. (Class II)

11.3.j. Outer openings that are left open for extended periods of time shall be screened to prevent the entrance of insects. Insect screening shall be maintained free of openings large enough

to permit the entrance of insects. (Class III)

11.3.k. The personal care home shall have a heating system capable of maintaining a temperature in all rooms used by residents of at least seventy-two degrees Fahrenheit (72°F) during cold weather. (Class II)

11.3.l. Supplemental heating devices, such as portable heaters, are prohibited. (Class I)

11.3.m. Cooling devices or systems shall be provided for the use of residents to assure that inside temperatures do not exceed eighty degrees Fahrenheit (80°F). Acceptable cooling devices include, but are not limited to, air conditioners, electric fans and heat pumps. (Class II)

11.3.n. Ramps shall not be less than forty-eight inches (48") wide nor steeper than one foot (1') of rise in twelve feet (12') of run, and shall be finished with a non-slip surface. (Class II)

11.3.o. Handrails shall be provided on all sides of elevators and inside and outside stairs and ramps. Handrails shall be installed between thirty-two inches (32") and thirty-four inches (34") high and support a concentrated load of two hundred and fifty (250) pounds. (Class II)

11.3.p. Personal care homes shall have a call system which is audible to staff who are on duty and which can be accessed from each bed and other areas as necessary for the safety of residents. Electronic call systems may be required based on the size of the personal care home, the staffing patterns and configuration of the building. (Class II)

11.3.q. The personal care home shall have space adequate for the storage of linens, maintenance and housekeeping supplies, equipment, and food supplies. (Class II)

11.3.r. All personal care homes shall have at least one (1) janitor's closet with a service sink for each story that houses residents. However, if existing buildings cannot comply with the janitor closet requirement on each floor, the facility must demonstrate a sanitary means of disposal of waste water. (Class II)

11.3.s. Corridors, stairways and elevators shall be of a width and design that will easily accommodate the removal of residents by stretcher, and shall be constructed and maintained in compliance with all applicable fire and safety requirements. Non-slip surfaces are required for stairways. Elevators shall comply with all appropriate State and federal laws. (Class II)

11.3.t. The licensee shall implement measures to ensure resident safety if it admits residents who exhibit behaviors which may cause harm to themselves or others or may place themselves or others in imminent danger or jeopardy. The safety measures may include but not be limited to, door alarms. (Class I)

11.4. Bedrooms

11.4.a. The licensee shall provide each resident with a bed in a bedroom and shall not place

beds in corridors, living rooms, kitchens, dining rooms, a basement, attic, or any other area not commonly used as a bedroom. (Class II)

11.4.b. Bedrooms shall contain at least eighty (80) square feet of floor area per resident and shall have sufficient floor space to accommodate all items required by this rule relating to furnishings and equipment of a resident's bedroom. If a bedroom has a built-in closet, up to nine (9) square feet per closet may be counted in calculating the square footage of the floor space. (Class III)

11.4.c. The licensee of an existing personal care home shall assure that no bedroom is occupied by more than four (4) persons. In newly constructed or renovated personal care homes no more than two (2) persons shall occupy a bedroom. (Class III)

11.4.d. Staff of the personal care home may not share bedrooms with residents and may not use resident bedrooms for any purpose. (Class III)

11.4.e. There shall be at least three feet (3') of space separating beds on the sides and the ends of the beds. Beds shall not be placed so that residents will experience discomfort because of proximity to heat sources or exposure to drafts. (Class III)

11.4.f. Each bedroom shall have direct access to a corridor without passing through a bathroom or another bedroom. A bedroom shall not be used as a passageway by staff or other residents to access bathrooms or other parts of the building. (Class III)

11.4.g. Each resident shall be provided with a bed at least thirty-six inches (36") wide which is substantially constructed, is in good repair, accommodates the resident's needs and promotes independence. (Class III)

11.4.h. Each bed shall have a clean comfortable pillow with a protective cover and pillow case. A protective cover and two (2) sheets, a bed spread or other type of covering shall be provided for the bed and additional bed covering shall be available to keep residents warm during emergencies and cold weather. (Class III)

11.4.i. The licensee shall provide clean bed linens for each resident at least once a week and more often if needed. (Class III)

11.4.j. Every closet door latch shall have the capability of being readily opened from inside in case of emergency. (Class II)

11.4.k. In new personal care homes the clear area of windows shall be a minimum of ten percent (10%) of room floor area in each resident bedroom. Windows shall be at a height to provide a direct view to the outside and operable for ventilation. Windows shall have curtains, shades, or blinds, which may be opened and closed and are kept clean and in good repair. In existing facilities bedrooms shall have an outside exposure through a vertical transparent window. Bedrooms extending below ground level are allowed only on the approval of the secretary. (Class III)

11.4.l. Each bedroom shall have at least one (1) light controlled by a switch at the door to

the room. (Class III)

11.4.m. Each resident of each bedroom shall be provided with at least the following furniture that accommodate the resident's needs and promotes independence:

11.4.m.1. A night stand, chest or its equivalent; (Class III)

11.4.m.2. A closet, locker, or wardrobe space with a minimum dimension of twenty inches (20") by twenty-two inches (22") by sixty inches (60"), excluding shelf and storage space; (Class III)

11.4.m.3. A chest of drawers or the equivalent with at least three (3) drawers to meet the resident's needs for the storage of clothing and personal items shall be provided for each resident; (Class III) and

11.4.m.4. A chair and a lamp. (Class III)

11.4.n. Bedroom furnishings shall be in good repair and shall be of a nature to suggest a private home setting. Furnishings shall be reasonably attractive and comfortable. Individual tastes of the residents shall be taken into consideration, including the use of their personal furniture where space permits. (Class III)

11.5. Toilets, Hand Washing and Bathing Facilities

11.5.a. There shall be indoor flushing toilets with hand washing lavatories in the same room at a ratio of at least one (1) toilet and lavatory for every five (5) residents. There shall be a mirror over each lavatory. Toilets, hand washing lavatories, and bathing fixtures shall be in good repair and maintained in a sanitary condition. There shall be at least one (1) bathing facility and one (1) flush toilet with hand washing facilities on each floor used by residents. (Class III)

11.5.b. The personal care home shall have bath tubs or showers at a ratio of one (1) per ten (10) residents. Tubs and showers shall be equipped with non-slip surfaces. (Class III)

11.5.c. Toilet and bathing facilities shall be supplied with soap. Bar soap is acceptable when each bar is used only by one (1) resident. Toilet facilities shall be supplied with toilet tissue and disposable towels. (Class III)

11.5.d. Bath towel bars shall be provided either in the residents bedroom or the bathroom. Space for towel bars shall accommodate the number of residents utilizing the bathing facility. (Class III)

11.5.e. Bathing and hand washing facilities shall not be used for storage of linens and clothing to be laundered or for laundering of soiled linens and clothing. (Class III)

11.5.f. Grab-bars shall be provided at toilets, tubs, and showers. These grab-bars shall be securely mounted to the finished wall with a steel plate or a two inch (2") by six inch (6") wood plate

backing behind the wall. Grab bar brackets shall be provided at spacings which would support two hundred and fifty (250) pounds of concentrated load at any point on the grab bar. (Class II)

11.5.g. Bathing and toilet facilities shall ensure the privacy and safety of residents. Door shall be provided with locking type hardware which can be opened from outside in the event of an emergency. Keys or tools to unlock the door, shall be readily accessible to the personal care home staff. In new construction, doors shall swing outward one hundred eighty degrees or until flush with a permanent wall. (Class II)

11.6. Dining Area

11.6.a. The personal care home shall have a dining area of at least fifteen (15) square feet per resident. (Class III)

11.6.b. The type and quantity of artificial lighting shall be adequate in the dining area. (Class III)

11.7. Recreation and Leisure Area

11.7.a. A leisure room shall be provided for reading and recreational purposes. This room shall be equipped at minimum with seating furniture which provides good lower back support, arm rests, and which is clean, odor free and in good repair. (Class III)

11.7.b. The leisure area shall provide a sufficient level of artificial lighting for safety and for leisure activities. (Class III)

11.7.c. An area of at least fifteen (15) square feet per resident shall be provided for the leisure spaces. The dining room may serve as part of the leisure room. The minimum total square footage per resident for the dining and leisure room should be thirty (30) square feet. (Class III)

11.8. Water Supply

11.8.a. The personal care home shall have a water supply which:

11.8.a.1. Is safe and sized to meet all residential needs and requirements of the sprinkler system; (Class I) and

11.8.a.2. Has as its source of water a public water system which complies with Division of Health rules, "Public Water Systems", 64CSR3, or a water well which complies with Division of Health rules, "Water Well Regulations", 64CSR19, and "Water Well Design Standards," 64CSR46. (Class I)

11.8.b. The personal care home shall have hot and cold running water in sufficient supply to meet the needs of the residents, household members and employees. (Class I)

11.8.c. Hot water temperatures shall be maintained:

11.8.c.1 Above one hundred five degrees Fahrenheit (105°F) (Class II) and

11.8.c.2 Below one hundred ten degrees Fahrenheit (110°F) at all hot water sources except for, dishwashers and congregate laundry facilities. A thermostatic mixing valve shall be utilized to control the temperature of hot water which is used by residents. (Class I)

11.9. Sewage.

11.9.a. Sewage disposal shall be in accordance with Division of Health rules, "Sewage System Rules", 64CSR9, and "Sewage Treatment and Collection System Design Standards," 64CSR47. (Class I)

11.9.b. The sewage system shall be adequate to meet the personal care home's needs, shall be kept in good working order and shall be properly operated and maintained. (Class II)

11.10. Solid Waste.

11.10.a. All garbage and refuse shall be stored in durable, covered, leak-proof and vermin-proof containers and the containers shall be kept clean and free of all residue accumulation. Dumpsters in good repair are acceptable. (Class III)

11.10.b. The personal care home shall have solid waste containers in sufficient numbers and capacity to properly store all solid waste. (Class III)

11.10.c. Solid waste, including garbage and refuse, shall be removed from the building daily and the premises weekly, or more often if necessary. (Class II)

11.10.d. A concrete platform or metal rack is required for outside storage of solid waste containers. The method of storage shall prevent animals from getting into the contents of the waste containers. (Class III)

11.10.e. When municipal or private garbage and refuse disposal service is not available, all garbage and refuse shall be disposed of in accordance with the applicable provisions of state and local law and rules governing the management of garbage and refuse. (Class II)

11.11. Electrical Requirements.

11.11.a. Each personal care home shall be supplied with electrical service, wiring, outlets, and fixtures which shall be installed to meet the national electric code and shall be maintained in good and safe working conditions. (Class I)

11.11.b. The electrical service shall be of the proper size to handle the load connected to it. (Class I)

11.11.c. Electrical duplex outlet receptacles shall be provided as follows:

11.11.c.1. In new facilities electrical outlets shall be located in the living room, recreation room, dining room and bedrooms. There shall be at least one (1) receptacle on each wall. Walls longer than twelve (12) feet in the leisure room shall have at least two (2) receptacles on the walls. In existing facilities electrical outlets to meet the needs of the residents shall be provided; (Class I)

11.11.c.2. Other habitable rooms shall have a minimum of two (2) receptacles; (Class I)

11.11.c.3. All receptacle outlets within six (6) feet of any water supply shall be provided with ground fault circuit interrupter protection; (Class I)

11.11.c.4. Kitchens shall be provided with one (1) receptacle per four (4) lineal feet or a fraction thereof of the counter top preparation area with a minimum of two (2) receptacles per counter. In addition all counters wider than twelve inches (12") of any length shall provide a minimum of one (1) receptacle. On walls without counters there shall be receptacles with a maximum spacing of twelve feet (12'). Separate outlets are required for refrigerators and cooking equipment which require specialty outlets; (Class I) and

11.11.c.5. A minimum of one (1) exterior receptacle duplex outlet with ground fault circuit interrupter protection shall be provided. (Class III)

11.12. Lighting Requirements.

11.12.a. General outdoor lighting shall be provided to illuminate walks, porches, patios, steps and drive areas. (Class I)

11.12.b. Emergency lights shall be mounted on walls in sufficient number to illuminate all exits on all levels. Emergency lights shall also be provided in the kitchen and as needed in areas where residents congregate. (Class I)

11.12.c. Minimum interior lighting levels are as follows:

11.12.c.1. Ten (10) foot candles in entrances, hallways, stairways, stair landings; (Class III)

11.12.c.2. Twenty (20) foot candles in general areas of living room, leisure rooms, dining rooms, and bedrooms; (Class III)

11.12.c.3. Thirty (30) foot candles in reading, writing and game playing areas in living room, leisure rooms, dining rooms and bedrooms; (Class III)

11.12.c.4. Fifty (50) foot candles in the cleaning and food preparation, cooking, and laundry areas; (Class III)

11.12.c.5. Thirty (30) foot candles in bath, lavatory, and toilet areas; (Class III) and

11.12.c.6. Fifty (50) foot candles in facial shaving and grooming areas, and at mirrors and hair styling areas. (Class III)

11.13. Pets and Other Animals.

11.13.a. Pets are permitted, provided that all residents are advised prior to admission that pets are kept on the premises. If pets are added after the admission of residents, all residents shall be in agreement to the addition of the pets. (Class III)

11.13.b. Wild, dangerous or obviously ill animals are prohibited. (Class I)

11.13.c. Animals and their quarters shall be kept in a clean condition at all times. (Class II)

11.13.d. Dogs and cats kept in the personal care home or on the grounds shall be properly vaccinated (for dogs this includes rabies, leptospirosis, distemper, and parvo and for cats this includes rabies). Documentation of the vaccination and prevention measures shall be available on the premises. (Class II)

11.14. Laundry and Linens.

11.14.a. Laundry facilities or services for residents' personal laundry shall be provided. Laundry services may be provided by an outside laundry service. (Class III)

11.14.b. Electric or gas clothes dryers shall be vented to the outside. (Class I)

11.14.c. All laundry shall be dried mechanically in an electric or gas clothes dryer which is vented to the outside or a chemical sanitizing agent shall be added to the rinse water, and the laundry air-dried. (Class II)

11.14.d. Soiled and clean laundry shall not be stored together at any time. (Class II)

11.14.e. Soiled laundry shall be stored in non-absorbent, easily cleanable covered containers or disposable plastic bags. (Class II)

11.14.f. Table and kitchen linens shall be laundered separately from other washable goods. Sanitizing agents shall be used when laundering kitchen, bath, and bed linens. (Class II)

11.14.g. Locked storage facilities shall be utilized for laundry supplies, housekeeping supplies, insecticides, work supplies and any other toxic or hazardous materials. Food and drugs shall be stored in separate locations. (Class I)

11.14.h. There shall be a supply of sheets, pillow cases, bed coverings, towels, wash cloths, and other linens necessary to provide a minimum of two (2) changes per bed. (Class III)

11.15. Alzheimer's and Other Dementia Units

11.15.a. The personal care home shall provide a staff control point within the unit. (Class III)

11.15.b. The personal care home shall provide a secure accessible outdoor space such as a porch, court or yard. (Class III)

11.15.c. The personal care home shall provide, within the unit, at least two (2) lounge or activity areas. One (1) of the lounge or activity areas may be shared with the dining area. (Class III)

11.15.d. The personal care home shall provide dining space within the unit or share dining space with another part of the personal care home. (Class III)

11.15.e. Resident call systems shall comply with 11.3.o. of this rule. In units that are separated by construction from other areas within the home the call system shall be an independent system. (Class II)

11.15.f. Security shall be provided through systems that secure the unit. These shall comply with applicable rules of the state fire commission. (Class I)

11.15.g. Windows shall be operable, but opening shall be restricted to prevent residents from climbing out. (Class I)

11.15.h. If windows require the use of a tool or key for operation, the tool or key shall be located in the unit in a prominent location, easily accessible to staff. (Class I)

11.15.i. Windows and glass vision panels shall have safety glazing or another appropriate type of safety precaution, however, wired glass shall not be used on bedroom windows. (Class II)

11.15.j. Electrical receptacles and convenience outlets in resident rooms, and common use areas shall be tamper resistant or equipped with ground fault circuit interrupters. (Class I)

§64-14-12. Requirements Related to the Provision of Limited and Intermittent Nursing.[7]

12.1. Standard Requirements.

12.1.a. The licensee of a personal care home which provides limited and intermittent nursing care shall arrange for a registered professional nurse to assume responsibility for the oversight of nursing care and services. The licensee shall enter into a written agreement with the registered professional nurse which specifies the responsibilities of the registered professional nurse and the licensee. Arrangements for nursing services may be made by contract with an individual or a nursing service with a management entity; or the personal care home may employ a registered nurse; or the

[7] The provisions of this section apply only to personal care homes providing limited and intermittent nursing. See Paragraph 4.1.d. of this rule.

administrator of the personal care home may act in this capacity, if he or she is a licensed registered professional nurse. Arrangements with a home care agency providing only direct care does not satisfy the requirements for nursing management over-sight of all residents. (Class I)

12.1.b. Nursing support staff shall be under the supervision of the registered professional nurse who has assumed the overall responsibility for the oversight and care provided to the residents. (Class I)

12.1.c. The licensee shall implement, within reasonable expectation, the recommendations of the registered nurse regarding care, services and staff training intended to protect the residents. (Class II)

12.1.d. The licensee shall provide written notice to each resident regarding the availability of nursing services at the time of admission, or, for current residents, within thirty (30) days of the effective date of this rule. (Class III)

12.1.e. All physician's orders shall be reviewed every thirty (30) days for accuracy by the registered professional nurse or other lawfully authorized professional, unless there is a medical condition requiring a more frequent review as determined by the resident's physician. (Class II)

12.1.f. A physician or a consultant pharmacist shall conduct quarterly pharmacy reviews on all residents receiving limited or intermittent nursing services. (Class III)

12.1.g. The licensee shall assure that the registered professional nurse maintains a general record with a complete signature for each entry which shall include at least the following:

12.1.g.1. The date, time in and time out for each visit (unless the registered professional nurse is employed by the personal care home at least thirty-five (35) hours per week); (Class III)

12.1.g.2. A list of duties performed by the registered nurse during each visit; (Class III) and

12.1.g.3. A brief statement regarding identified concerns and recommended actions taken to resolve them. (Class III)

12.1.h. The licensee shall develop a system that provides for twenty-four (24) hour accessibility between the personal care home, the registered professional nurse, and/or other emergency personnel. (Class I)

12.2. Nursing Services.

12.2.a. A registered professional nurse shall document the following in each resident's individual case record using a complete signature or initials with a complete signature on each page of the record:

12.2.a.1. A monthly progress note in the resident's record as indicated by the needs of

the resident to document the status of the resident and any changes in his or her health or welfare; (Class II)

12.2.a.2. Any significant temporary or permanent changes in condition including changes resulting from incidents or accidents; (Class II) and

12.2.a.3. Any verbal or written orders received from a licensed health care professional. (Class I)

12.2.b. The registered professional nurse shall:

12.2.b.1. Provide oversight of the nursing care and services through contact with the licensee and personal care home staff as necessary to ensure appropriate resident care. Visits to the personal care home shall occur at least weekly and be of sufficient duration to perform all required duties; (Class I)

12.2.b.2. Provide overall supervision of the provision of nursing services to residents by ensuring that the services established within the resident's service plan are met and that the resident's physical, mental and social well-being are not compromised; (Class I)

12.2.b.3. Complete a written nursing assessment for each resident with nursing needs within twenty-four (24) hours following admission, and update the assessment at the time of any significant temporary or permanent change in the resident's condition. In the absence of a significant temporary or permanent change in condition, the assessment shall be reviewed quarterly; (Class I)

12.2.b.4. Coordinate the development of a component of the service plan to meet any identified nursing and medical needs of the resident with the resident and the attending physician or other licensed health care professional. This component shall be completed within seven (7) days after admission and shall be reviewed by the registered nurse at least quarterly or at the time of a significant temporary or permanent change in condition; (Class I)

12.2.b.5. Review training needs of personal care home staff members; (Class II)

12.2.b.6. Provide needed training or recommend to the personal care home appropriate training for staff; (Class II)

12.2.b.7. Provide to the licensee a written record of training provided by the registered nurse to individuals or groups with an outline of the items discussed, the date and time of the session, and signatures of individuals involved in the training; (Class II)

12.2.b.8. Provide overall supervision of medication storage, dispensing systems and disposition; (Class I) and

12.2.b.9. Coordinate admission and discharge planning as it relates to the medical component of resident care. (Class II)

§64-14-13. Penalties; Administrative Due Process.

13.1. Civil Penalties.

13.1.a. The secretary shall administer penalties for violations of this rule and of W. Va. Code §§16-5D-1 et seq. as specified in W. Va. Code §§16-5D-1 et seq. and this rule.

13.1.b. Upon completion of a report of inspection, the secretary shall determine what, if any, civil penalties are to be imposed pursuant to the West Virginia Code and this rule, and issue citations. The secretary shall issue citations and assess supplemental penalties for failure to correct continuing violations: Provided, That for continued failure to correct a violation of a non-life threatening nature, the secretary shall, prior to issuing a citation with a supplemental penalty, notify the licensee or non-licensed operator by certified mail, return receipt requested, that a citation will be issued with a supplemental penalty on a date to be specified by the secretary unless the corrective actions specified by the secretary are implemented in an acceptable manner.

13.1.c. All citations shall be in writing and shall include the basis upon which the secretary assessed the penalty and selected the amount of civil penalty.

13.1.d. The name of any resident jeopardized by the violation shall not be specified in the citation.

13.1.e. In both determining to assess a civil penalty and in fixing the amount of the civil penalty to be imposed for violations, the secretary shall consider the gravity of the violation, which shall include:

13.1.e.1. The degree of substantial probability that death or serious harm will result and if applicable, did result from the violation;

13.1.e.2. The severity of serious harm most likely to result, and if applicable, that did result from the violation; and

13.1.e.3. The extent to which the provisions of the applicable statutes or rules were violated.

13.1.f. If a licensee or a non-licensed operator does not plan to contest a citation which imposes a penalty, he or she shall submit to the secretary, within ten (10) business days after the issuance of the citation, the total sum of the penalty assessed.

13.1.g. If a licensee or a non-licensed operator desires to contest a citation which imposes a penalty or the date specified for correction of a violation, he or she shall, within four (4) business days after service of the citation or specification of time in which a violation is to be corrected, serve upon the secretary, either personally or by registered or certified mail, the licensee's or non-licensed operator's written notice pursuant to West Virginia Department of Health and Human Resources Administrative Rules, "Rules of Procedure for Contested Case Hearings and Declaratory Rulings", 64CSR1.

13.1.h. The secretary shall, in a civil judicial proceeding, recover any unpaid assessment which: (a) has not been contested under W. Va. Code §16-5D-12 within thirty (30) days of receipt of notice of the assessment; (b) has been affirmed under the provisions of W. Va. Code §16-5D-12 and not appealed within thirty (30) days of receipt of the secretary's final order; or (c) has been affirmed on judicial review, as provided in W. Va. Code §16-5D-13. All money collected by assessments of civil penalties or interest shall be paid into a special resident benefit account. The secretary shall apply the money only for the protection of the health or property of residents of facilities operated within the State of West Virginia, including: payment for the costs of relocation of residents to other facilities; operation of a personal care home pending correction of deficiencies or closure; and reimbursement of residents for lost personal funds.

13.2. Restrictions; Revocation.

13.2.a. The secretary may place restrictions upon or revoke the current license of a community, if he or she finds evidence of one (1) or more of the following:

13.2.a.1. Lack of financial stability to operate, such as insufficient capital, delinquent accounts, checks returned because of insufficient funds, and nonpayment of taxes, utility expenses and other essential services;

13.2.a.2. The licensee or the administrator of the personal care home has been arrested for, adjudicated, and convicted of any felony or of a misdemeanor relevant for the provision of care in a health care facility or for operating a health care facility;

13.2.a.3. The licensee has been denied or has had a license to operate a health care facility revoked in West Virginia or any other jurisdiction during the previous five (5) years;

13.2.a.4. The licensee has a record of noncompliance with lawful orders of the department or other licensing or certification agency for any jurisdiction in which the applicant has operated, directed or participated in the operation of a health care facility;

13.2.a.5. The licensee or other person in charge of the personal care home refuses entry to the secretary's duly authorized representative for an inspection or survey;

13.2.a.6. The licensee has inappropriately converted for its own use the property of a resident;

13.2.a.7. The licensee has secured property, or a bequest of property, from a resident by undue influence; or

13.2.a.8. The licensee has submitted false information either on the licensure or renewal application forms or during the course of an inspection or survey of the facility.

13.2.b. The secretary shall consider all available evidence at the time of the determination, including the history of the personal care home and the applicant in complying with this rule, notices of violations which have been issued to the facility and the applicant, findings of surveys and

inspections, and any evidence provided by the facility, residents, law enforcement officials, and other interested individuals.

13.2.c. In addition to all other actions and penalties specified in this rule, the secretary may ban new admissions by order until further notice by the secretary or reduce the bed capacity of the facility or both, when on the basis of inspection he or she determines that:

13.2.c.1. There is an immediate and serious threat to one or more residents; or

13.2.c.2. There are poor care outcomes resulting in an avoidable decline in a resident's condition; or

13.2.c.3. There has been a decline in the functional abilities of one or more residents resulting from neglect or abuse; and

13.2.c.4. An admission ban or reduction in bed capacity or both would place the facility in a position to render adequate care.

13.2.d. The secretary shall notify a licensee of an admissions ban or reduction in bed capacity or both, stating the terms of the order, the reasons for the order and the date set for compliance.

13.2.e. In addition to all other actions and penalties specified by law and this rule, the secretary may revoke a license which has been obtained through the use of fraud or subterfuge.

§ 64-14-14. Administrative Due Process.

Administrative due process and remedies for actions taken under this rule, W. Va. Code §§16-5D-1 et seq. and this rule, shall be in accordance with the Division of Health Procedural Rule, "Rules of Procedure for Contested Case Hearings and Declaratory Rulings", 64CSR1.

Table 64-14 A Surety Bond Schedule

AVERAGE RESIDENT FUNDS MONTHLY BALANCE	REQUIRED SURETY BOND AMOUNT
$ 1 to $2,000	$2,500
$2,001 to $2,100	$2,625
$2,101 to $2,200	$2,750
$2,201 to $2,300	$2,875
$2,301 to $2,400	$3,000
$2,401 to $2,500	$3,125
$2,501 to $2,600	$3,250
$2,601 to $2,700	$3,375
$2,701 to $2,800	$3,500
$2,801 to $2,900	$3,625
$2,901 to $3,000	$3,750
$3,001 to $3,100	$3,875
$3,101 to $3,200	$4,000
$3,201 to $3,300	$4,125
$3,301 to $3,400	$4,250
$3,401 to $3,500	$4,375
$3,501 to $3,600	$4,500
$3,601 to $3,700	$4,625
$3,701 to $3,800	$4,750
$3,801 to $3,900	$4,875
$3,901 to $4,000	$5,000
$4,001 to $4,100	$5,125
$4,101 to $4,200	$5,250
$4,201 to $4,300	$5,375
$4,301 to $4,400	$5,500

Table 64-14 A Surety Bond Schedule (Contd.)

AVERAGE RESIDENT FUNDS MONTHLY BALANCE	REQUIRED SURETY BOND AMOUNT
$4,401 to $4,500	$5,625
$4,501 to $4,600	$5,750
$4,601 to $4,700	$5,875
$4,701 to $4,800	$6,000
$4,801 to $4,900	$6,125
$4,901 to $5,000	$6,250
$5,001 to $5,100	$6,375
$5,101 to $5,200	$6,500
$5,201 to $5,300	$6,625
$5,301 to $5,400	$6,750
$5,401 to $5,500	$6,875
$5,501 to $5,600	$7,000
$5,601 to $5,700	$7,125
$5,701 to $5,800	$7,250
$5,801 to $5,900	$7,375
$5,901 to $6,000	$7,500
$6,001 to $6,100	$7,625
$6,101 to $6,200	$7,750
$6,201 to $6,300	$7,875
$6,301 to $6,400	$8,000
$6,401 to $6,500	$8,125
$6,501 to $6,600	$8,250
$6,601 to $6,700	$8,375

Table 64-14 A Surety Bond Schedule (Contd.)

AVERAGE RESIDENT FUNDS MONTHLY BALANCE	REQUIRED SURETY BOND AMOUNT
$6,701 to $6,800	$8,500
$6,801 to $6,900	$8,625
$6,901 to $7,000	$8,750
$7,001 to $7,100	$8,875
$7,101 to $7,200	$9,000
$7,201 to $7,300	$9,125
$7,301 to $7,400	$9,250
$7,401 to $7,500	$9,375
$7,501 to $7,600	$9,500
$7,601 to $7,700	$9,625
$7,701 to $7,800	$9,750
$7,801 to $7,900	$9,875
$7,901 to $8,000	$10,000
$8,001 to $8,100	$10,125
$8,101 to $8,200	$10,250
$8,201 to $8,300	$10,375
$8,301 to $8,400	$10,500
$8,401 to $8,500	$10,625
$8,501 to $8,600	$10,750
$8,601 to $8,700	$10,875
$8,701 to $8,800	$11,000
$8,801 to $8,900	$11,125
$8,901 to $9,000	$11,250

Table 64-14 A Surety Bond Schedule (Contd.)

AVERAGE RESIDENT FUNDS MONTHLY BALANCE	REQUIRED SURETY BOND AMOUNT
$9,001 to $9,100	$11,375
$9,101 to $9,200	$11,500
$9,201 to $9,300	$11,625
$9,301 to $9,400	$11,750
$9,401 to $9,500	$11,875
$9,501 to $9,600	$12,000
$9,601 to $9,700	$12,125
$9,701 to $9,800	$12,250
$9,801 to $9,900	$12,375
$9,901 to $10,000	$12,500
$10,001 or more	Calculate[8]

[8] 1.25 times the prior year's average monthly balance of client's funds