

CALIFORNIA

Citation Residential care facilities for the elderly (RCFEs) Title 22, Division 6, Chapter 87100-87730

General Approach and Recent Developments

A series of changes are being implemented following passage of several bills by the legislature. The changes replace the exceptions requirements for facilities serving people with health conditions with requirements for documentation, staff training and oversight, add requirements for special care facilities, and admissions agreements. Due to budget reductions, the licensing agency is unable to continue its technical support program that provided consultation to facilities. Staffing shortages have also changed the schedule for inspection visits. Instead of inspecting each facility annually, a sample of facilities will be visited each year.

The Department of Health Services (DHS) was directed by the legislature to develop a pilot program to test two models for covering assisted living services under a Medicaid HCBS waiver. One model will cover services in licensed residential care facilities for the elderly and the second will deliver services in elderly housing settings.

The Community Care Licensing Division plans to revise and post technical guides on their Web site. The Web site includes a manual that interprets regulations and gives guidance to facilities about how to apply the rules.

Category	Supply					
	2004		2002		2000	
	Facilities	Units	Facilities	Units	Facilities	Units
Residential care facilities for the elderly	6,543	154,830	6,207	147,580	6,152	136,719

Definition

A residential care facility for the elderly is defined as a housing arrangement chosen voluntarily by the resident--or the resident's guardian, conservator, or other responsible person--where 75 percent of the residents are 60 years of age or older, or, if younger, have needs compatible with other residents, and where varying levels of care and supervision are provided, as agreed to at time of admission or as determined necessary at subsequent times of reappraisal.

Unit Requirements

Occupancy is limited to two residents per bedroom, which must be large enough to accommodate easy passage between beds, required furniture, and assistant devices such as wheelchairs or walkers. One toilet and sink is required for every six residents and a bathtub or shower for every 10 residents.

Admission/Retention Policy

Facilities may admit or retain residents who are capable of administering their own medications; receive medical care and treatment outside the facility or from a visiting nurse; residents who need to be reminded to take medications; and people with mild dementia or mild temporary emotional disturbance resulting from personal loss or change in living arrangement. Facilities may not admit or retain anyone with a communicable disease; anyone who requires 24-hour skilled nursing or intermediate care. The regulations allow residents with health conditions requiring incidental medical services which are specified in the rules (e.g., administration of oxygen, catheter care, colostomy/ileostomy care, contractures, diabetes, enemas, suppositories, and/or fecal impaction removal, incontinence of bowel and/or bladder, injections, intermittent positive pressure breathing machine, and Stage 1 and 2 dermal ulcers) to be admitted and retained if the resident can perform the care or a licensed professional provides care. Facilities may not serve people who require care for Stage 3 and 4 dermal ulcers, gastrostomy care, naso-gastric tubes, tracheostomies, staph infection or other serious infection, and/or who depend on others to perform all activities of daily living.

Residents who will be bedridden more than 14 days may be retained if the facility notifies the Department of Social Services that the condition is temporary.

Nursing Home Admission Policy

Beneficiaries must have a medical condition that requires an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration.

Services

Services are divided into (1) basic services and (2) care and supervision. Basic services include safe and healthful living accommodations; personal assistance and care; observation and supervision; planned activities; food service; and arrangements for obtaining incidental medical and dental care. Care and supervision covers assistance with activities of daily living and assumption of varying degrees of responsibility for the

safety and well being of residents. Tasks include assistance with dressing, grooming, bathing, and other personal hygiene; assistance with self-administered medications; and central storing and distribution of medications.

Legislation enacted a few years ago requires that RCFEs inform residents that they have the right to have an advance directive. A brochure explaining advance directives was developed for care providers to give residents.

Legislation enacted in 1994 allows hospice care provided the resident contracts individually with a hospice agency. Facilities must request a waiver to allow hospice care and be able to meet the resident's needs when the hospice agency is not present. If the resident shares a room, the other party needs to agree to allow hospice care in the shared living space.

Dietary

The total daily diet must meet the recommended dietary allowances of the Food and Nutrition Board of the National Research Council. At least three meals and snacks must be provided in facilities that have responsibility for all food arrangements. Meals must include an appropriate variety of foods, planned in consideration of cultural and religious backgrounds and resident preferences. Modified diets prescribed by physicians are provided. Facilities with 16 to 49 residents must designate one person with appropriate training to be responsible for food planning, service, and preparation. Staff must have training or related experience on the assigned job tasks.

Agreements

Admission agreements must be signed within 7 days of admission and include provisions for: the basic services available; optional services; payment provisions (basic rate, optional service rate, payer, due date, funding source); process for changing the requirements and a 60-day notice; and refunds.

Legislation passed in 2003 (SB 211, Chapter 211, Statutes of 2003), adds Health and Safety (H&S) Code Sections 1569.880 through 1569.888 to ensure that RCFE admission agreements do not violate residents' rights and to provide residents with the information necessary to make informed choices. Many requirements overlap existing statutes or regulations in Title 22 California Code of Regulations (CCR) chapter 6. The applicability of some requirements will depend on the type of services provided by the facility. The law specifies that the admission agreement includes the following: a comprehensive description of any items and services provided under a single fee; a comprehensive description of, and the fee schedule for, all items and services not included in a single fee; the resident shall receive a monthly statement itemizing all separate charges incurred by the resident and authorized by the admission agreement;

a statement acknowledging the acceptance or refusal to purchase the additional services shall be signed and dated by the resident or the resident's representative and attached to the admission agreement; an explanation of the use of third-party services within the facility that are related to the resident's service plan, including, but not limited to, ancillary, health, and medical services, how they may be arranged, accessed, and monitored, any restrictions on third-party services, and who is financially responsible for the third-party services; a comprehensive description of billing and payment policies and procedures; the conditions under which rates may be increased; the facility's policy concerning family visits and other communication with residents; refund policy; conditions under which the agreement may be terminated; and an explanation of the resident's right to notice prior to an involuntary transfer, discharge, or eviction, the process by which the resident may appeal the decision and a description of the relocation assistance offered by the facility.

Provisions for Serving People with Dementia

During 1995, legislation (Chapter 550 of the Acts of 1995) was passed that allows RCFEs that serve people with dementia to develop secure perimeters. Based on the results of a pilot project, the law allows facilities that meet specific additional requirements to secure exterior doors or perimeter fences, or to install delayed egress devices on exterior doors and perimeter fence gates. Resident supervision devices-- wrist bracelets that activate a visual or auditory alarm when a resident leaves the facility--may also be used. Facilities must provide interior and exterior space for residents to wander freely, must receive approval from the local fire marshal, and must conduct quarterly fire drills. Facilities with delayed egress devices must be sprinklered and contain smoke detectors, and the delayed egress devices must deactivate when the sprinkler system or smoke detectors activate. The devices must also be able to be deactivated from a central location and deactivate when a force of 15 pounds is applied for more than two seconds to the panic bar. In addition, facilities shall permit residents to leave, who continue to indicate such a desire, and staff must ensure continued safety. Reports must be submitted when residents wander away from the facility without staff. Delayed egress devices may not substitute for staff.

Facilities may admit and retain people with dementia who are not able to respond to verbal instructions to leave a building without assistance provided they have:

- A plan of operation which specifically addresses the needs of residents with dementia;
- A training plan which ensures that facility staff can meet the needs of residents;
- An activity program and resident assessment and re-assessment procedures;
- Procedures to notify physicians when behavior changes;
- A written plan to minimize the use of psycho-tropic medications; and
- A disaster and mass casualty plan.

Medication Administration

Facility staff may assist with self-administration of medications and, if authorized by law, administer injections. Medications may also be administered by licensed home health agency personnel.

Public Financing

The California legislature (HB 499, 2000) directed the Department of Health Services to develop an Assisted Living Waiver Pilot Project (ALWPP) in three counties: Sacramento, San Joaquin and Los Angeles, and will serve 1,000 people over 3 years in two different settings--licensed RCFEs and conventional elderly housing sites. About 100 sites are expected to participate in the pilot. An HCBS waiver will be submitted to CMS to implement the pilot. The pilot defines assisted living based on the work of the Assisted Living Work group:

“Assisted living is a state regulated and monitored residential long-term care option. Assisted living provides or coordinates oversight and services to meet the residents’ individualized scheduled needs, based on the residents’ assessments and service plans and their unscheduled needs as they arise.”

The pilot will require private occupancy, with shared occupancy only by residents’ choice. Units will have a kitchen area equipped with a refrigerator, a cooking appliance (microwave is acceptable), and storage space for utensils and supplies.

The project developed a four-tiered payment methodology based on the tiers used in Arkansas. The bundled rate will include payment for the following services: 24-hour awake staff to provide oversight and meet the scheduled and unscheduled needs; provision and oversight personnel and supportive services (assistance with activities of daily living and instrumental activities of daily living); health related services (e.g., medication management services); social services; recreational activities; meals; housekeeping and laundry; and transportation

As of January 1, 2004 the SSI/State Supplement in licensed facilities is \$853 a month with a personal needs allowance of \$111. The remainder of \$742 pays for Room and Board.

Staffing

Administrators of facilities with 16 to 49 beds must have 15 college credits and in facilities with 50 or more units, 2 years of college or 3 years of experience or equivalent education and experience. Administrators who do not have a license must complete a certification program and 12 hours of classroom training.

Sufficient staff must be employed to deliver services required by residents. On-the-job training or experience is required in the principles of nutrition, food storage and preparation, housekeeping, and sanitation standards; skill and knowledge to provide necessary care and supervision; assistance with medications; knowledge to recognize early signs of illness; and knowledge of community resources.

Requirements for awake staff vary by the size of the facility. For 16 or fewer, staff must be available in the facility; 16 to 100, at least one awake staff; 101 to 200, one on call and one awake, with an additional awake staff for each additional 100 residents.

Training

Administrators. Individuals shall complete an approved certification program prior to being employed as an administrator. The program must include 40 hours of classroom training which covers laws, rights, regulations, and policies (12 hours); business operations (3 hours); management and supervision (3 hours); psycho-social needs of the elderly (5 hours); physical needs of the elderly (5 hours); community and support services (2 hours); use, misuse, and interaction of drugs (5 hours); and admission, retention, and assessment procedures (5 hours). All administrators shall be required to complete at least 20 clock hours of continuing education per year in areas related to aging and/or administration.

Staff. Personnel must be given on-the-job training or have related experience in: the principles of good nutrition, good food preparation and storage and menu planning; housekeeping and sanitation procedures; skill and knowledge required to provide necessary resident care and supervision including the ability to communicate with residents; knowledge required to safely assist with prescribed medications which are self-administered; knowledge necessary in order to recognize early signs of illness and the need for professional help; and knowledge of community services and resources.

Facilities licensed for 16 or more must have a planned on-the-job training program in the above areas including orientation, skill training, and continuing education.

Background Check

The licensing agency conducts a criminal background check of officers of the organization, staff responsible for administration and direct supervision, persons providing direct care, and employees having frequent contact with residents and others and may approve or deny a license or employment based on its findings. A fingerprint clearance shall be received by the licensing agency on all persons subject to criminal record review prior to issuing a license. All facility staff must be fingerprint cleared prior to their physical presence in the facility.

Monitoring

Facilities are inspected on a rotating basis. Facilities are inspected on a random sample basis, but at least once every 5 years. Facilities that require “targeted visits” will be visited on an annual basis. These consist of facilities that need closer attention because of their compliance histories. Three levels of penalties are allowed for violations with an (A) immediate, (B) potential, and (C) technical impact. Fifty dollars per day civil penalties are allowed for A and B violations increasing to \$100 per day if the same violation is repeated three times in a 12-month period. Consultation is provided for Type C violations. The licensing agency is mandated to conduct an investigation within 10 days on any complaint received against a facility.

Fees

Licensing fees required at initial licensure and annually thereafter are adjusted by facility size: 1 to 6--\$375, 7 to 15--\$563, 16 to 49--\$750, and 50+--\$938 (effective August 4, 2003). A proposal to increase the licensing fees due to declines in state revenues is pending.

STATE RESIDENTIAL CARE AND ASSISTED LIVING POLICY: 2004

PDF Files Available for This Report

Cover, Table of Contents, and Acknowledgments

<http://aspe.hhs.gov/daltcp/reports/04alcom.pdf>

SECTION 1: Overview of Residential Care and Assisted Living Policy

<http://aspe.hhs.gov/daltcp/reports/04alcom1.pdf>

SECTION 2: Comparison of State Policies <http://aspe.hhs.gov/daltcp/reports/04alcom2.pdf>

SECTION 3: State Summaries <http://aspe.hhs.gov/daltcp/reports/04alcom3.pdf>

Also available: A complete list of sections and tables, with HTML and PDF links to each, is available at <http://aspe.hhs.gov/daltcp/reports/04alcom.htm>. This table of contents also includes links to Section 3 summaries, broken down by state.