MAINE

Citation Assisted Living Programs: 10-149 Chapter 113

General Approach and Recent Developments

The state licenses five types of facilities providing assisted living services -- ALPs and four levels of RCFs. The levels vary primarily by size. RCFs may offer the same services ALPs do, but provide bedrooms rather than apartment units. The scope sections of the rules establish a philosophy of regulation to support services that are individualized to meet resident needs and encourage each resident's right to independence, choice and decision making, while providing a safe environment.

Minor revisions to the regulations were made in 2006. Legislation is pending that would provide injunctive relief to intervene with unlicensed facilities and to set maximum fines that may be imposed for licensing violations.

Adult Foster Care

The licensing rules include requirements based on the size of the facility, ownership and staffing.

Web Address	Content
http://www.maine.gov/dhhs/beas/alls/assisted.htm	Rules, list

Supply							
Category	2007		2004		Category	2000	
	Facilities	Units	Facilities	Units		Facilities	Units
Level I residential care facility	67	121	95	161	Level I residential care facility	473	1,711
Level II and III residential care facility	396	1,675	415	1,785	Level II residential care facility	192	5,220
Level IV residential care facility	184	5,283	201	5,647			
Assisted living program	34	1,624	30	1,429	Congregate housing	24	1,133

Definition

Assisted living services means the provision by an ALP, either directly by the provider or indirectly through contracts with persons, entities or agencies, of assisted living services which include personal supervision; protection from environmental hazards; assistance with ADLs and IADLs; diversional, motivational or recreational activities; dietary services; care management services; administration of medications; and nursing services.

Assisted living services may be provided in two types of settings -- ALPs and RCFs. RCFs are further divided into four subgroups.

Assisted living program means a program of assisted living services provided to consumers in private apartments in buildings that include a common dining area, either directly by the provider or indirectly through contracts with persons, entities or agencies. The types of ALPs governed by these regulations include:

- Type I -- an ALP that provides assisted housing services and medication administration directly or indirectly through contracts with persons, entities or agencies.

- Type II -- an ALP that provides assisted housing services, medication administration and nursing services directly or indirectly through contracts with persons, entities or agencies to provide services of a registered professional nurse; and/or registered professional nurse coordination and oversight of consumer services provided by unlicensed health care assistive personnel.

Residential care facility means a house or other place that, for consideration, is maintained wholly or partly for the purpose of providing residents with assisted living services.

[**NOTE**: Both ALPs and RCFs provide assisted living services. The definition of the living unit differs.]

RCFs provide housing and services to residents in private or semi-private bedrooms in buildings with common living areas and dining areas. There are four types of RCFs:

- Level I -- licensed capacity of 1-2 residents (licensing is voluntary for this group).
- Level II -- licensed capacity of 3-6 residents.
- Level III -- licensed capacity of 3-6 residents and which employs three or more persons who are not owners and are not related to the owner.
- Level IV -- licensed capacity of more than six residents.

Alzheimer's/dementia care unit means a unit, facility, or distinct part of a facility that provides care/services in a designated separate area for residents with Alzheimer's disease or other dementia. The unit, facility, or distinct part provides specialized programs, services, and activities and is locked, segregated, or secured to provide or limit access by a resident outside the designated or separated area.

Unit Requirements

ALPs are multi-unit residential buildings that provide apartments and must meet state and local building codes.

Level I-IV RCFs must offer 100 square feet for single rooms and 80 square feet for double rooms. Level IV facilities provide one toilet and sink for every six residents. Facilities licensed

on or after May 30, 2002, must have one bathing facility for ten users (one for 15 residents for facilities licensed prior to May 30, 2002). No more than two residents may share a room.

Admission/Retention Policy

The rules encourage aging-in-place and have very flexible policies to achieve that goal. In its application, all facilities must describe who may be admitted and the types of services, including the scope of nursing services, to be provided. Facilities may discharge tenants who pose a direct threat to the health and safety of others, damage property, or whose continued occupancy would require modification of the essential nature of the program. The rules also require facilities to permit reasonable modifications at the expense of the tenant or other willing payer to allow persons with disabilities to reside in licensed facilities. Providers may require the disabled individual to return the premises to its prior condition.

Nursing Home Admission Policy

Individuals must meet medical, medical/functional or cognitive/behavior requirements. Individuals must have a need for daily skilled nursing *or* extensive assistance in three of the following ADLs: bed mobility, transfer, locomotion, eating and toileting; *or* a combination of three needs in the following areas: skilled nursing, cognition, behavior, and at least limited assist in one of the following ADLs: bed mobility, transfer, locomotion, eating and toileting.

The list of nursing services includes any specified physician-ordered services provided on a frequent rather than daily basis; professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability; professional nursing assessment, observation, and management for problems including wandering, physical abuse, verbal abuse or socially inappropriate behavior; administration of treatments, procedures, or dressing changes that involve prescription medications and require nursing care and monitoring; and professional nursing for physician-ordered radiation therapy, chemotherapy, or dialysis. Skilled services also include physician-ordered occupational, physical, or speech/language therapy or some combination of the three, which must require the professional skills of a licensed or registered therapist.

The cognition and/or behavior requirements apply for individuals who do not require professional nursing intervention at least three days per week but are eligible if they have a qualifying score on the Cognitive Screen and/or Behavioral Screen, in combination with a need for at least “limited assistance” with an ADL, for a total of three service needs. The qualifying scores are cognitive score = 13 points and two ADL’s; or cognitive score = 13 points, and behavioral score = 14 and one ADL; or behavioral score = 14 points and two ADL’s.

Services

All facility levels are required to describe the scope of services provided, including scope of nursing services consistent with applicable state and federal law as part of their licensing application.

ALPs must offer service coordination, housekeeping services, assistance with ADLs and IADLs, at least one nutritious meal a day, chore services and other services identified in a service plan.

Level I, II, and III residents have the right to receive assistance from the provider to implement any reasonable plan of service developed with community or state agencies.

Level IV residents are able receive individualized services that help them age in place, function optimally in the facility and in the community, engage in constructive activity, and manage their health conditions and accommodate individual choices and preferences. The regulations require reasonable accommodation in regulations, policies, practices or services, including permitting reasonable supplementary services to be brought into the facility/program unless it imposes an undue financial burden or results in a fundamental change in the program.

Residents must be assessed within 30 calendar days of admission and reassessed annually or when there is a significant change in condition. A service plan must be developed and implemented within 30 calendar days of admission based upon the assessment. The plan addresses areas in which the resident needs encouragement, assistance or an intervention strategy. The plan describes strategies and approaches to meet the resident's needs, names of who will arrange and/or deliver services, when and how often services will be provided and goals to improve or maintain the resident's level of functioning. Residents are encouraged to be as independent as possible in their functioning, including ADLs and normal household tasks if they choose, unless contraindicated by the resident's duly authorized licensed practitioner.

Dietary

Assisted living program. A registered dietician must approve menus and menu cycles annually. Menus must be planned in accordance with resident needs and preferences. Therapeutic diets must be ordered by any duly licensed practitioner in all levels. A least one nutritious meal a day must be delivered by the ALP.

Levels I-IV require a nourishing, well-balanced diet that meets the daily nutritional and special dietary needs of each resident and that meets the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences (NAS). Level IV facilities must have a meal plan that provides three meals in a 24-hour period and a dietary coordinator who has experience and/or training in food service suitable to the size of the facility.

Agreements

The state requires adoption of a standard contract for all assisted living services. All resident contracts contain standard provisions regarding services and accommodations to be provided and the rates and charges for such and any other related charges not covered by the facility/program's basic rate. Each contract may not contain a provision for the discharge of a resident that is inconsistent with state law or rule; a provision that may require or imply a lesser standard of care or responsibility than is required by law or rule; provide for at least 30 calendar day's notice prior to any changes in rates, responsibilities, services to be provided or any other items included in the contract; may not require a deposit or other prepayment, except one month's rent in an ALP, which may be used as a security deposit provided there is a statement of the explicit return policy of the facility with regard to the security deposit; and may not contain a provision that provides for the payment of attorney fees or any other cost of collecting payments from the resident. Additional information is appended to the contract -- grievance procedure, tenancy obligations, resident rights, and a copy of the admissions policy.

In addition, an information packet must also be provided that contains advance directives information; information regarding the type of facility and the licensing status; the Maine Long-Term Care Ombudsman Program brochure; toll-free telephone numbers for the Office of Advocacy of the Department of Behavioral and Developmental Services (BDS) if the facility has residents who receive services from BDS; Adult Protective Services; Assisted Living Licensing Services and Division of Licensing and Certification; the process and criteria for placement in, or transfer or discharge from, the program; and the program's staff qualifications.

Provisions for Serving People with Dementia

The provisions for serving people with dementia apply to all levels. Facilities must provide written information about their philosophy; the process used for resident assessment and establishment of a residential services plan and its implementation; the physical environment and design features that support the functioning of adults with cognitive impairments; the frequency and types of group and individual activities provided by the program; a description of family involvement and the availability of family support programs; a description of security measures provided by the facility; a description of in-service training provided for staff; and policies with criteria and procedures for admission and discharge of residents to and from the facility/unit.

The design must include secured outdoor space and walkways; high contrast between floors, walls, and doorways; non-reflective surfaces; and even lighting to minimize glare. Residents may not be locked inside or outside of their rooms. Residents are encouraged and assisted to decorate their unit with personal items and furnishings. Facilities try to individually identify each resident's room to help with recognition. Facilities also have policies and procedures to deal with wandering. Electronic locking devices may be used on exterior doors if they release in an emergency.

These facilities must provide individual and/or group activities covering gross motor skills, self care, social interaction, crafts, sensory enhancement, as well as outdoor and spiritual activities.

For pre-service training, all facilities with Alzheimer's/dementia care units must provide a minimum of eight hours of classroom orientation and eight hours of clinical orientation to all new employees assigned to the unit. The trainer(s) shall be qualified with experience and knowledge in the care of individuals with Alzheimer's disease and other dementias. In addition to the usual facilities orientation, which should cover such topics as resident rights, confidentiality, emergency procedures, infection control, facility philosophy related to Alzheimer's disease/dementia care, and wandering/egress control, the eight hours of classroom orientation should include the following topics: a general overview of Alzheimer's disease and related dementias, communication basics, creating a therapeutic environment, activity focused care, dealing with difficult behaviors, and family issues.

Medication Administration

Unlicensed staff who have successfully completed a training program approved by the licensing agency may administer medications and/or treatments. All residents are assessed for their ability to self-administer medications or their need for assistance. A standard curriculum for training in medication administration was adopted for use statewide.

Public Financing

Maine covers services in RCFs under the Medicaid state plan. The state plan program provides reimbursement for personal care services through contracts with Private Non-Medical Institutions (PNMIs). A PNMI is defined "as an agency or facility that is not, as a matter of regular business, a health insuring organization, hospital, nursing home, or a community health care center, that provides food, shelter, and treatment services to four or more residents in single or multiple facilities or scattered site facilities."

MaineCare (Medicaid) reimburses assisted living providers for the services based on individual case-mix or resource group classifications. The $42 base price per day is adjusted based on the resource group assigned. The base price is the price set for reimbursement for assisted living services for all members receiving a MaineCare weight of 1.0, based on the minimum data set-assisted living services (MDS-ALS) assessment tool. The base price is then adjusted by a resource group weight to calculate a resource adjusted price. Each resident receives a score of "0" or "1" for each of nine indicators from the MDS-ALS including: use of incontinence supplies, medication administration, depression, resident did not administer PRN medications, resident needs help with phoning or arranging transportation, physician order changes, or modified cognitive skills. The nine indicators are summed to create the assisted living score (ALS), ranging from 0-9. Indicators for need for assistance with ADLs and IADLs are scored scores ranging from 0-28. The ALS and ADL/IADL score are used to assign members to one of eight resource groups. They will also assess a $13.65 program allowance to this

resource-adjusted price, resulting in a range of $36.59-$83.24 per day for assisted living services. Individuals in resource group "7-9" (ALS of 7-9 and an ADL score of 7-28) is weighted 1.657. The $42 base price is adjusted by 1.657 to produce the resource-adjusted price of $69.59.

Resource Weight Group Chart			
Resource Group	**Order**	**Description**	**MaineCare Weight**
Assisted living score 7-9	1	ADL = 7-28	1.657
	2	ADL = 0-6	1.210
Assisted living score 5-6	3	ADL = 7-8	1.360
	4	ADL = 0-6	1.027
Assisted living score 2-4	5	IADL = 12-18	0.924
	6	IADL = 10-11	0.804
Assisted living score 0-1, or assisted living score 2-4 and IADL 0-9	7	IADL = 0-9	0.551
Unclassified	8	Unclassified	0.551

Medicaid Participation					
2007		**2004**		**2002**	
Facilities	**Participation**	**Facilities**	**Participation**	**Facilities**	**Participation**
211	4,571	150	3,762	151	3,096

The state SSI payment standard $623 which includes PNA of $70/month ($50 if there is no earned income). State general fund are available to supplement the resident's room and board payment when the allowable cost of room and board exceeds the resident cost of care. A state-funded demonstration program is now a permanent part of the Medicaid program[2] and serves beneficiaries in affordable ALPs.

Staffing

Administrators

Assisted living programs. The sponsor must assure that services will be provided to residents in accordance with individual service plans. Administrators must hold a professional license related to residential or health care or have a combination of five years of related education and experience.

Residential care facilities. Level IV administrators must demonstrate capacity to operate and manage the facility and allow access to records of professional licensing boards or registers, any criminal record, child protective record or adult protective record relating to the applicant/licensee and administrator, and other records.

Administrators must successfully complete a Department-approved training program for administrators unless they have a license from the Nursing Home Administrators Licensing Board as a Residential Care Administrator or Multi-Level Facility Administrator. They must obtain 12 hours a year of continuing education.

[2] See regulations at http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s006.doc.

Staff

Levels I and II. Operators must have a person available to provide supervision in their absence. Staffing must be adequate to implement service plans. The department may require additional staff based on the needs of residents and the size and lay out of the facility.

Level III. Staffing must be adequate to implement service plans. Additional staffing may be required by the Department. The licensing agency has the authority to require that Level I–III facilities obtain services from a consulting nurse, pharmacist or dietician and a consulting dietician for Level IV facilities.

Level IV. RCFs serving over ten residents must have two awake staff on duty at night (one must be direct care staff. The rules require a ratio of one direct care staff to12 residents from 7 a.m. to 3 p.m.; one direct care staff to 18 residents from 3 p.m. to 11 p.m.; and one direct care staff to 30 residents from 11 p.m. to 7 a.m. The revised rules require a RN on staff or contract to observe signs and symptoms; review records, medication records, medication administration practices and procedures, and therapeutic diets; and recommend staff training. The frequency of these activities varies with the size of the facility from weekly for larger facilities to quarterly for smaller facilities.

Level IV facilities with more than ten beds must have a pharmacy consultant no less than quarterly to review written policies and procedures for pharmaceutical services; medication areas for labeling, storage, temperature, expired medications, locked compartment, access to keys and availability and completeness of a first aid kit; review to ensure that only approved drugs and biologicals are used in the facility; review medication records and initial and date the records when reviewed; review adherence to stop orders; and review staff performance in carrying out pharmaceutical policies and procedures.

Training

Administrators must successfully complete a department approved training program. On-going training of at least 12 classroom hours annually is required in areas related to care of the population served.

Staff -- Level I, II, III. Residential care staff must attend and show evidence of successful completion of any training that the department determines to be necessary.

Level IV. All staff, other than CNAs and licensed professional staff, whose job responsibilities include direct service to residents for at least 20 hours per week, shall successfully complete a Personal Support Specialist certification course within 120 days of hiring. Additional training specific to a facility's programs may be identified and required by the Department for any staff.

Any person working in the facility must demonstrate the following: conduct which demonstrates an understanding of, and compliance with, residents' rights; the ability and

willingness to comply with all applicable laws and regulations; the ability to provide safe and compassionate services; and a history of honest and lawful conduct.

Individuals who administer medications in Levels III and IV must complete a training program approved by the department and must have eight hours of refresher training every two years. If the training program is substantially revised, they must be re-certified within one year of the change.

Background Check

During the licensure process, a criminal background check is conducted for the applicant and the administrator. Facilities must contact the CNA Registry and determine that the CNA or CNA-M is on the Registry and has not been annotated. Facilities may not employ a CNA or CNA-M who is not on the Registry, or who has been annotated for abuse, neglect or misappropriation of patient/client/resident funds in a health care setting. Further changes are pending that would expand the types of individuals for whom the registry must be checked and who may not be employed if there is a positive finding.

Monitoring

The department is authorized to make regular and unannounced inspections of all facilities. The regulations specify the grounds for imposition of intermediate sanctions and the method of calculating penalties. The state ombudsman program is authorized to visit facilities and receive and investigate complaints.

Fees

Chapter 1664 sets fees of $10 per bed for RCFs and $200 for ALPs.

RESIDENTIAL CARE AND ASSISTED LIVING COMPENDIUM: 2007

Files Available for This Report

REPORT INTRODUCTION (*including Cover, Table of Contents, Acknowledgments, and Acronyms*)

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom.pdf

SECTION 1. Overview of Residential Care and Assisted Living Policy

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.pdf

SECTION 2. Comparison of State Policies

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.pdf

SECTION 3. State Summaries

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.pdf

Each state's summary can also be viewed separately at:

Alabama	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAL.pdf
Alaska	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAK.pdf
Arizona	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAZ.pdf
Arkansas	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAR.pdf
California	http://aspe.hhs.gov/daltcp/reports/2007/07alcomCA.pdf
Colorado	http://aspe.hhs.gov/daltcp/reports/2007/07alcomCO.pdf
Connecticut	http://aspe.hhs.gov/daltcp/reports/2007/07alcomCT.pdf
Delaware	http://aspe.hhs.gov/daltcp/reports/2007/07alcomDE.pdf
District of Columbia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomDC.pdf
Florida	http://aspe.hhs.gov/daltcp/reports/2007/07alcomFL.pdf

Georgia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomGA.pdf
Hawaii	http://aspe.hhs.gov/daltcp/reports/2007/07alcomHI.pdf
Idaho	http://aspe.hhs.gov/daltcp/reports/2007/07alcomID.pdf
Illinois	http://aspe.hhs.gov/daltcp/reports/2007/07alcomIL.pdf
Indiana	http://aspe.hhs.gov/daltcp/reports/2007/07alcomIN.pdf
Iowa	http://aspe.hhs.gov/daltcp/reports/2007/07alcomIA.pdf
Kansas	http://aspe.hhs.gov/daltcp/reports/2007/07alcomKS.pdf
Kentucky	http://aspe.hhs.gov/daltcp/reports/2007/07alcomKY.pdf
Louisiana	http://aspe.hhs.gov/daltcp/reports/2007/07alcomLA.pdf
Maine	http://aspe.hhs.gov/daltcp/reports/2007/07alcomME.pdf
Maryland	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMD.pdf
Massachusetts	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMA.pdf
Michigan	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMI.pdf
Minnesota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMN.pdf
Mississippi	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMS.pdf
Missouri	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMO.pdf
Montana	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMT.pdf
Nebraska	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNE.pdf
New Hampshire	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNH.pdf
New Jersey	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNJ.pdf
New Mexico	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNM.pdf
New York	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNY.pdf
Nevada	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNV.pdf
North Carolina	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNC.pdf
North Dakota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomND.pdf
Ohio	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOH.pdf
Oklahoma	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOK.pdf
Oregon	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOR.pdf
Pennsylvania	http://aspe.hhs.gov/daltcp/reports/2007/07alcomPA.pdf
Rhode Island	http://aspe.hhs.gov/daltcp/reports/2007/07alcomRI.pdf
South Carolina	http://aspe.hhs.gov/daltcp/reports/2007/07alcomSC.pdf
South Dakota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomSD.pdf
Tennessee	http://aspe.hhs.gov/daltcp/reports/2007/07alcomTN.pdf
Texas	http://aspe.hhs.gov/daltcp/reports/2007/07alcomTX.pdf
Utah	http://aspe.hhs.gov/daltcp/reports/2007/07alcomUT.pdf

Vermont	http://aspe.hhs.gov/daltcp/reports/2007/07alcomVT.pdf
Virginia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomVA.pdf
Washington	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWA.pdf
West Virginia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWV.pdf
Wisconsin	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWI.pdf
Wyoming	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWY.pdf