



Oklahoma State
Department of Health

Ad Hoc Assisted Living Regulation Review Committee

Appointed by the Long Term Care Facility Advisory Board August 11, 2004

August 17, 2006 Special Meeting

1:30 p.m.

Shepherd Mall

Aging Services Division

2401 NW 23rd St. – Suite 40

Roy Keen Conference Room

Oklahoma City, OK

AMENDED

Minutes

Consensus reached October 12, 2006.

1) Call to Order

Esther Houser called the special meeting to order at 1:33 p.m. Thursday, August 17, 2006. The meeting notice was filed and posted with the Secretary of State's office June 28, 2006. The agenda was posted at the front entrance of OSDH, and the front entrance of Aging Services Division, DHS, on August 16, 2006.

Introductions proceeded. Identified attendees were: Esther Houser, Committee Chair, State Long-Term Care (LTC) Ombudsman and LTC Facility Advisory Board (LTCFAB) member; L. Dewey Sherbon, LTCFAB member; James Joslin, Assistant Chief, LTC, OSDH; Kay Stewart, Tamarack-Altus; Dorothy Cassel, President, OSHL; Belinda Arguello, Silver Oak Senior Living; Wendell Short, RC Administrator and LTCFAB member; Bill Pierce, Baptist Village Communities; George Gibbs, Attorney, Gibbs & Armstrong; Brett Lessley, OAHCP; Dorya Huser, Chief, LTC, OSDH; Penny Ridenour, Executive Director, Oklahoma Assisted Living Association (OKALA); Greg Guymon, OKALA & Gold Medallion; Lavonne Kroeker, Golden Oaks; Ginny Rahme, AL and LTCFAB member; Diane Hambric, Residential Care (RC) and LTCFAB Chair; Chris Mahen, Brookdale; Eric Lindsey, Silver Oak; Mary Brinkley, Oklahoma Association for Homes and Services for the Aging (OKAHS); Norma Noles, Silver Oak; Martin Hall, Corn Heritage Village; Kay Parsons, LPN and LTCFAB member; L. Louise Drake, OK Board of Nursing; Stefanie Beesley, Silver Oak; James Duchning, Silver Oak; Janine McCullough, APS LTCI; Beth M. Mell, Alterra; Rita Carter, Alterra; Mary Womack, General Counsel, OSDH; Donna Bowers, Daily Living Centers and LTCFAB member; Adrienne Vasquez, OSDH; Grant Gilchrist, Arbor House; Clara Haas, LTCFAB member; Tammy Crawford, Intern at OKALA; Jan Ellis; Bryan Moore, Legend Senior Living; Sue Harris; Helen Patrick; Amy Talley, Sunrise – BG of Tulsa; Linda Smith, Sunrise – BG of Tulsa; Kathleen Best, Touchmark at Coffee Creek; Christian Sangree, Senior Care Services; Stacy Scott, Allevé Home Care & Hospice; Shaye Tipton, Arbor House; Angie Shepherd, Silver Oak Senior Living; Macy Tooke, AL-Family; Loree Smith, The Parke Assisted Living; Patricia Shidler, LTC Ombudsman Program; Tricia A. Coleman, Jean Coleman Family/Self; John Gatliff,

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Attorney, C. Craig Cole & Associates and OKALA; C. Craig Cole, Attorney, C. Craig Cole & Associates and OKALA; Jim Killackey, Oklahoman Newspaper; Chris Kincaid, AL and LTCFAB member; Mary Ann Duncan, Alzheimer's Association; Neeley Snyder, Alzheimer's Association; Germaine Odenheimer, M.D., OUHSC; William P. *last name illegible*, Sojourn Care; Vicki Estes, MSW, Sojourn Care; Rosalie *last name illegible*, LCSW, Sojourn Care; Deborah Holmes, Sojourn Care; *name illegible*, Alzheimer's Association; Vickie Trent, Countrywood Assisted Living-Silver Oak; Amy Talley, Sunrise – BG of Tulsa; Amy Camarala, Vistech; Kristina Bolin, Weatherwood Assisted Living – Silver Oak; Rachel Boggess, Integris; Sean Voskuhl, AARP; and Leslie Roberts, LTC, OSDH.

2) Review of the July 17, 2006 Special Meeting Minutes

Brief review of the July 17, 2006 special meeting minutes.

Ms. Hambric asked about the minutes being written verbatim. Ms. Roberts replied the state statute regarding meeting minutes requires the meeting minutes to reflect a summary of the meeting. However, some meeting planners prefer verbatim minutes. Audiotapes of the meetings will be kept on file at the Department and copies may be requested.

After a brief review of the minutes, the Committee reached consensus with one amendment. Ms. Donna Bowers, Daily Living Centers and a member of the LTCFAB, was inadvertently missed in the list of identified attendees. Her name will be added to the list of attendees.

Ms. Houser stated the proposed rule amendments listed in John Gatliff's letter from Craig Cole & Associates will be addressed as the Committee covers them on the agenda. The items on which the Committee has already reached consensus that are in Mr. Cole's letter may be revisited after the other items have been covered, if the Committee consents to reopen those sections.

3) Review, Continued Discussion, and Consensus of Proposed Amendments to OAC 310:663, Continuum of Care and Assisted Living Rules

These proposed amendments were presented at the February 8, 2006 LTC Facility Advisory Board Regular Meeting. This special meeting is to focus on the proposed amendments and continue the line-by-line discussion. The goal of the Committee is to reach consensus on the proposed amendments and present them to the LTC Facility Advisory Board.

a) 310:663-19-1. Incident Reports

Mr. Joslin provided an overview of the proposed changes. Issues regarding accidental fires [(b)(4)] were discussed including whether a facility is required to report even if the facility was not aware of the incident.

John Gatliff, Attorney, C. Craig Cole & Associates, pointed out the alternative language proposed by OKALA located on page 6 of their proposal. Mr. Gatliff believes their proposal on fire reporting covers fires with more specificity because it identifies fires *resulting in personal injury, necessitating evacuation of the continuum of care facility or assisted living center, or notification of a local fire department*. Thus reporting would be limited to serious fires and the cause of the fire whether arson, an intentional fire, or accidental fire. Mr. Gatliff continued that the threshold would be the seriousness of the fire.

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Mr. Gatliff described as “ordinary” fires such as when someone leaves a cigarette smoldering on a couch, but the fire doesn’t require the dislocation of residents, doesn’t require a response from the fire department and no one is hurt. Those sorts of occurrences under the OKALA proposal would not be reportable; Mr. Gatliff stated they believe this is a common sense compromise on fire reporting. If a resident in his or her own apartment sets a grease fire and puts it out himself, the facility may never know about it until a survey occurs. Mr. Gatliff described that a survey is when the State comes out and looks for deficiencies in the facility, and then they can assess fines on that basis. The fines the facility pays come from the money the resident pays to the facility. Mr. Gatliff provided a scenario to the group: if a surveyor talked to a resident and the resident mentioned he or she had a fire in his apartment and it was not reported under the State’s proposal, that fire may result in a fine or penalty. Mr. Gatliff stated that does not seem reasonable or like a practical standard. Under the OKALA language, serious fires regardless of the cause would be reportable.

Rachel Boggess disagreed with not reporting a resident who starts a couch fire with a cigarette. Ms. Boggess considers this serious and would want it reported. Mr. Gatliff countered that if it was a serious fire the facility would know about it. Smoking in facilities was discussed. Unless an apartment is equipped with double ventilation, a resident is not allowed to smoke there. Ms. Houser clarified that a fire from a cigarette would not happen unless someone was doing something against his or her residency requirement. Ms. Houser wondered if any family members have questions regarding the appropriateness of reporting and what their comfort level is for reporting fires. Ms. Houser clarified Mr. Gatliff’s comment regarding Health Department surveys. In her experience, the Department surveys are based on concrete examples of compliance or non-compliance; [surveyors] assess for regulatory compliance, not to seek out deficiencies.

There was discussion of accidental fires and what is considered accidental. Mr. Joslin stated the Department is concerned with the residents with dementia, or other [disability], that because of some event the resident is starting a fire. While folks were not evacuated, the fire department was not notified and there was no injury, the facility’s response is a critical issue that concerns the Department. Mr. Joslin explained what the Department is looking for in the facility report. It should state what happened, what the facility is doing to address the situation, and what measures are being put in place to ensure it does not recur.

Ms. Ridenour expanded on OKALA’s rationale to have a baseline of seriousness on the fire issue. For instance: the cook has a small grease fire, smothers it with a towel, and does not report it. Later, the employee becomes disgruntled/gets fired, and then calls the Department saying the facility had a fire and did not report it, resulting in the facility being out of compliance for that incident. Ms. Ridenour stated this is the reason they (OKALA) were looking for a baseline of seriousness. Mr. Joslin said if the facility had no awareness about the incident, then they could not have reported it. Discussion revealed that smoke detectors are required.

Mr. Cole stated the problems with the terminology are that the rules are taken from LTC [nursing homes]. In his experience, incident reports lead to site visits, resulting in deficiencies

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being cited. Mr. Gatliff stated their (OKALA) proposed regulation creates a bright line standard for the facility and also for the surveyors. These are events that are outside of the fire. If there is a personal injury, the facility evacuates, or the smoke detector goes off, it would be routine practice to investigate the incident and likely have an evacuation if necessary. The facility will know about it. But if rules are vague and do not provide a bright line standard, then the facility is put at a disadvantage. This could raise costs by over-reporting or have malicious after-the-fact reporting, as when someone conceals a fire and then later reports it to get the facility in trouble. Mr. Gatliff stated the real issue is whether or not a fire rises to a sufficient seriousness that it ought to be on the radar of the Health Department. This definition (OKALA) limits the fire reporting incidents to the types of incidents with the highest potency for adverse outcomes.

Ms. Houser stressed the seriousness of a couch or cigarette smoldering fire and how many fatal house fires have resulted from such an incident. Ms. Houser is concerned that in an assisted living facility which is licensed [by the Department], if there are repeat incidents of cigarettes smoldering in couches in one apartment, then an investigation might be appropriately triggered – relating to the appropriateness of the individual to live with that degree of supervision in a multi-person housing unit.

Dorya Huser, Chief of Long Term Care, offered that in any investigation it is incumbent upon the surveyors to determine if a regulation is violated. When the Department reviews incident reports and identifies repeat incidents at a facility, this is a red flag that the measures the facility put in place are not working to prevent recurrences.

Wendell Short stated any fire is a dangerous situation and should be considered serious. His local fire department prefers all fires be reported. George Gibbs questioned what kind of fire occurs in an assisted living center that is not serious. Discussion included the possibility of combining the language proposed from all parties. Mr. Joslin will look at the proposed language regarding fires.

There was brief discussion regarding the timeline for reporting and the facility's responsibility to determine if a resident is missing. Suggested language for (b)(7) included *residents missing from the facility upon determination by the facility that a resident is missing*. Also, Ms. Parsons suggested working on consistent language between nursing facilities and assisted living centers. Discussion involved the facility's responsibility to identify if a resident is missing and if it could be reported to the Department on the next business day versus 24-hours. Ms. Huser will check on the reporting requirement. Ms. Brinkley stated [an assisted living center] is a licensed facility and it is ultimately the facility's responsibility to report a missing resident.

Dorothy Cassel asked the Committee to think about their decisions. Ms. Cassell stated her uncle was a resident at a nursing center. He walked out of the facility and was found four (4) days later – dead. Mrs. Cassel informed the committee of the newly enacted “Silver Alert”, which parallels the “Amber Alert” but is for use when older adults are missing. She expressed hope that all providers will work with their local law enforcement and use this new tool.

Ms. Houser explained about the Committee's purpose and responsibility to family members present at the meeting. Ms. Houser stated appropriate level of care will be discussed at a later date, probably at the September 27th meeting.

After a brief discussion of section (b)(6), the Committee reached consensus. It will be amended as follows: 'deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes, and deaths that may be attributed to a medical device;'

Further discussion of incident reports followed. Mr. Joslin informed the attendees that an initial incident report may also be a final report. The number of investigations that result from incident reports is small. Ms. Huser stated the Department has staff that review incident reports. The Department provides oversight to licensed facilities to protect the health, safety, and welfare of the residents.

b) 310:663-19-3. Maintenance of records

After a brief discussion, the Committee reached consensus on this section.

c) 310:663-25-4. Notice of violation, plans of correction, and right to hearing

The Committee agreed to postpone discussion of this item. Mr. Joslin will incorporate some of Mr. Cole's proposed changes and present to the Committee at the next meeting. Ms. Ridenour stated she wants to discuss OKALA's proposed 'Provider Bill of Rights.'

d) 310:663-15-3. Complaints

Mr. Joslin provided an overview of the proposed language.

After a brief discussion, the Committee reached consensus on this section.

4) Adjournment

The meeting was adjourned at 4:36 p.m.

For reference, the link to the current and complete Continuum of Care and Assisted Living Rules is <http://www.health.ok.gov/PROGRAM/condiv/663ccast.pdf>.