902 KAR 20:480, Assisted Living Communities.
FAQs

1. Which licensure option do I choose if my facility has both a secured dementia unit and living units for residents that receive either social model assisted living services or basic health services?

   A campus with a secured dementia unit in addition to other assisted living community (ALC) living units must apply for two licenses:
   - One license as an ALC with dementia care (ALC-DC); and
   - The other license as a social model ALC or ALC with basic health care (ALC-BH) depending on whether the remaining units are exclusively social model or otherwise offer basic health services.

   The campus will be surveyed in accordance with the requirements that apply to how the units are licensed.

   NOTE: *If an ALC intends to provide services to a mix of residents on the same campus who need social model assisted living services as well as residents who need basic health and health-related services, the ALC must apply for an ALC-BH license. This will help avoid any disruption in care for social model residents whose care needs are expected to increase over time.*

2. Is there a scenario where a single ALC campus could have all three licenses?

   No. An ALC without a secure dementia care unit must be licensed at the highest level of care the facility provides to any individual within the community and other residents with lower acuities can still be serviced in the same community. Therefore, if the highest level of care is for a resident(s) in need of basic health and health-related services, the facility must be licensed as an ALC-BH even if some residents receive only non-health services.

   Because the same campus cannot have both an ALC and an ALC-BH license, it cannot hold all three licenses.

3. My facility plans to convert to ALC-BH and/or ALC-DC licensure after 902 KAR 20:480 is final. Does my facility have to comply with a separate "facility specifications" regulation and submit plans for architectural review?

   A certified Assisted Living Facility transitioning to a licensed Assisted Living Community will not trigger a change in use or occupancy classification requirements pursuant to the 2018 Kentucky Building Code regardless of the number of beds simply due to its change from residential to institutional. A transition to licensure wherein an Assisted Living Facility performs activities exceeding those currently performed could trigger a change in use or occupancy.

4. My freestanding facility is currently licensed as a personal care home (PCH). Does my licensure status change?

   State law (KRS 194A.704) only requires apartment-style PCHs to convert to ALC licensure.

   Additionally, an apartment-style PCH must apply for ALC licensure by submitting the Form OIG – 20:480, accompanying documentation, and applicable licensing fee at least 60 days prior to the date of annual renewal of the facility's personal care home license.

5. What qualifies as an apartment-style PCH for purposes of ALC licensure?

   In accordance with KRS 194A.703, each living unit shall:

   (a) Be at least two hundred (200) square feet for single occupancy, or for double occupancy if the room is shared with a spouse or another individual by mutual agreement;
   (b) Include at least one (1) unfurnished room, a lockable entry door unless in a secured dementia care unit, a private bathroom with a tub or shower, provisions for emergency response, a window to the outdoors, and a telephone jack;
   (c) Unless living units are in a secured dementia care unit, have an individual thermostat control if the assisted living community has more than twenty (20) units; and
   (d) Have temperatures that are not under a resident's direct control at a minimum of seventy-one (71) degrees Fahrenheit in winter conditions and a maximum of eighty-one (81) degrees Fahrenheit in summer conditions if the assisted living community has twenty (20) or fewer units, or the living units are in a secured dementia care unit.

   Each resident shall be provided access to central dining, a laundry facility, and a central living room.

6. Many nursing facilities have licensed personal care (PC) beds within their facility. Will facility-based PC beds located within a nursing facility be subject to 902 KAR 20:480?

   No. In accordance with KRS 194A.704, only apartment-style PCHs are required to convert to licensure in the appropriate ALC category.

7. Will there be a grace period for unlicensed staff to obtain a certified medication aide credential if they administer medication delegated by a nurse?

   KRS 194A.705 allows additional time for all apartment-style PCHs required to convert to an ALC to come into compliance with the certified medication aide requirements. Within ninety (90) days of final passage of the Kentucky Board of Nursing regulation establishing the certified medication aide training program, the OIG expects all facilities will be appropriately staffed according to its licensure.

   Keep in mind, a currently certified ALC must retain its social model status until it has hired a sufficient number of unlicensed personnel who have obtained the certified medication aide

credential from a training program approved by the Kentucky Board of Nursing.

8. If an ALC retains its social model status, does an unlicensed staff person who assists a resident with self-administration of medication have to be a CMA?

   No. An unlicensed staff person who only provides assistance with self-administration of medication is not required to be a CMA.

9. Does the regulation require facilities providing basic health services to use special medication storage in resident rooms, medication carts, or medication rooms?

   The following are the minimum requirements for medication storage in ALCs-BH and ALCs-DC that provide medication management services:

   - 902 KAR 20:480, Section 15(1)(d)5 requires facilities to maintain policies and procedures that ensure:
     - All medications shall be kept in a locked place;
     - All medications requiring refrigeration shall be kept in a separate locked box in the refrigerator in the medication area; and
     - Drugs for external use shall be stored separately from those administered by mouth or injection.

   - 902 KAR 20:480, Section 15(17) states that, "Except for the storage of controlled substances that shall be kept under a double lock in accordance with subsection (21)(b) of this section, an ALC-BH or ALC-DC shall store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access."

   - Subsection (21)(b) requires that, "Controlled substances shall be kept under double lock, for example, stored in a locked box in a locked cabinet, and keys or access codes to the locked box and locked cabinet shall be accessible to designated staff only."

   The above requirements for medication storage are similar to the requirement for PCHs and SPCHs in 902 KAR 20:036.

10. Is a resident of an ALC-BH allowed to self-administer their own medications or receive assistance with self-administration of medications?

    Yes. As long as the facility determines that the resident can safely self-administer medications or receive assistance with self-administration. ***However,*** it is important to note that in the case of controlled substances, the resident's medical record must include a written determination from an appropriately authorized health professional that the resident is able to safely self-administer a controlled substance under supervision.

11. KRS 194A.700(7)(k) includes, "Hands-on assistance with transfers and mobility, including use of gait belts" as an assisted living service. Can a social model ALC provide this type of hands-on assistance to a resident?

No. Hands-on assistance with transfers and mobility, including the use of gait belts, for residents who are not capable of moving from place to place independently exceeds the scope of non-health related social model care.

12. Section 13(4)(j) and (o) of the regulation requires ALCs to maintain documentation of incidents or accidents involving the resident and documentation of complaints received.

    If the ALC maintains a log of incidents/accidents and grievances, is this information required to be maintained in the resident record?

    Yes. Although there is no prohibition against maintaining a separate log of incidents and grievances, 902 KAR 20:480, Section 13(4)(j) and (o) requires ALCs to maintain this information in the resident's record.

13. Section 18(1)(l) authorizes the cabinet to take negative action against an ALC's license if, "There have been *repeated* incidents in the facility of personnel performing services beyond their competency level."

    At what point would the cabinet revoke a license for repeated violations of this standard?

    The OIG will take into consideration whether a clear pattern exists in which personnel are performing services beyond their competency level or scope, whether repeat violations of the requirement have occurred during a short period of time, and the severity of the violations such as negative resident outcomes prior to taking negative action against an ALC's license.

14. Does the cabinet provide sample lease agreements?

    No. Each provider will be responsible for drafting their own lease agreement in accordance with the required elements of KRS 194A.713.

15. How do facilities ensure compliance with the requirement for providing culturally appropriate programs that help residents remain connected to their traditional lifeways?

    A person-centered approach is important to successfully providing culturally appropriate programs. While the cabinet acknowledges that there is no way for staff to know all of the nuances of every culture, staff should be alert and responsive to beliefs or conventions that might be determined by a resident's cultural heritage. Staff should also be aware of a resident's personal lifestyle preferences, including a customary routine that is important to the resident's quality of life, spiritual and cultural preferences, and any dietary requirements of a resident's religion.

16. KRS 194A.705(1)(b) requires, "Three (3) meals and snacks made available each day, with flexibility in a secured dementia care unit to meet the needs of residents with cognitive impairments who may eat outside of scheduled dining hours."

If an ALC makes snacks readily available in a bistro or at some other centralized place in the building, do staff need to physically offer a snack between each meal and prior to bedtime?

Having snacks available in a bistro or centralized place in the building is acceptable. ***However***, if OIG surveyors interview residents and find that residents are unaware that snacks are available, the facility would be cited. Moreover, given that some residents are dementia-care residents, offering a between-meal snack to such residents may be recommended to ensure compliance.

17. Section 9(4)(c) states, "Modified diets, nutrient concentrates, and supplements shall be given only on the written order of a licensed health professional."

    Are family members prohibited from bringing nutritional supplements or protein shakes to a relative who resides in the facility?

    No. However, over-the-counter dietary supplements given to ALC residents by family members should be documented in the resident's care plan. For clinical purposes, it is important to document a resident's intake of such substances and to monitor their potential effects as they can interact with other medications.

    In addition, 902 KAR 20:480, Section 15(16) states the following: "Medications provided by resident or family members. If a staff person becomes aware of any medications or dietary supplements that are being used by the resident that are not included in the assessment for medication management services, the staff person shall advise the nurse and document that in the resident record."

    The language of the regulation takes into consideration that facility staff may not know every over-the-counter medication or supplement that a resident is consuming, but if a staff person does become aware of something being used that is not in the medication management assessment of a resident of an ALC-BH or ALC-DC, the staff person must tell the nurse and it should be documented.

18. If an owner is a silent partner/investor only and does not have direct interaction with residents, is he/she required to have a background check?

    An owner who has direct contact with residents or an individual who has a "significant financial interest" in the ALC, defined as greater than 25% of the total ownership of the facility, will be subject to the background check requirements.

    If a facility is owned by a corporate entity and no single individual has more than a 25% ownership interest, at least the CEO should submit to a background check.

19. Will the Functional Needs Assessment (FNA) be put into a digital format or will it only be completed on paper? Could it be added to an electronic medical record and completed in that format?

An ALC may convert the paper FNA to an identical digital format and store the completed FNA in each resident's electronic health record. It must be easily retrievable and available upon request to an OIG surveyor.

20. KRS 194A.707(2) requires ALCs to be surveyed every 24 months, unless the cabinet found a violation(s) during the previous inspection that presented imminent danger to a resident creating substantial risk of death or serious mental or physical harm in which case the facility would be subject to a routine survey 12 months later.

    Section 4(2) of the regulation states, "Nothing in this administrative regulation shall prevent the cabinet from … making an on-site survey of an ALC, ALC-BH, or ALC-DC more often if necessary."

    Other than a complaint investigation, under what circumstances would the cabinet conduct an on-site survey more often than the survey frequency required by KRS 194A.707(2)?

    The OIG may make conduct a follow-up visit after a complaint inspection to ensure that the violations have been corrected or otherwise conduct an on-site inspection more often than the statutorily required survey interval upon consideration of factors such as multiple complaints or a recent history of multiple violations.

21. Section 7(2)(h) of the regulation requires ALCs to, "Allow the resident the right to choose a roommate if sharing a unit."

    Does this apply to residents of an ALC-DC unit if the facility's staff think that a resident's choice to have a roommate would be problematic?

    The OIG would not cite against an ALC-DC if the facility denies a dementia care resident's request to have a roommate if facility staff determine that the resident's choice of roommates would be problematic or otherwise pose a risk.

22. Section 7(2)(j) states that, "Each ALC, ALC-BH, and ALC-DC shall…develop and implement a staffing plan for determining staffing levels that…ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' functional needs assessments and service plans on a twenty-four (24) hour per day basis."

    What is an example of a "reasonably foreseeable unscheduled need?"

    The OIG does not expect ALCs to staff for every possible scenario. However, if a resident's care needs have increased and they are requesting assistance more often than previously, a reasonably foreseeable unscheduled need may be to staff for the ability to conduct more frequent safety checks on the resident.

23. Section 10(2) requires employee records to include, "a record of any health exams related to

employment, including compliance with the tuberculosis testing requirements of 902 KAR 20:205."

What other health exams are required beyond TB testing?

If an ALC's policies require, for example, a pre-employment health examination to ensure that the individual is medically capable of performing their anticipated duties, documentation of the exam should be included in the employee's record.