



## **Economic Impact Analysis Virginia Department of Planning and Budget**

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**22 VAC 40-72 – Standards for Licensed Assisted Living Facilities  
Department of Social Services  
April 8, 2013**

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### **Summary of the Proposed Amendments to Regulation**

The Board of Social Services (Board) proposes to repeal its current regulations that govern standards for licensed assisted living facilities and replace them with revised regulations that contain numerous changes. In addition to clarifying and organizational changes, the Board is proposing various substantive changes as well. The most significant of the changes proposed for these regulations include:

1. The development and implementation of an enhanced infection control program that addresses the surveillance, prevention, and control of disease and infection. Proposed requirements for the enhanced program include that the program be written down, that a licensed health care professional be involved in its development and that a staff person be appointed as a point of contact.
2. Requiring administrators who are not registered medication aides but who supervise medication aides to have annual refresher training in medication administration.
3. Increasing the annual training that direct care staff who work for assisted living facilities are required to complete from 16 hours to 18 hours. Annual training for direct care staff at residential care facilities is proposed to increase from 8 to 14 hours.
4. Increasing the cognitive impairment training required for direct care staff (except for administrators) who work in mixed population facilities from four to six hours to be completed within four months of employment. Non-direct care staff training (again, excepting administrators) must be completed within one month of employment and was increased from one to two hours.

5. Increasing the number of hours of training in cognitive impairment for administrators of facilities with special care units from 10 hours within a year of hiring to 12 hours within 3 months. The time period in which cognitive impairment training must be completed by direct care staff who work in a special care unit is proposed to shorten from within a year of hiring to within four months. Other staff cognitive impairment training is proposed to increase from one to two hours within a month of hiring.
6. Increasing the hours of training that managers of smaller facilities that share an administrator must complete from 16 hours to 20 hours annually. As part of the required annual training, managers of facilities that have residents with mental impairment will have to complete six hours of training (rather than the four hours required now) specifically geared toward meeting the needs of the mentally impaired. The Board also proposes to newly require two hours of annual training on infection control as part of the 20 hours of proposed required annual training.
7. Requiring direct care staff who work with residential care level residents to meet the same staff qualifications as individuals who work with assisted living level residents. Residential direct care staff will newly be required to complete some sort of approved nurse aide or personal care aide training. The proposed regulations will give these individuals one year from the effective date of these regulations to get the additional training that would be newly required.
8. Adding requirements regarding private duty personnel that would incorporate into the regulation some of the standards that are currently in the Department of Social Services (DSS's) technical assistance document.
9. Increasing the number of staff needed with certification in cardiopulmonary resuscitation from one for every 100 to one for every 50 residents.
10. Changing a staffing requirement exception that allows staff to sleep at night in facilities that house 19 or fewer residents to limit its application to residential living facilities only.
11. Listing additional specifications regarding agreements between facilities and hospice programs when hospice care is provided to a resident.
12. Requiring a fall risk assessment to be conducted for residents who meet the criteria for assisted living care.

13. Reducing the number of health care oversight reviews when a facility employs a full-time licensed health care professional (usually a registered nurse or a licensed practical nurse). For assisted living level residents, the requirement would decrease from four times per year to two times per year. For residential living level residents, the requirement would decrease from twice per year to once per year. The Board also proposes to require that all residents, rather than just a sampling, be included in the review.
14. Reducing the number of times a review must be conducted to oversee special diets from quarterly to every six months.
15. Requiring that staff at facilities with residents who are unable to use their room's signaling/call systems device have a plan to keep those residents safe. This information would be included on the resident's individualized service plan (ISP). Residents' ISPs must also indicate with what frequency rounds will be done.
16. Eliminating activated charcoal and adding antibiotic cream or ointment and aspirin to the list of what first aid kits must contain. This section would also add a flashlight or battery lantern requirement for each employee who is directly responsible for resident care.
17. Modifying the current requirement to have 96 hours of emergency food and water supply available to include a requirement that 48 hours of the supply be available on-site.
18. Removing the exception for facilities licensed for ten or fewer residents with no more than three individuals with serious cognitive impairments that applied to all requirements for mixed populations so that it only applies to the staffing requirement.
19. Increasing the number of hours per week of activities that must be offered to residents in a safe, secure environment from 16 hours weekly, with not less than one hour each day, to 21 hours weekly, with not less than two hours each day.
20. Specifying that there must be at least two direct care staff members on each floor in each special care unit. Residents' ISPs must also indicate the frequency that rounds are done.
21. Specifying that visiting hours may not be restricted unless a resident chooses.
22. Allowing residents to determine whether they want to have certain furnishings that are otherwise required in their bedrooms.
23. Permitting residents to set the thermostats to a temperature other than what is otherwise required so long as they do not have a roommate.

24. Allowing residents who do not have serious cognitive impairments increased flexibility pertaining to the storage of cleaning supplies and personal care items that could be considered hazardous.

## **Result of Analysis**

Benefits likely outweigh costs for some proposed changes. For other proposed changes, there is insufficient information to ascertain whether benefits will outweigh costs. Costs likely outweigh benefits for one proposed change.

## **Estimated Economic Impact**

### **Infection Control:**

Current regulations require Licensed Assisted Living Facilities (ALFs) to develop and maintain an infection control program that addresses the surveillance, prevention and control of infections by: 1) training staff and volunteers in hand washing and preventing cross contamination between residents or tasks, 2) prohibiting staff and volunteers with communicable diseases from direct contact with residents or their food and 3) training staff how to properly handle, store and transport linens, supplies, equipment and medical waste so as to not spread infection. Current regulations also require that methods used for infection control be described in a written document.

The Board proposes to amend infection control program requirements so that ALFs will have to develop and write the required infection control programs with input from a licensed health care professional (usually a nurse), will have to review their infection control programs at least annually and will have to designate a staff person as point of contact to monitor compliance with the facilities' infection control programs. Board staff reports that some licensed facilities already have a licensed health care professional on staff that will be able to help create or review infection control programs for the facilities in which they work. Where that is true, the costs to facilities on account of the proposed changes to infection control programs will be limited to the opportunity cost of having the health care professional work at this task for however many hours it takes rather than working at some other task(s). For licensed facilities that do not have a health care professional on staff, the costs associated with these proposed changes will include the cost of hiring a health care professional to help with the infection control program. Board staff estimates that a nurse can be hired for approximately \$30 an hour and that it would take

approximately eight hours to write an infection control plan. Using these numbers, the costs associated with these changes will be \$240 initially plus the wage costs for other staff that would be involved in writing the plan. Since each facility's infection control program will have to be reviewed annually, and a health care professional will have to be involved each time the program is reviewed, facilities may incur approximately the same costs (~\$240 + the cost for other staff members' time) each year after these proposed regulations are promulgated. While the Board's goal in proposing these changes to infection control programs is presumably to decrease the number of diseases spread in licensed facilities, the magnitude of any future effects from these changes is unknown. Because of this, there is insufficient information to tell whether there will be ameliorative effects on disease control sufficient to justify the costs of these proposed changes to facilities.

**Training Requirements:**

Current regulations of the Department of Social Services require assisted living facility administrators who supervise medication aides, but who are not licensed or registered to administer medication themselves, to complete 68 hours of Board of Nursing approved training on administering medication. The Board now proposes to also require affected administrators to complete yearly refresher training. Board staff reports that this training will be approximately four hours in length and will cost approximately \$50 per year per affected administrator plus the implicit cost of administrators' time to take the course. The Board also proposes to increase the amount of annual general continuing education that direct care staff at assisted living level facilities must complete from 16 hours to 18 hours and to increase the annual general continuing education that direct care staff at residential care facilities must complete from 8 hours to 14 hours. Board staff estimates that this training will cost \$20 plus the salary costs for each staff person who is required to train. Board staff estimates that salary costs will be approximately \$8 per hour of additional training.

Required hours of cognitive impairment training are also proposed to increase over several categories. Direct care staff at facilities with mixed populations will have to complete 6 hours of annual cognitive impairment training rather than the 4 hours they must currently complete. Administrators of facilities with special care units would have to complete 12 hours of initial cognitive impairment training within three months of hire rather than the currently

required 10 hours of training within 12 months of hire. Non-direct care staff at mixed population facilities and in special care units would see their annual cognitive impairment training increase from one to two hours. Board staff did not report specifically on how much cognitive impairment training will cost it but costs will likely be roughly the same as those for general training for all staff but the administrators (i.e. – approximately \$20 for the training itself plus \$8 x the number of additional hours required for each affected staff member). Time costs incurred on account of these proposed training standards will likely be higher for facility administrators since their salaries are likely higher.

Managers at smaller ALFs that share an administrator currently have to complete 16 hours of annual training relating to management or operations of the type of facilities where they are employed with the addendum that managers who work at facilities that have mentally impaired residents must current complete 4 hours of mental impairment training as part of their 16 hours per year. The Board proposes to increase annual training for managers to 20 hours and increase the mental impairment training for managers who have to complete such training to 6 hours (of the required 20). Additionally, the Board proposes to require that managers complete 2 hours of annual infection control training that can be counted toward their 20 hour total. Additional training for managers will have costs attached that are more in line with the additional training costs for administrators listed above.

For all of the categories of training listed in the three paragraphs above, Board staff reports that training is being increased to address concerns that have arisen on account of complaints to the Board and on account of issues raised during inspections. Since the magnitude of possible benefits of additional training cannot be measured (as they have not happened yet), there is insufficient information to judge whether benefits will outweigh costs for these proposed training increases.

Under current regulations, direct care staff who care for assisted living level residents must meet certain qualifications within two months of employment. They must either 1) have a certification as a nurse aide issued by the Virginia Board of Nursing, 2) have successfully completed a Virginia Board of Nursing approved nursing assistant, geriatric assistant or home health aide education program, 3) have successfully completed a personal care aide training program approved by the Department of Medical Assistance Services (DMAS) , 4) have

successfully completed a DSS approved nursing assistant, geriatric assistant or home health aide education program or 5) have successfully completed DSS approved 40 hour direct care staff training.

The Board now proposes to slightly change the training options available to direct care staff that care for assisted living level residents and to also require direct care staff who care for residential living level residents to meet one of these same criteria within one year of the promulgation of these proposed regulations. Under proposed regulations affected direct care staff must either 1) have a certification as a nurse aide issued by the Virginia Board of Nursing, 2) have successfully completed a Virginia Board of Nursing approved nurse aide education program, 3) have successfully completed a nursing education program preparing for registered nursing licensure or practical nursing licensure, 4) be enrolled in a nursing education program and have completed at least one course that includes 40 hours of direct client care clinical experience, 5) have successfully completed a personal care aide training program approved by the DMAS, 6) have successfully completed an education program on geriatric assistants or home health care aides or for nurse aides which is provided by a hospital, nursing facility or educational institution approved by DSS or 7) have successfully completed DSS approved 40 hour direct care staff training.

Board staff reports that the lowest cost option for attaining one of the required credentials would be to have a qualified individual who is already employed by a facility or who comes into a facility specifically to teach new direct care staff the department approved 40 hour direct care staff training program. The costs associated with this credentialing would be the time value of the approximately 40 hours times the instructor's hourly wage plus 40 hours times the wage of the newly hired direct care employee times the number of employees taught at once. So, assuming an hourly wage for the health care professional teaching the class is \$30 per hour and an hourly wage for direct care staff of \$8 per hour, the cost of this instruction would be  $40 \times 30$  or \$1,200 plus  $8 \times 40$  or \$320 per trainee. Since residential living level residents do not require as intense a level of care as assisted living level residents it is likely that direct care staff for residential living level residents do not need all of the training that direct care staff for assisted living level residents do. Therefore, it is likely that the costs of requiring the same level of training for all direct care staff will likely outweigh the anticipated benefits of doing so.

**Staffing Requirements:**

Current regulations require that there be one staff member trained in cardiopulmonary resuscitation (CPR) be on site for every 100 residents in a facility. The Board proposes to amend this standard so that the ratio of CPR trained staff to residents is 1:50. Board staff estimates that the costs associated with changing this standard will include \$50 for the class in CPR plus \$8x4 hours of a staff member's time to take the class for each additional trained staff member required. Board staff also reports that 52% of facilities house fewer than 50 residents and would, therefore, be unaffected by this proposed change. Of the remaining facilities, most would have to have only one additional CPR trained staff member on site during each shift. Since the populations served by assisted living facilities and residential care facilities are, by and large, older and more prone to illnesses such as heart attack and stroke that would likely require CPR to be administered, the benefits of this proposed change likely outweighs its costs.

Current requirements that personal care staff hired by residents or their families must meet are located in DSS's technical assistance document. The Board proposes to move these requirements to regulation. Under the proposed regulations, facilities will have to have a written agreement outlining the services to be provided by the private personal care personnel and will also have to ensure that these individuals have a tuberculosis screening and orientation and initial training. Board staff reports that the requirements for private duty personnel in these proposed regulations are less restrictive than those currently enforced so both facilities and families ought to benefit from these proposed changes.

Current regulations allow staff at licensed facilities that house 19 or fewer residents to sleep at night so long as all residents are also asleep and do not need care. The Board proposes to change this allowance so that it only applies to residential living level facilities with 19 or fewer residents. This means that staff at assisted living level facilities will have to remain awake at night. Given that assisted living level residents require a greater level of care, and are likely more prone to needing sudden intervention at any time including the night, the benefits of this change likely outweigh any inconvenience that staff may experience from not being able to sleep during their work hours.

Current regulations require that there be two direct care staff members awake and on duty in each special care unit in a facility. The Board proposes to amend this requirement so that there

will have to be two direct care staff members on each floor of a special care unit. This change will significantly increase the number of staff that will be required to be on premises in special care units that are housed on multiple floors of a facility or will require facilities to reconfigure special care units so that they are housed only on one floor. These costs must be weighed against any benefit that might accrue to residents of special care units because of the presence of additional staff. The benefits of this change would likely have to be quite large if they are to outweigh its costs.

**Other requirements:**

The Board proposes to newly require that residents entering assisted living level care undergo a fall risk assessment and that this assessment be conducted by the time each resident's ISP is complete. The proposed regulations also require that a resident's fall risk assessment be updated annually or when a resident has a fall or a change in condition. There will be time costs for staff to do fall risk assessments but these costs should be minimal and, in any case, are likely outweighed by the benefits that will likely accrue to residents when direct care staff is more aware of how at risk of falling a resident is.

Current regulations require that assisted living level facilities conduct four health care oversight reviews per year and that residential living level facilities conduct two health care oversight reviews each year. These are general reviews of health outcomes and care at the facility rather than specific reviews of any particular residents. Current regulations also require facilities to conduct a review of how well special dietary needs are being met quarterly. The Board now proposes to reduce the number of health care oversight reviews when a facility employs a full-time licensed health care professional, from four per year to two per year for assisted living level care and from two per year to one per year for residential living level care, and to also reduce the frequency of special dietary oversight reviews from quarterly to every six months. These changes are likely to benefit facilities by reducing the time needed to comply with regulatory requirements each year. There are likely no costs attached to these proposed changes because individual residents' health care and dietary needs are analyzed individually apart from these aggregate reviews.

Current regulations require assisted living facilities to have signaling devices in residents' bedrooms or attached bathrooms that can be pulled or otherwise activated and that alert direct

care staff that a resident needs assistance. Some assisted living residents, however, have difficulty reaching or pulling signaling devices. As a consequence, the Board proposes to require facilities to have a plan to monitor residents who cannot use signaling devices and also proposes to require that each such resident have written into his/her ISP the frequency with which staff will be checking in on them. This change may require staff to check in on affected residents more often but the costs of both staff time and keeping records as to how often residents are checked on are likely outweighed by the health benefits that will likely accrue to residents whose acute health issues will likely get a quick response despite them not being able to alert staff that is a distance from them.

Current regulation exempt facilities with no more than 10 total residents and with no more than three residents with serious cognitive impairments from cognitive impairment safety requirements that larger facilities must adhere to. Currently, facilities that are licensed for more than 10 residents and that have residents with serious cognitive impairments must have some sort of system that monitors such residents so that they do not wander, must have at least two direct care staff on duty and awake in each building of the facility and must have staff provide sight and sound supervision for impaired residents while on trips away from the facility. The Board proposes to amend these requirements so that facilities licensed for 10 or fewer residents, that house three or fewer residents with serious cognitive impairments, will have to have a mechanical monitoring system of some sort but will not have to meet the additional staffing requirements that larger facilities have to meet.

Board staff reports that affected facilities can install door alarms (estimated cost – \$2 to \$40 per door plus the cost of batteries) or they can install a camera system (estimated cost – approximately \$300). Facilities may also choose to pay for bracelets that are monitored by the local sheriff's office and that allow residents who wander to be tracked down. The initial cost of bracelets varies from locality to locality (free in some localities and several hundred dollars in other localities); localities charge a monthly fee of approximately \$10 per bracelet per month for monitoring and tracking, if necessary. Alternately, facilities might choose to install door alarms with keypads (estimated cost – \$4,500 to \$5,100) or purchase a ResidentGuard system that has several safety systems for residents (estimated cost – \$1,000 to \$2,000). Whatever the safety system chosen, the attendant costs would need to be measured against any benefits in additional

safety that might accrue to impaired residents. There is insufficient information at this time to accurately measure costs against benefits.

Current regulations require facilities to offer 16 hours of planned activities each week with at least one hour of activity each day. The Board proposes to increase the hours of activity required to 21 hours per week with at least two hours of activity being offered each day. This change will likely cost facilities some additional staff time and perhaps some additional cost in activity materials, depending on what kind of activity is being offered. Residents may benefit from additional activities that will likely increase interaction with other residents and staff of the facility and that may slow the degradation of health and mental faculties that may occur in inactive seniors<sup>1</sup>. There is insufficient information to measure the magnitude of costs versus benefits for this proposed incremental change to required planned activity.

The Board proposes a number of other changes to these regulations that will allow residents more autonomy in setting their own environment. For instance, the Board proposes to allow residents who are in single rooms to set the thermostat in their room to some other temperature than what is required now. The Board also proposes to specify that visiting hours may not be restricted unless a resident chooses, to allow residents to remove furniture from their rooms and to allow residents to keep cleaning supplies and personal care chemicals out of sight in their rooms so long as they do not have a serious cognitive impairment. Costs associated with these changes will likely be minimal and might include staff time to move furniture and monitor guests and/or some additional heating and cooling cost for residents that change their thermostat settings. These costs are likely outweighed by the benefits to residents of having a friendlier more personalized environment that might be individually safer.

## **Businesses and Entities Affected**

Board staff reports there are currently 552 licensed assisted living facilities; of these, approximately 12%, or approximately 66 facilities, house only residential living care residents. The remaining facilities house both residential living care residents and assisted living care residents or house only assisted living care residents. Board staff also reports that most of these facilities would qualify as small businesses in the Commonwealth.

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<sup>1</sup> <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2010/fr-rc/cphorsphc-respcacsp-06-eng.php>

## **Localities Particularly Affected**

No locality will be particularly affected by this proposed regulatory action.

## **Projected Impact on Employment**

Proposed increases in training requirements for staff of ALFs, particularly training that is currently not required of residential care level staff but will be required under these proposed regulations, will increase the costs of being eligible to work in residential care and assisted living care facilities. As a consequence of these increased costs, fewer individuals are likely to seek employment in these facilities; especially if they can earn a comparable wage in another field that does not require training at all or requires less training than this. Facilities may also hire fewer staff and/or take in fewer residents if their costs increase because they have to cover increased training costs directly.

## **Effects on the Use and Value of Private Property**

These proposed regulatory changes are unlikely to affect the use or value of private property in the Commonwealth.

## **Small Businesses: Costs and Other Effects**

Affected small businesses will likely incur costs for hiring health care professionals to perform certain newly required tasks and for additional staff training. Smaller facilities with 19 or fewer residents and with 10 or fewer residents will incur costs to meet regulatory requirements that they are currently exempted from.

## **Small Businesses: Alternative Method that Minimizes Adverse Impact**

The Board may wish to revisit the issue of proposed qualifications for staff that work solely with residential care level residents. Since these residents do not require the same level of care as assisted living level residents, the Board may be able to lessen the adverse impact of these regulations on affected small businesses by not requiring the same staff qualifications for working with residents that require less intervention and care as they do for working with residents that require more.

## **Real Estate Development Costs**

This regulatory action will likely have no effect on real estate development costs in the Commonwealth.

## **Legal Mandate**

The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007.04 of the Administrative Process Act and Executive Order Number 14 (10). Section 2.2-4007.04 requires that such economic impact analyses include, but need not be limited to, a determination of the public benefit, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. Further, if the proposed regulation has an adverse effect on small businesses, Section 2.2-4007.04 requires that such economic impact analyses include (i) an identification and estimate of the number of small businesses subject to the regulation; (ii) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the regulation, including the type of professional skills necessary for preparing required reports and other documents; (iii) a statement of the probable effect of the regulation on affected small businesses; and (iv) a description of any less intrusive or less costly alternative methods of achieving the purpose of the regulation. The analysis presented above represents DPB's best estimate of these economic impacts.