

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
BUREAU OF HUMAN SERVICES LICENSING
Assisted Living Residences (55 Pa.Code Chapter 2800)

Q/A - Regulatory Clarifications – January 2015

The clarifications and interpretations below will remain on the Department's web site until the information is included in the next updated Regulatory Compliance Guide (RCG).

Regulation: § 2800.57(a) – Direct Care Staffing

§ 2800.57(a) At all times one or more residents are present in the residence, a direct care staff person who is 21 years of age or older shall be present in the residence. The direct care staff person may be the administrator if the administrator provides direct care services.

Question: Does a direct care staff person have to be present in each building if the legal entity has multiple buildings listed on one license?

ANSWER: Yes. If the home consists of multiple buildings on one license, direct care staff aged 21+ must be present in each building at all times residents are present in the residence.

Regulation: § 2800.190(a) – Medication Administration Training

§ 2800.190(a) A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Question: Must a person who successfully completed the Department's Medication Train-The-Trainer course with a valid certificate be a current employee of an assisted living residence to be considered a qualified trainer?

ANSWER: The trainer must work for a licensed legal entity that uses the training. This includes legal entities licensed under the following regulations: 2380, 2600, 2800, 3800, 6400, 6600 or Adult Day Living Centers. No independent trainers who do not work for a legal entity licensed under any of the specified regulations may provide this training.

Regulation: § 2800.253 – Record Retention and Disposal

(a) The resident's entire record shall be maintained for a minimum of 3 years following the resident's death, discharge from the residence or until any audit or litigation is resolved.

(b) Records shall be destroyed in a manner that protects confidentiality.

(c) The residence shall keep a log of resident records destroyed on or after January 18, 2011. This log must include the resident's name, record number, birth date, admission date and discharge date.

(d) Records required under this chapter that are not part of the resident records shall be kept for a minimum of 3 years or until any audit or litigation is resolved.

Question: How long does resident record documentation need to be kept?

ANSWER: Resident documentation such as initial preadmission screenings, resident rights notification, resident-community contract, and any referral information should be kept for a minimum of 3 years following the resident's death, discharge from the residence or until any audit or litigation is resolved. Annual and less frequently required documentation, such as medication administration records, lab reports, assessments and support plans should be kept for a three-year period.