

Georgia

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Licensure Term Personal Care Homes (PCH) and Assisted Living Communities (ALC)

Definition PCH: Any dwelling, whether operated for profit or not, which undertakes through its ownership or management to provide or arrange for the provision of housing, food service, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage.

ALC: A personal care home serving 25 residents or more that is licensed by the department to provide assisted living care. Assisted living care means the specialized care and services provided by an assisted living community which includes the provision of personal services, the administration of medications by a certified medication aide, the provision of assisted self-preservation, and the provision of limited nursing services.

Memory Care Center/Unit: Means the additional watchful oversight systems, program, activities and devices that are required for residents who have cognitive deficits which may impact memory, language, thinking, reasoning, or impulse control, and which place the residents at risk of eloping. No memory care center shall be operated and no residents admitted without a certificate which is current under the rules and regulations.

Regulatory and Legislative Update The Department of Community Health, Healthcare Facility Regulation Division, licenses personal care homes (PCHs) and assisted living communities (ALCs). While the two levels of licensure have many common requirements, ALC standards are more stringent than PCHs in a number of areas, including disclosure, required services, admission thresholds, resident assessment, medication management, physical plant requirements, staffing, staff training, and fire safety. Requirements apply to both settings unless otherwise noted. PCHs tend to be much smaller homes.

Facilities that provide "memory care" services must meet additional requirements.

In 2023, legislation was enacted amending financial stability requirements for PCHs and ALCs. Effective July 1, 2023, affidavits of financial stability previously applicable when applying for initial licensure now also apply to a change of ownership.

Facility Scope of Care

For both PCHs and ALCs, personal services provided must include 24-hour responsibility for the well-being of the residents and protective care and watchful oversight.

An ALC must also provide assisted living care, including protective care and watchful oversight that meet the needs of the residents it admits and retains. Protective care includes the provision of personal services, the administration of medications by a certified medication aide and the provision of assisted self-preservation.

Limitations of Services

PCH: Except for aging in place exceptions, residents must be ambulatory and may not require the use of physical or chemical restraints, isolation, or confinement for behavioral control. Residents must not be bedridden or require continuous medical or nursing care and treatment.

Aging in Place Exceptions - The home may allow up to three (3) non-ambulatory residents to remain in the home to support an aging in place strategy that is in the best interests of the resident, subject to the requirements of the Department and may be revoked by the Department at any time, as part of the survey process.

ALC: Residents' physical condition must be such that the resident is capable of actively participating in transferring from place to place and must be able to participate in the social and leisure activities provided in the community. The resident must not have active tuberculosis or require continuous medical or nursing care and treatment or require physical or chemical restraints, isolation, or confinement for behavioral control.

Move-in Requirements Including Required Disclosures/Notifications

PCH: None specified.

ALC: Must complete and maintain an accurate, current licensed residential care profile on file with the Department and must provide services consistent with the information reported.

Resident Assessment Requirements and Frequency

PCH: There is a requirement for a specific resident assessment form. A sample physician's report form is available at the agency Web site under Long Term Care Programs, Personal Care Homes. Additional requirements for Specialized Memory Care

Units or Homes specify that a physical examination completed within 30 days prior to admission must be provided to the facility and must clearly reflect that the resident has a diagnosis of probable Alzheimer's disease or other dementia and has symptoms that demonstrate a need for placement in the specialized unit. In addition, there is a post-admission assessment requirement that addresses family support, ADLs, physical care needs, and behavior impairment.

ALC: Facilities must complete an assessment addressing the resident's care needs, taking into account the resident's family supports, the resident's functional capacity relative to the activities of daily living, physical care needs, medical information provided, cognitive and behavioral impairments, if any, and personal preferences relative to care needs. An individual care plan, including all elements specified in the regulations, at minimum, must be developed within 14 days of admission and updated annually or more frequently if the resident's needs change substantially.

Medication Management

PCH: All medications must be self-administered by the resident except when the resident requires administration of oral or topical medication by or under the supervision of a functionally literate staff person. There are exceptions. Staff may administer epinephrine and insulin under established medical protocols.

Further, licensed nursing staff of a Specialized Memory Care Unit or Home may administer medications to residents who are incapable of self administration of medications. The use of "proxy caregivers" in licensed facilities also allows unlicensed staff who have been trained to perform "health maintenance activities," including the administration of medications by a proxy caregiver. Proxy caregivers must be designated by the resident and determined to have the requisite skills necessary to administer medications. Certified medication aides are also permitted.

Medications for residents living in the memory care center must be provided to the residents by a proxy caregiver trained in accordance with the requirements of Chapter 111-8-100; a licensed registered nurse; a licensed practical nurse working under the supervision of a physician or registered nurse; or a certified medication aide subject to the requirements listed in the Rules.

ALC: Can allow the self-administration of medications, provide assistance with self-administration using unlicensed staff, or use

certified medication aides (at a minimum) to administer medications.

Staffing Requirements

Rules for Specialized Memory Care Units or Homes include requirements concerning disclosure of information; physical design, environment, and safety; staffing and initial staff orientation; initial staff training; special admission requirements for unit placement, post-admission assessment, individual service plans, and therapeutic activities. Facilities that serve residents who have cognitive deficits that may place them at risk for unsafe wandering behavior must have safety devices on doors and current pictures of residents on file, and train staff on elopement procedures.

For both types of licensure, facilities or programs that advertise, market, or offer to provide specialized care, treatment, or therapeutic activities for one or more persons with a probable diagnosis of Alzheimer's disease or Alzheimer's-related dementia must disclose the form of care, treatment, or therapeutic activities provided beyond that care, treatment, or therapeutic activities provided to persons who do not have a probable diagnosis of Alzheimer's disease or Alzheimer's-related dementia. Disclosure must be made in writing on a standard disclosure form. Additional Requirements for Specialized Memory Care Units or Homes specify that a facility that holds itself out as providing additional or specialized care to persons with probable diagnoses of Alzheimer's disease or other dementias or charges rates in excess of that charged other residents because of cognitive deficits must meet additional requirements including disclosure of information.

In addition to the requirements for all staff, staff in facilities that serve residents with cognitive deficits must develop and train staff on policies and procedures to deal with residents who may elope from the facility. Staff of a specialized memory care unit or home must also have training on the facility's philosophy of care for residents with dementia, common behavior problems, behavior management techniques, the nature of Alzheimer's disease and other dementias, communication skills, therapeutic interventions and activities, the role of the family, environmental modifications that create a more therapeutic environment, development of service plans, new developments in diagnosis and therapy, skills for recognizing physical or cognitive changes that warrant medical attention, and skills for maintaining resident safety.

ALC/PCH: At a minimum, the memory care center must provide

the following staffing:

- (1) One dementia trained direct care staff person for every 12 residents on-site during all waking hours and for every 15 residents on-site during all non-waking hours based on a monthly average; provided, however, that such ratio is adequate to meet the needs of the residents;
- (2) One registered professional nurse, licensed practical nurse, or certified medication aide on-site at all times;
- (3) Two direct care staff persons on-site at all times, with at least one on each occupied floor; and
- (4) One registered professional nurse or licensed practical nurse on-site or available in the building at all times as follows:
 - (A) For memory care centers with one to 12 residents, a minimum of 8 hours per week;
 - (B) For memory care centers with 13 to 30 residents, a minimum of 16 hours per week;
 - (C) For memory care centers with 31 to 40 residents, a minimum of 24 hours per week; or
 - (D) For memory care centers with more than 40 residents, a minimum of 40 hours per week.

For both types of licensure, at least one administrator, on-site manager, or responsible staff person, all of whom must be at least 21 years of age, must be on the premises 24 hours a day. There must be sufficient staff to meet residents' needs always.

PCH: There should be a minimum of one on-site staff person per 15 residents during waking hours and one staff person per 20 residents during non-waking hours. Additionally, there must be 1 direct care staff on-site at all times on each floor.

ALC: There should be a minimum of one on-site staff person per 15 residents during waking hours and one staff person per 20 residents during non-waking hours. Additionally, there must be 2 direct care staff on-site at all times with one on each floor.

RN/LPN Coverage in ALC: One registered professional nurse or licensed practical nurse on-site or available in the building at all times as follows:

- For communities with one to 30 residents, a minimum of 8 hours per week;
- For communities with 31 to 60 residents, a minimum of 16 hours per week;
- For communities with 61 to 90 residents, a minimum of 24 hours per week;
- For communities with more than 90 residents, a minimum of 40 hours per week;

Memory Care: At a minimum, the memory care center must provide the following staffing:

(i) One dementia trained direct care staff person for every 12 residents on-site during all waking hours and for every 15 residents on-site during all non-waking hours based on a monthly average; provided, however, that such ratio is adequate to meet the needs of the residents;

(ii) One registered professional nurse, licensed practical nurse, or certified medication aide on-site at all times;

(iii) Two direct care staff persons on-site at all times, with at least one on each occupied floor; and

(iv) One registered professional nurse or licensed practical nurse on-site or available in the building at all times as follows:

- For memory care centers with one to 12 residents, a minimum of 8 hours per week;
- For memory care centers with 13 to 30 residents, a minimum of 16 hours per week;
- For memory care centers with 31 to 40 residents, a minimum of 24 hours per week; or
- For memory care centers with more than 40 residents, a minimum of 40 hours per week.

**Administrator/Director
Education and Training
Requirements**

For ALC and PCH licensed for twenty-five (25) or more beds must hold a valid license from the State Board of Long Term Care Facility Administrators with an effective date no greater than sixty (60) days from the date of hire or July 1, 2021, whichever is later.

PCH with twenty-four (24) beds or less: Administrator must have either an Associate's Degree or a G.E.D. or high school diploma and 2 years of experience working in a licensed personal care home or other healthcare related setting.

**Direct Care Staff Education
and Training Requirements**

For both PCHs and ALCs, all persons working in the facility must receive work-related training acceptable to the state Department of Community Health within the first 60 days of employment. Training is required in the following areas: CPR, first aid, emergency procedures, medical and social needs and characteristics of the resident population, residents' rights, the long-term care resident abuse reporting act, and general infection control principles. Additionally, all staff must complete a minimum of five hours on fire safety training within 90 days of employment. Additionally, a minimum of two hours of fire safety refresher training shall be required every three years from the date of initial training. Direct care staff must complete a total of at least 24 hours of continuing education within the first year of employment. All direct care staff, including the administrator or

on-site manager, must have at least sixteen (16) hours of training per year.

Quality Requirements

There are no specific quality requirements detailed.

Infection Control Requirements

ALCs: Each assisted living community must have an effective infection control program which includes, at a minimum, the following:

- training provided to staff on effective measures for minimizing the spread of infections and food borne illnesses;
- responding to disease outbreaks appropriately and participating in infection control investigations;
- staff demonstrating their understanding and use of proper infection control practices in their delivery of care to the residents;
- enforcing work and return to work policies to minimize the spread of infection and illnesses; and
- implementing the additional infection control requirements set forth in the Rules and Regulations for Disaster Preparedness Plans, regarding pandemic plans, supplies and policies and procedures.

The assisted living community must have an adequate supply of sanitizing and cleaning agents, e.g.. effective hand hygiene products, hand soap, laundry soap, household disinfectants and other cleaning materials, available and used in the assisted living community to minimize the spread of infections. Toilet tissue, soap, hot and cold running water and clean towels must be available for use wherever commodes are located. The assisted living community must have a supply of first aid materials available for use, including, at a minimum, gloves, band aids, thermometer, tape, gauze, and an antiseptic.

The storage and disposal of bio-medical and hazardous wastes must comply with applicable federal, state, and local rules and/or standards. Solid waste which is not disposed of by mechanical means must be stored in vermin-proof, leak-proof, nonabsorbent containers with close-fitting covers until removed. Waste must be removed from the kitchen at least daily and from the premises at least weekly.

An insect, rodent or pest control program must be maintained and conducted in a manner which continually protects the health of residents.

Residents' private living spaces or bedrooms must be thoroughly cleaned and sanitized after residents move out of the rooms. The assisted living community must clean the residents' private living

spaces periodically and as needed to ensure that the space does not pose a health hazard.

The assisted living community must notify residents of infectious disease outbreaks or incidents as specified in the Rules and Regulations for Disaster Preparedness Plans.

PCHs: The home must have a supply of first-aid materials available for use. This supply must include, at a minimum, gloves, band aids, thermometer, tape, gauze, and an antiseptic. A home must also provide hand-sanitizing agents or soap and water at the sinks, clean towels and toilet tissue at each commode. Hand washing facilities provided in both kitchen and bathroom areas must include hot and cold running water, soap, and clean towels. Each PCH must have an effective infection control program which includes, at least :

- Training provided to staff on effective measures for minimizing the spread of infections and food borne illnesses.
- Responding to disease outbreaks appropriately and participating in infection control investigations.
- Staff demonstrating their understanding and use of proper infection control practices in their delivery of care to the residents.
- Enforcing work and return to work policies to minimize the spread of infection and illnesses.
- Providing notices as recommended by public health regarding outbreaks and infestation issues to residents, staff and any visitors. Homes licensed for twenty-five (25) or more beds must meet the notification requirements of the Rules and Regulations for Disaster Preparedness Plans.

PCHs must also have an adequate supply of sanitizing and cleaning agents, e.g. effective hand hygiene products, hand soap, laundry soap, household disinfectants and other cleaning materials, properly stored to prevent accidental ingestion but available for and properly used in the home to minimize the spread of infections.

Residents' private living spaces or bedrooms must be thoroughly cleaned and sanitized after residents move out of the rooms. The home must clean the residents' private living spaces periodically and as needed to ensure that the space does not pose a health hazard. Homes licensed for twenty-five (25) or more beds must follow the additional infection control requirements set forth in the Rules and Regulations for Disaster Preparedness Plans, regarding pandemic plans, supplies and policies and procedures.

Emergency Preparedness Requirements

ALCs:

(1) must comply with the requirements of Chapter 111-8-16, Rules and Regulations for Disaster Preparedness Plans.

(2) Have building evacuation maps with routes of escape clearly marked must be posted conspicuously on each floor of the assisted living community. Assisted living communities must have a clearly accessible route for emergencies throughout the common areas of the assisted living community.

(3) The disaster preparedness plan must be readily accessible to staff, residents and their families at the assisted living community and identify the staff position(s) responsible for implementing the plan, obtaining necessary emergency medical attention or intervention for residents.

(4) The assisted living community must provide timely notification of the relocation address to the residents, their family contacts and representatives, if any, and the Department whenever the assisted living community must relocate the residents as a result of an emergency situation which disrupts the provision of room and board for the residents at the licensed location.

PCHs must train all new employees within the first 30 days on emergency preparedness training and must comply with the requirements of Chapter 111-8-16, Rules and Regulations for Disaster Preparedness Plans.

Disaster Preparedness Plan requirements apply to both facility types. The plan must include:

(1) a section in which the unique needs of the facility's residents are identified and assessed

(2) a section which identifies the emergency situations to be addressed by the plan. As a minimum the following emergency situations shall be addressed:

(a) fire;

(b) explosion;

(c) unanticipated interruption of each utility used by the facility; i.e., electricity, gas, other fuel, water, etc.;

(d) loss of air conditioning or heat; and

(e) damage to physical plant resulting from severe weather, i.e., tornadoes, ice or snowstorms, etc. Other emergencies or hazards may be included in the plan.

(3) For each of the emergencies identified in (2) above, the plan shall include a set of emergency guidelines or procedures. A standardized format should be used throughout the plan that

clearly describes how the emergency procedures should be carried out. The emergency procedures should answer the questions of "who, what, when, where, and how", and allow the facility to be ready to act effectively and efficiently in an emergency situation.

(4) The written procedures referred to in (3) above should address as a minimum: assignment of responsibility to staff members; care of the residents; notification of attending physicians and other persons responsible for the resident; arrangements for transportation and hospitalization; availability of appropriate records; alternate living arrangements; and emergency energy sources.

(5) The plan must contain a section that outlines the frequency of rehearsal and the procedures to be followed during rehearsal. The rehearsal should be as realistic as possible and designed to check the following:

(a) knowledge of facility staff regarding their responsibility under the plan;

(b) the reliability of individuals or community agencies or services that are listed in the plan as resources to be called upon in the event of an emergency. However, the quest for realism in the rehearsal of the plan should not require the actual movement of non-ambulatory patients/residents nor those whose physical or mental condition would be aggravated by a move.

(6) When portions of the plan are contingent on services or resources of another agency, facility, or institution, the facility shall execute a written agreement with the other party or parties acknowledging their participation in the plan. Such agreement(s) shall be made a part of the plan.

(7) Long-term care facilities shall include in the plan a pandemic plan for influenza and other infectious diseases which conforms to CDC standards and contains the following minimum elements:

(a) Protocols for surveillance and detection of epidemic and pandemic diseases in residents and staff;

(b) A communication plan for sharing information with public health authorities, residents, residents' representatives or their legal surrogates, and staff;

(c) An education and training plan for residents and staff regarding infection control protocols;

(d) An infection control plan that addresses visitation, cohorting measures, sick leave and return-to-work policies, and testing and immunization policies; and

(e) A surge capacity plan that addresses protocols for

contingency staffing and supply shortages.

Each Long-term care facility shall:

(1) Inform its residents and their representatives or legal surrogates by 5:00 P.M. the next calendar day following the occurrence of either a single confirmed infection of COVID-19 or another airborne infectious disease identified by the department or the CDC as a threat to public health, or three or more residents or staff with new-onset of respiratory symptoms occurring within hours of each other. Such information shall:

(a) Not include personally identifiable information;

(b) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and

(c) Include any cumulative updates for residents and their representatives or legal surrogates at least weekly or by 5:00 P.M. the next calendar day following the occurrence of any subsequent confirmed infection of COVID-19, or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours of each other;

(2) Maintain a minimum of a seven-day supply of protective masks, surgical gowns, eye protection, and gloves sufficient to protect all residents and staff based on CDC guidance and with consideration given to any widespread supply shortages documented by the facility or known to the department;

(3) Maintain and publish for its residents and their representatives or legal surrogates policies and procedures pertaining to infection control and mitigation within their facilities and update such policies and procedures annually; and

(4) On or before September 28, 2020, ensure that each resident and direct care staff person has received an initial baseline molecular SARS CoV-2 test as outlined by the CDC.

Life Safety Requirements

PCH: Facilities licensed for two to six beds must meet all local fire safety ordinances. Facilities licensed for seven or more beds must comply with state fire safety regulations. Sprinkler systems are required in all homes with seven or more beds and in areas where local ordinances require such systems. All personal care homes, regardless of size, must have sufficient smoke detectors that are hard wired into the building's electrical system with a battery backup. Georgia has adopted the 2000 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code.

ALC: Must meet all local fire safety ordinances and must be rated as a limited or existing healthcare facility.

Medicaid Policy and Reimbursement

Medicaid reimbursement is generally not available for ALCs. A Section 1915(c) Medicaid home and community-based services waiver may reimburse services provided in two models of PCHs, which are much smaller homes.

Found in the Elderly & Disabled Waiver Program, the Community Care Services Program and Service Options Using Resources in a Community Environment Programs serve frail elderly and disabled Georgians otherwise eligible under a nursing facility level of care through the provision of case management for service coordination, adult daycare, alternative living services, personal care, home-delivered meals, and respite care for family caregivers.

Citations

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