Adult Foster Care Administrative Licensing Rules

Technical Assistance Manual



DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

Bureau of Community and Health Systems

Adult Foster Care Division

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ADULT FOSTER CARE/ HOMES FOR THE AGED

INTRODUCTION

The Adult Foster Care (AFC) "*Technical Assistance (TA) Manual*" is not a new set of rules or regulations. Instead, it is a companion resource to the AFC Licensing Act and administrative licensing rules. The AFC TA Manual was created to ensure consistent application and enforcement of the AFC Licensing Act and rules.

Licensing staff routinely inspect and conduct special investigations in AFC homes to ensure licensees are compliant with the AFC Licensing Act and rules. The AFC TA Manual provides clarification of the inspection and investigation process.

The AFC TA Manual gives a general overview of licensing rules and provides additional information to broaden one's knowledge about the intent and meaning of specific rules, as well as offers recommendations that go above minimum licensing rules. ***Every rule is listed in the AFC TA Manual. However, only the rules where additional context may be helpful are expanded.*** The AFC TA Manual is organized in the following format:

RULE- Includes the actual text for the rule.
TECHNICAL ASSISTANCE- Provides additional and supporting information for a rule requirement. Offers additional information to assist licensees with meeting and maintaining rule compliance, including various resources.
INDICATORS- Explains how licensing staff may assess the rule(s) to determine compliance.
RECOMMENDATIONS- Provides valuable recommendations for implementing higher levels of quality that may go beyond the minimum rule requirements within Adult Foster Care homes.

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PART 1. GENERAL PROVISIONS

Definitions

R 400.601 Definitions. Rule 601. (1) As used in these rules:

(a) "*Act*" means the adult foster care facility licensing act, 1979 PA 218, MCL 400.701 to 400.737.
(b) "*Administrator*" means the individual who is designated by a licensee to be responsible for the daily operation and management of an adult foster care facility. An administrator may be the licensee.
(c) "*Admission policy*" means a written statement of the facility's purpose, eligibility requirements for admission, fees as a condition of admission, and application procedures for admission.
(d) "*Alzheimer's*" means a progressive disease or like conditions that destroys memory and other important mental functions.
(e) "*Assessment plan*" means a written plan that is prepared in cooperation with a responsible agency or individual that identifies the specific care and on-going support, services, and activities appropriate for a resident's physical and behavioral needs and well-being and the methods of providing the care and services, considering the preferences and competency of the resident.
(f) "*Assistive device*" means the use of an item such as a pillow, pad, or medically supplied therapeutic support that is intended to achieve or maintain the proper position, posture, or balance of a resident. An assistive device may also be an item that is intended to promote, achieve, or maintain the resident's independence. Anything that is used with the intent to restrain a resident and that does not permit the resident to remove the device by themself is a restraint and is not an assistive device.
(g) "*Continuous nursing care*" means a nurse's around-the-clock presence to provide ongoing nursing assessments, judgments, or interventions.
(h) "*Crisis intervention*" means techniques that enable trained staff to maintain control in crisis situations through actions to deescalate the resident and reduce the chance for physical injury to those present. Physical restraint is only used when all verbal and nonverbal techniques have been exhausted, and a resident's actions are escalating toward physical aggression.
(i) "*Department*" means the department of licensing and regulatory affairs.
(j) "*Designated representative*" means an individual or agency that has been granted written authority by a resident to act on their behalf or is the legal guardian of a resident.

TECHNICAL ASSISTANCE

Pursuant to the adult foster care rules, a resident may appoint a designated representative. "Designated representative" means a person or agency that has been granted ***written authority*** by a resident to act on behalf of the resident. Licensees and

residents may use the division's Appointment of Designated Representative form to appoint a designated representative, or utilize a similar form. *If a resident has a court-appointed guardian, the guardian is automatically the designated representative, and the appointment of a third party as designated representative is not acceptable.*

A designated representative often assumes many responsibilities and interacts with the residents and AFC home on a regular basis. If a resident appoints a designated representative, it does not replace the resident's right to make his/her own decisions. Limited exceptions to this may exist for court-appointed guardians and/or other persons with lawful authority, acting on behalf of the resident.

The following references to AFC licensing rules illustrate the role of a designated representative:

- Participation in the admission process
- Handling of resident funds R 400.637
- Provide a written health care appraisal or medical discharge summary. R 400.685 (10).
- Assist with the completion of a written assessment plan at the time of admission and review with the licensee at least annually. Rule 400.685 (4).
- Review and approve a written resident care agreement at the time of admission and at least annually thereafter. R 400.685 (6) & (9).
    - Receipt of notices of incidents from the licensee. R 400.693 (1).
    - Discharge or emergency discharge. R 400.687 (4) & (6).
    - Property remaining on the licensee's premises after discharge or death. R 400.637 (18).
- Occurrence damage that impacts the facility to provide adult foster care or relocation of the residents to a different address, or any fire. R 400.647 (18).
- Sharing of a resident bedroom when residents are of different gender is allowed if residents, designated representatives, and responsible agencies agree. R 400.657 (8)
- Use of assistive devices. R 400.673 (1)
- Use of repeated or prolonged crisis intervention. R 400.643 (1) & (7).
- Initiation process regarding the repeated and prolonged use of medicine prescribed on an "as-needed" basis. R 400.675 (4)(d)

The resident's designated representative should receive a copy of the following items:

- House rules. R 400.687 (2).
- Resident care agreement. Rule 400.14301/400.15301(8).
- Refund agreement. R400.837 (15)-(17).
- Resident rights. R 400.681 (4)

- Change of residency of resident and provide written consent. R 400.687 (8).
- Admission and discharge policies. R 400.687 (1).
- Handling of resident funds and valuables as required by Rule 637 (1)-(14).

(k) "*Direct care staff*" means an individual designated by the licensee or administrator to provide personal care, protection, and supervision to residents.

TECHNICAL ASSISTANCE

Applies to <u>any individuals, including contracted staff,</u> who provide personal care, supervision, and protection to residents.

(l) "*Discharge policy*" means a written statement of the conditions and procedures by which a resident is discharged from a facility.
(m)"*Elopement*" means a resident who has a service plan that requires notice or arranged supervision to leave the facility and is absent without notice or supervision
(n) "*Health care appraisal*" means a written statement by a licensed physician, licensed physician's assistant, or registered nurse that provides an assessment of the general physical condition of a resident.
(o) "*House rules*" means those rules that may be established by the licensee and that set the expectations for resident conduct.
(p) "*Incident*" means an intentional or unintentional event in which a resident sustains physical or emotional harm, dies unexpectedly or unnaturally, is displaced by a natural disaster, or elopes.
(q) "*Individual plan of service*" means a written plan developed by the resident or the resident's designated representative and the resident's responsible agency that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services that are to be provided to the resident.
(r) "*Isolation*" means complete and unattended separation of a resident from staff and other residents.
(s) "*Large group home*" means an adult foster care large group home as that term is defined in section 3 of the act, MCL 400.703.
(t) "*Members of the household*" means all individuals, including adults and children, that reside in the facility exclusive of residents.

TECHNICAL ASSISTANCE

Also includes occupants such as live in staff and "room and boarders". Members of the household do not include residents.

INDICATORS

At the time of an original or renewal inspection and/or special investigation, licensing consultants may establish the identity of all persons residing in the home.

(u) “Occupants” means all individuals who reside in the facility.

TECHNICAL ASSISTANCE

Occupants include the residents.

(v) "Physical restraint” means the bodily holding of a resident with no more force than necessary to limit the resident’s movement to prevent harm to self or others and discontinued at the earliest possible time.
(w) "Premises" means the facility, grounds, and other appurtenances.
(x) *Program statement*" means a written description of the program that includes all of the following:
i. Population to be served.
ii. Program goals, services, and community resources to meet the residents' needs.
iii. Services provided to residents, including a description of the types of staff competencies that are necessary to carry out these services.
iv. Description of any contract agreement for services and programs provided.

TECHNICAL ASSISTANCE

An applicant/licensee may choose to use the AFC Division’s **Program Statement Template** to create a Program Statement for their facility.

A contract agreement is a formal document outlining an agreement with any outside entities who provide services in the facility, such as, health care providers, home health agencies, physical therapists, hairdressers, etc.

Contract agreements can also mean a formal document outlining an agreement with an outside entity who is a payment/referral source for the facility, such as, community mental health agencies, senior services agencies, etc.

INDICATORS

The licensing consultant may review the program statement submitted for completeness, consistency with the home's house rules (if available) and admission policy, and the licensee/administrator's qualifications, training, and experience. A new program statement is to be obtained whenever there is a change in the home's program.

If the facility represents to the public that it provides services to persons with Alzheimer's Disease or any form of related dementia, the program statement must also comply with MCL 400.726b of Act 218 of 1979.

RECOMMENDATIONS

It is recommended that applicants/licensees view the division's Written Program Statements in AFC Homes video training.

(y) "Resident" means an adult as defined in section 3 of the act, MCL 400.703 in need of foster care, including an individual related to a licensee or live-in staff who needs foster care.

(z) "*Resident funds*" means paper currency, coins, gift cards, securities, bonds, stocks, debit cards, credit cards, and other like funds received by a licensee from, or on behalf of, a resident.

TECHNICAL ASSISTANCE

Monies include payment for adult foster care services, personal allowance, and/or monies in accounts with financial institutions. Food assistance program (FAP) benefits, aka food stamps, managed by nonprofit AFC homes are not considered "resident funds". This does not include contract monies received from a CMH authority for specialized services or Title XIX (19) Medicaid Personal Care Supplement payments.

(aa) "*Responsible agency*" means a public or private organization that, after written agreement with a resident or resident's designated representative, provides either or both of the following:

- (i) Assessment planning and establishment of an individual plan of service.
- (ii) Maintenance of ongoing follow-up services while the resident is in the facility.

(bb) "*Restraint*" means restraining a resident's movement using a device, equipment, or medication without an order from an appropriately licensed heath care professional.

(cc) "*Staff*" means the administrator, direct care staff, and other employees of the facility under the direction of the licensee excluding volunteers.

(dd) "*Street floor*" means any story or floor level that is accessible from the street or from outside the building at grade and at the main entrance is not more than 21 inches above, nor more than 12 inches below, street or grade level at those points.

(ee) "*Substantial risk*" means that a resident's behavior poses a serious imminent threat of bodily harm to self or others or the threat of the destruction of property and the resident can carry out such harm or destruction.

(ff) “Traumatic brain injury” means brain dysfunction caused by an outside force, usually a violent blow to the head.
(gg) "*Transportation services*" means travel by public or private vehicle and related cost to and from community program resources including consultation, medical, and other services.
(hh) "*Valuables*" means personal property of a resident held or stored by the licensee that includes, but is not limited to, clothing, jewelry, furniture, equipment, and appliances that each have a value of more than $100.00.
(ii) “*Volunteer*” means an individual under the direction of the licensee or administrator who is not considered staff of the facility and does not have unsupervised direct access to residents or resident records.

(2) Terms defined in the act have the same meanings when used in these rules. When terms are not defined in the act or in these rules, the standard definition contained in the Black’s Law dictionary is to be applied.

TECHNICAL ASSISTANCE

“Black’s Law Dictionary” is the most widely used and authoritative legal dictionary in the United states.

R 400.603 Applicability.

Rule 603. (1) R 400.601 to R 400.697 in parts 1 and 2 of these rules are applicable to all adult foster care facilities.
(2) R 400.699 in part 3 of these rules is applicable to family homes.
(3) R 400.701 in part 4 of these rules is applicable to small group homes, large group homes, and congregate facilities.
(4) R 400.703 to R 400.715 in parts 5 and 6 of these rules are applicable to adult foster care facilities seeking special certification.
(5) R 400.717 to R 400.745 in parts 7 and 8 of these rules are applicable to family homes and small group homes with 6 or fewer residents.
(6) An applicant or licensee shall ensure compliance with these rules.

R 400.605 Rule compliance; cooperation by applicant or licensee.

(1) An applicant or licensee shall make available to the department any document necessary to determine compliance with the act and these rules.

INDICATORS

Licensing staff may request to review facility documentation as needed, to verify compliance with the AFC Act and administrative licensing rules. Consultants may need access to resident areas to interview staff or residents privately.

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(2) An applicant or licensee shall cooperate with the department to determine compliance with the act and these rules during the review of an application and during an inspection or investigation.
(3) For purposes of these rules, the licensee designee shall meet all the requirements of the licensee.

R 400.607 Rule variance.

Rule 607.(1) A variance to an administrative rule may be granted by the department on written request from an applicant or licensee if there is demonstrated evidence that a proposed alternative complies with the intent of the rule from which a variance is sought.
(2) All the following apply to a variance that is granted:
- (a) May be time limited and subject to conditions set by the department.
- (b) Remains in effect for as long as the applicant or licensee continues to comply with the conditions set forth in the variance.
- (c) Is not transferable.

(3) Denial of a variance is not subject to administrative appeal.

TECHNICAL ASSISTANCE

Licensees who wish to request a variance to an administrative rule should contact their assigned consultant for assistance.

R 400.609 Compliance with local, state, or federal laws, rules, regulations, or standards.

Rule 609. (1) An applicant or licensee shall comply with applicable local, state, and federal laws, rules, regulations, and standards relevant to the act and these rules.
(2) During review of an application, a licensure inspection, or a complaint investigation, the department may request from the facility documentation of compliance or noncompliance with local, state, or federal authorities.
(3) The department may cite this rule only if the local, state, or federal authority that has jurisdiction over the specific law, rule, regulation, or standard has found the applicant or licensee to be noncompliant in writing and the department determines there is a need to protect the health, safety, and welfare of residents receiving care and services in or from the facility.

PART 2. REQUIREMENTS FOR ALL
Family Home, Small Group Home, Large Group Home, and Congregate Facility

SUBPART A: FACILITY OPERATION AND CONDUCT

R 400.611 Required information; fee; posting of license; change of information.

(1) An applicant or licensee shall maintain the following documents:

TECHNICAL ASSISTANCE

Electronic records are acceptable if the consultant is given access to the electronic records. Personnel records may be kept in a location outside the facility. These records must, however, be made available at the facility at the time of an announced inspection. If an unannounced inspection is conducted and those records are not available, the licensee is to make those records readily available to the licensing consultant.

(a) Admission policy and program statement.

TECHNICAL ASSISTANCE

Applicant licensees may choose to use the **Admission Policy Template** and **Program Statement Template** to create their admission policy and program statement.

RECOMMENDATIONS

It is recommended applicant licensees view the division's **Admission & Discharge Policies in AFC Homes** and **Written Program Statements in AFC Homes** video trainings.

(b) Personnel policies.
(c) Job descriptions.
(d) Standard or routine procedures.

TECHNICAL ASSISTANCE

"Standard or routine procedures" are the established, consistent, and repeatable steps staff are expected to follow to ensure the daily operation, safety, care, and well-being of residents. Procedures outline how tasks must be performed, who is responsible, and the expected quality or method for completing those tasks. Standard or routine procedures may include procedures on personal care routines, medication assistance procedures, meal preparation and food handling practices, supervision and resident safety checks, documentation and communication expectations, housekeeping and sanitation routines, and shift-change reporting and handoff procedures.

Applicants/licensees can download example job descriptions at **Example Direct Care Worker Job Description** and **Example Med Tech Job Description**

INDICATORS

Consultants may review the licensee's standard or routine procedures to ensure they do not conflict with administrative rules.

(e) Proposed staffing patterns.
(f) Organizational chart.
(g) Agreements or contracts with other organizations to provide care, treatment, or supplemental services that are required by the act or these rules.
(h) Floor plan of each level and basement of the entire structure, including the interior layout of foster care areas and room descriptions and specifics as to use, the number of beds, and the dimensions of floor space.

INDICATORS

Licensing consultants may review the floor plan to confirm it aligns with the original or addendum licensing study report.

(i) Verification of the lease, ownership, or right to occupy arrangements.

INDICATORS

Consultants may conduct city or township parcel searches to verify ownership of facilities or conduct a search at BS&A Online

(j) Articles of incorporation, a letter of authorization from the board of directors that designates the individual who is authorized to act on behalf of the corporation on licensing matters, a current list of the corporate directors, if applicable, and a certificate of incorporation.

INDICATORS:

Corporations – A corporation is a business or organization that the law treats as its own independent person, allowing it to operate, make decisions, and carry responsibilities separately from the people who run or own it. Corporations are more formal, structured, and designed for large or expanding companies.

LLCs – A type of business that protects the owners from personal liability while allowing them to run the business with fewer rules and greater flexibility than a corporation. An LLC is more flexible, easier to operate, and designed for small to mid-sized businesses.

Board of directors: While LLCs can have a board of directors, they are not required to do so. Corporations must have a board of directors, which oversee major decisions.

Articles of incorporation: Initial legal document filed with LARA to create a corporation or LLC. Business Entity Search

Certificate of Incorporation: Could also be titled “Certificate of filing/Certificate of Good Standing”. Official certificate issued by the state confirming Articles were filed and the corporation or LLC legally exists.

(k) Emergency preparedness policy.

R 400.613 Licensed capacity, occupants.

Rule 613. (1) The number of residents and number of resident beds must not be greater than the capacity authorized on the license.
(2) An individual related to the licensee or live-in staff is not counted in the licensed capacity but is considered an occupant.
(3) The total number of occupants must not be more than 6 over the licensed capacity.

TECHNICAL ASSISTANCE

Professionals who are not under the direct control or employment of the licensee, such as visiting nurses, hospice personnel, or pastoral care providers, may occasionally remain in the home to provide support to a resident, including overnight care. Individuals providing these services are present in the home solely to deliver care or support to a specific resident and are not considered occupants of the facility. Their presence does not change the licensed capacity of the home or the number of residents permitted under the license.

When a resident is receiving hospice services and it has been determined that the resident is at the end-of-life stage, family members or relatives may remain in the home to provide comfort and support to the resident, including staying overnight if necessary. Family members present for this purpose are there solely to support the resident during end-of-life care and are not considered occupants of the facility. Their temporary presence does not affect the licensed capacity of the home or the number of residents permitted under the license.

(4) If an occupant subsequently requires foster care and therefore becomes a resident, which causes the licensee to exceed the licensed capacity, the licensee has no more than 30 calendar days to return to the licensed capacity.

R 400.615 Resident register.

Rule 615. A licensee shall maintain a chronological register of all residents admitted that includes the following information for each resident:
(a) Resident full name.
(b) Resident date of birth.
(c) Date of admission.
(d) Date of discharge and location, if known, where the resident moved.

TECHNICAL ASSISTANCE

"Chronological" means arranged in the order that happened in time-from the earliest to the most recent. Subsequently, the resident register must include every resident that resided at the facility and not just the current residents.

Licensees may choose to use the division's **Resident Register-BCHS-535** template or create their own.

R 400.617 Records.

(1) A licensee shall maintain the following records:
- (a) Admission policy.
- (b) Program statement.
- (c) Discharge policy.
- (d) Resident records.
- (e) Resident register.
- (f) Resident care agreement.
- (g) Accident records and incident reports.
- (h) Staff records.
- (i) Personnel policies and procedures, excluding family homes that do not employ staff.
- (j) Certification as a specialized program, if applicable.
- (k) Fire drill records.
- (l) Emergency preparedness plan.
- (m) Reports of fire or severe property damage.
- (n) Records of variances granted.
- (o) Heating equipment inspection and approval records.
- (p) Fire detection and sprinkler equipment inspection and approval records. Electrical inspection records.
- (q) Fire safety reports from the department or the state fire marshal.
- (r) Environmental inspection reports.
- (s) Menus.
- (t) Vaccination and licensing records of pets in the facility in accordance with section 6 of the dog law of 1919, 1919 PA 339, MCL 287.266, and the local municipality.

(2) A licensee shall keep service records of emergency repair of heating, cooling, plumbing, and electrical equipment as well as include a list of persons to contact.

TECHNICAL ASSISTANCE

The applicant/licensee may choose to use the AFC Division's example Policies, Procedures, & Templates located at **Licensees** to create required records.

RECOMMENDATION

It is recommended that the licensee maintain all required records in a centralized, clearly labeled system (binder or secure digital folder) with consistent formats and dates. Assign one staff member to update records, use checklists to ensure no documents are missing, and schedule a routine review to verify accuracy and completeness. This reduces errors, supports compliance during inspections, and ensures quick access when records are requested.

It is recommended that licensees use the division's **Example Resident Record Format Outline** and **Example Employee-Volunteer Records Format Outline** to keep records organized.

R 400.619 Emergency preparedness plan.

(1) A licensee shall have a written emergency preparedness plan in case of fire, medical, weather, extended utility outage, or other emergencies. The plan must include where residents will receive care in the event the facility is no longer habitable.

(2) An emergency preparedness plan must include all of the following:

- (a) Specify persons responsible for carrying out the emergency preparedness plan and their responsibilities.
- (b) Persons to be notified during an emergency.
- (c) Locations of alarm signals and fire extinguishers.
- (d) Evacuation routes and designated point of safety.
- (e) Procedures and special staff response for evacuating residents of limited mobility or special needs and visitors.
- (f) Any special assistance needed by a resident.

(3) A licensee must have a written fire safety plan that includes all of the following:

- (a) Use of and response to alarms.
- (b) Notification of an alarm to the fire department.
- (c) Isolation of fire.
- (d) Evacuation of the facility.
- (e) Closure of bedroom doors and corridor access doors on exiting.
- (f) Use of fire extinguishers.

TECHNICAL ASSISTANCE

Resources include, but are not limited to:

Michigan Prepares

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

INDICATORS

The consultant may review the record of the items identified in this subrule and verify that this information is current. The consultant may verify that facility staff members know how to access this information. This may be done verbally or through interview and/or observation.

RECOMMENDATIONS

It is recommended that the licensee store their emergency preparedness plan in a clearly labeled, accessible location that is known to all staff. It is recommended that the plan be kept in multiple formats (printed copy in a binder, digital copy, etc.) and updated as needed.

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(4) The evacuation routes and designated point of safety must be prominently posted in the facility and include a floor plan that specifies locations of evacuation and exit routes to be followed.
(5) A licensee shall have a telephone available and accessible to anyone in the facility for emergency use and emergency telephone numbers posted in a conspicuous location that includes fire, police, and medical emergency services.

TECHNICAL ASSISTANCE

A cellular telephone provided by the licensee meets this rule requirement. Cellular telephones must be kept in the home at all times.

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(6) A licensee shall ensure that residents, volunteers, and members of the household are familiar with the emergency preparedness plan and fire safety plan and any assigned responsibilities to carry out the plan.
(7) A licensee shall ensure that all staff are instructed and retrained quarterly per calendar year, and new staff on hire, with respect to their duties and responsibilities under the emergency preparedness plan, on the operation of the fire alarm and other fire protection equipment. A record of the instruction must be maintained for 2 years.
(8) A licensee shall practice the emergency preparedness plan, including the fire safety plan, at least once a quarter per calendar year during each shift, 7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. A record of the practices must be maintained for 2 years.

TECHNICAL ASSISTANCE

Licensees and staff are to practice all emergency preparedness plans at least once a quarter, per calendar year during each shift. This includes plans in case of fire, medical, weather, extended utility outage, or other emergencies.

Staff must be able to determine whether all residents can be safely evacuated to the outside of the facility in a timely manner during a fire emergency. Subsequently, all residents, including those receiving hospice services, are required to participate in fire drills conducted under the facility's emergency preparedness plan.

Licensees must contact their assigned licensing consultant regarding any residents with significant medical conditions whose evacuation to the outside of the facility may be detrimental to their health, according to written documentation from their licensed health care professional, to discuss appropriate accommodations or alternative planning. In these situations, licensees should not independently exclude residents from fire drills without consultation and proper documentation. Any accommodation must allow staff to demonstrate the ability to protect the resident during a fire emergency. Medical restrictions and approved accommodations must be identified in resident assessment plans.

For **Fire Emergencies**, practices must include:

- Conducting a fire drill where staff practice activating the alarm system, assisting residents to evacuate, and ensuring residents move to a designated safe location outside the home.
- Practicing staff responsibilities such as checking bedrooms and bathrooms, accounting for all residents, and contacting emergency services if needed.

With the exception of fire emergency practices, residents are not required to participate in other emergency preparedness practices. However, residents may participate voluntarily if the licensee determines that participation would be beneficial and safe for the residents.

Emergency preparedness practices for **Medical Emergencies**, **Severe Weather**, **Extended Utility Outages**, and **Other Emergencies** may include, but are not limited to, the following types of scenarios:

Medical Emergency

- Staff practicing/reviewing procedures on how to respond if a resident experiences a medical crisis such as choking, a seizure, or loss of consciousness.
- Practicing calling 911, retrieving first aid supplies, and assigning staff roles during the emergency.

Severe Weather

- Practicing/reviewing procedures for tornado warnings or severe storms, including moving residents to a designated safe area such as a basement or interior room away from windows.
- Reviewing procedures on how staff monitor weather alerts and account for all residents during the event.

Extended Utility Outage

- Practicing/reviewing procedures to follow during a prolonged power outage, such as locating flashlights, ensuring backup lighting is available, monitoring indoor temperatures, and determining when relocation may be necessary.

Other Emergencies

- Practicing/roleplaying responses to situations such as a missing resident, gas leak, carbon monoxide alarm, or evacuation due to environmental hazards.

Practices for each type of emergency may be conducted separately or combined into the same practice session.

Licensees are required to document each practice and maintain these records for at least 2 years. Documentation should include:

- The date and time of the practice
- The shift during which the practice occurred
- The type of emergency scenario practiced
- Staff participating in the practice
- Whether residents participated (if applicable)
- Any issues identified or corrective actions taken

INDICATORS

Licensing consultants may use a combination of record review, staff interviews, and direct observation to determine whether the licensee is compliant with emergency preparedness practice requirements. Consultants may review practice and/or training records to ensure compliance, including identifying any missing shifts or calendar quarters, evaluating the time required to evacuate residents in the event of a fire, and noting any documented delays or barriers.

Consultants may compare fire drill documentation to the current resident roster, review resident records for evidence of participation and identify any residents who are routinely excluded from fire drills without appropriate documentation.

Consultants may interview direct care staff across various shifts to assess their knowledge of emergency procedures, resident-specific evacuation needs, and overall preparedness.

Appropriate accommodations and alternative planning that licensing consultants may share with licensees when a resident has a documented medical condition affecting evacuation include, but are not limited to:

- Use of evacuation devices, such as evacuation chairs, transfer sheets or sleds, and wheelchairs positioned for immediate access.
- Relocating resident to a bedroom closer to an exit when appropriate.
- Staff simulation of the resident's evacuation (without physically moving the resident) to evaluate response time and required assistance.
- Resident's participation in a partial drill (e.g., moving to a designated safe area instead of exiting the home).

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(9) A licensee shall ensure immediate emergency transportation through use of a recognized available community service or vehicle that is owned by the licensee, administrator, or direct care staff on duty.

R 400.620 Special license.

Rule 620. (1) A special license may be issued in accordance with section 18 of the act, MCL 400.718, if there is an instance where adult foster care residents of another licensed facility have been displaced due to fire, tornado, flood, or other disaster. The department may issue a special license for a period of up to 1 year while the resident's original home is being restored.
(2) The special license must comply with all administrative rules determined to be quality-of-care rules in accordance with section 6 of the act, MCL 400.706.
(3) The department may issue a special license when there are physical plant deficiencies if those deficiencies do not create an immediate risk to the residents, and the residents, a designated representative of a resident, and the responsible agency are made aware of the physical plant deficiencies.

SUBPART B: CHARACTER, CAPABILITY, TRAINING, AND QUALIFICATIONS

R 400.621 Capability.

Rule 621. Licensees, staff, volunteers, and members of the household shall be capable of ensuring the welfare of residents.

R 400.623 Applicant, licensee and administrator qualifications; licensee, administrator and staff requirements; parole or probation or convicted of felony.

(1) An applicant, licensee, and administrator shall have the financial and administrative capability to operate a facility as specified in the act and these rules.

TECHNICAL ASSISTANCE

The administrative capability of a license applicant may be met when he/she has met the competency requirements contained in subrules (2)(3)(4)(5)(6) and has demonstrated compliance with the Act and the administrative rules.

An applicant must demonstrate the administrative capability to operate an adult foster care facility in accordance with the Adult Foster Care Facility Licensing Act and applicable rules. During the licensing process, the Division may consider the applicant's ability to follow application instructions and submit complete, acceptable documentation within the timeframes provided. If a documented pattern of missing or noncompliant submissions demonstrates that the applicant lacks the required administrative capability, the Division may refuse to issue an original AFC license.

Existing licensees' compliance may also be based upon their demonstrated ability to operate the facility, provide care and services consistent with their Program Statement, Admission/Discharge Policy, and care needs of the residents in the home and the ability to maintain substantial compliance with the Act and these Administrative Rules.

INDICATORS

Licensing consultants may review items to determine compliance. Documentation may include:

- Program statement
- Admission policy
- Financial statement
- Budget
- Contracts for services
- Resumes
- References

Licensing consultants can also consider approving administrative capability based on operation of other AFCs.

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(2) An applicant, licensee, and administrator shall be competent in all of the following areas:

TECHNICAL ASSISTANCE

Competency can be demonstrated through any one or more of the means identified in subrule (4) of this rule.

Note that the license designee must also meet the competency requirements of this rule R 400.605 (3).

(a) Nutrition

TECHNICAL ASSISTANCE

Documentation from the applicant and administrator confirming the completion of a nutrition course covering the basics of nutrition, food shopping, storage, preparation, kitchen safety, food service and cleanup is acceptable. Acceptable sources of training include but are not limited to local public health departments, local cooperative extension services, local community colleges, nutrition training provided by LARA-BCHS or Department of Health and Human Services.

Training resources include but are not limited to:

AFC Division's Nutrition Training videos/quizzes
MyPlate.gov | MyPlate Tools

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

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(b) First aid

TECHNICAL ASSISTANCE:

Documentation maintained by the applicant and administrator confirming the completion of a course (class) in basic first aid is acceptable. Acceptable sources of training include but are not limited to local public health departments, hospitals, the American Red Cross, a licensed physician, registered nurse (R.N.), emergency medical technician (E.M.T.), physician's assistant, or a person certified by the American Red Cross in this subject as a trainer.

A list of training resources can be located at AFC Self-Study Training and On-Going Training

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(c) Cardiopulmonary Resuscitation (CPR).

TECHNICAL ASSISTANCE:

Competency in CPR is demonstrated by participation in and successful completion of a CPR training course. CPR training includes two essential components: **Knowledge** and **hands-on skill performance**. While the knowledge portion can be delivered effectively through online learning, the skills component must be completed in person to ensure accuracy, safety, and competency.

A list of training resources can be located at AFC Self-Study Training and On-Going Training

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(d) Foster Care.

TECHNICAL ASSISTANCE:

Training resources include, but are not limited to:

Intro to Adult Foster Care, Supervision, Protection, and Personal Care

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training
Documentation demonstrating the applicant and administrator's knowledge of the adult foster care administrative rules and requirements of Act 218 of 1979.

INDICATORS

Examples of documentation consultants may review include, but are not limited to, confirmation of previous experience providing personal care, protection, and supervision of vulnerable adults (this may require third party confirmation), and verification of the completion of AFC Rule-Based Training.

(e) Safety and fire prevention.

TECHNICAL ASSISTANCE:

Documentation from the applicant and administrator confirming training in emergency preparedness, e.g., knowledge of basic emergencies and disasters; knowledge of responsibilities during emergency situations; knowledge of how to develop an emergency preparedness plan; knowledge of what to do to help residents with special needs; knowledge of how to prevent and respond to common types of home fires (grease, careless smoking, etc.), is acceptable. Training resources may include but are not limited to local fire departments, MDHHS, CMH, Fire Safety/Emergency preparedness training, National Fire Protection/Prevention Association training courses.

Training resources include, but are not limited to:

AFC Division's Safety & Fire Prevention videos/quizzes

Fire Prevention and Community Risk Reduction

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

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(f) Financial and administrative management.

TECHNICAL ASSISTANCE

Demonstrated ability on the part of the applicant based upon the successful operation of other licensed facilities and the ability of the applicant to follow through the application process in a timely and organized manner. Other management/supervisory experience and/or course work or training workshops in business management may be considered.

A list of training resources can be located at AFC Self-Study Training and On-Going Training

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(g) Knowledge of the needs of the population to be served.

INDICATOR

Documentation from the applicant and administrator confirming one year of experience working with the population identified in the home's admission policy and program statement, [see subrule (4) of this rule], is acceptable.

(h) Resident rights.

TECHNICAL ASSISTANCE

Licensees may choose to use the AFC Division's **Resident Rights Policy Template** to create a policy on Resident Rights.

Training resources include, but are not limited to:

AFC Division's Resident Right's training/quizzes

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

INDICATORS

The licensing consultant will review the applicant's policies and procedures to determine compliance with resident rights as specified in 400.681.

(i) Prevention and containment of communicable diseases.

TECHNICAL ASSISTANCE

Documentation from the applicant and administrator confirming completion of training in the prevention and containment of communicable diseases consistent with current OSHA guidelines on bloodborne pathogens is acceptable. Acceptable course content should address such areas as: identification of situations where risk of exposure to bloodborne pathogens exist; the need to keep work and room surfaces clean, orderly and in a safe and sanitary condition; the purpose of universal precautions; precautions that should be taken to prevent the spread of diseases; and correct hand washing procedures. Sources of training may include but are not limited to local health departments, American Red Cross, training by a licensed physician, registered nurse, hospitals, and DHHS/CMH training in the subrule subject matter.

Training resources include, but are not limited to:
AFC Division's Prevention and Containment videos/quizzes

Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings | Infection Control | CDC

CDC Infection Prevention and Long-Term Care Facility Residents

Influenza

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

(j) Medication administration.

TECHNICAL ASSISTANCE

The division provides an ongoing "Medication Administration Rules and Best Practices in AFC Homes" Training. This is a free virtual training opportunity for licensees, administrators, and direct care staff members. Upcoming training sessions are announced via GovDelivery. GovDelivery allows licensees and their staff members to sign up for announcements and alerts. Sign up to receive announcements and alerts from BCHS!

(3) Training for subrule (2)(b) and (c) of this rule must be in accordance with these rules and the individual providing the training shall be trained and follow nationally recognized standards.
(4) A licensee and administrator shall have a high school diploma or general education diploma or equivalent and not less than 1 year of direct experience working with individuals that are aged or have been diagnosed with a mental illness, developmental disability, physical disability, traumatic brain injury, or Alzheimer's disease. This

experience must align with the intended population to be served that is identified in the facility's program statement and admission policy. The education requirement of this subrule does not apply to family or congregate facilities licensed on or before promulgation of these rules that has been continuously licensed.

TECHNICAL ASSISTANCE

“Direct experience” refers to “hands on” and “face to face” work providing care or support services to individuals that are aged or have been diagnosed with a mental illness, developmental disability, physical disability, traumatic brain injury, or Alzheimer’s disease. “Direct experience” typically includes work such as, assisting with personal care, providing supervision and monitoring, supporting individuals with daily living activities, and helping individuals with behavioral supports, redirection or structured routines.
Roles that would meet this requirement may include, but are not limited to, direct care workers, CNAs, home health aides, behavioral technicians, group home staff members, case managers, social workers, supportive living aids, and/or supervisory roles with caregiving responsibilities.

Experience that is not hands-on and subsequently would not be considered “direct experience” includes, but is not limited to, administrative office work, observational roles, billing and finance, maintenance, and transportation.

The term “continuously licensed” means a facility that has remained licensed without any lapse, closure, revocation, or period of operating unlicensed. This includes situations in which a new license was required due to a change in ownership, licensee, location, or licensure status, provided there was no interruption in licensure between the previous and subsequent license.

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(5) A licensee and administrator or their designee shall possess all of the following qualifications:
- (a) Be capable of meeting the physical, emotional, social, and intellectual needs of each resident.
- (b) Be capable of appropriately handling emergency situations.
- (c) Be capable of ensuring program planning, development, and implementation of services to residents consistent with the facility's program statement and in accordance with a resident's assessment plan and care agreement.

(6) A licensee, administrator, and staff shall cooperate with a resident, resident's family as appropriate, designated representative of a resident, and the responsible agency.
(7) A licensee or administrator shall designate, in writing, an individual who is on-site or who is immediately available, and who has the authority to carry out the licensee's or administrator's responsibilities in the temporary absence of the licensee or administrator. The identified designated individual shall be made known to all staff.

TECHNICAL ASSISTANCE

The individual designated to act in this capacity must be qualified to perform the duties of the licensee or administrator and must meet all applicable licensee/administrator training and health screening requirements. This individual can be the administrator, if they are not also the licensee or licensee designee, or can be a different individual.

The designated individual must also comply with the same background check requirements as a direct care staff member, including fingerprinting and eligibility determination through the Workforce Background Check system.

A “temporary absence” is short-term, occasional, and limited in duration. A “temporary absence” means any period of time the licensee or administrator is not available and is unable to immediately perform their required duties, even though they remain responsible for the operation of the facility. An absence that is permanent or long-term is not considered “temporary”.

INDICATORS

Licensing consultants may verify compliance with this rule by:

- Reviewing written designation documentation
- Confirming the individual meets training and health screening requirements
- Verifying Workforce Background Check eligibility status
- Interviewing staff to ensure awareness of the designated individual
- Assessing whether the individual demonstrates sufficient knowledge and authority to fulfill the role.

RECOMMENDATION

It is recommended that licensees designate more than one individual to act in this capacity to ensure coverage across all shifts, weekends, and unexpected absences and to reduce the risk of noncompliance if the primary individual is unavailable.

It is also recommended that licensees develop a clear written “chain of command” that outlines the primary and secondary authorized facility designees, order of responsibilities, and their contact information. It is recommended that this written information be posted in a staff-accessible area and included in orientation materials.

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(8) A licensee, administrator, and staff shall not be the legal guardian or conservator of a resident who lives in the facility, as specified in section 5313 of the estates and protected individuals code, 1998 PA 386, MCL 700.5313. Exceptions to this rule are allowed if an individual is a relative of the resident or if the guardianship or conservatorship of the licensee existed before April 1, 1989.
(9) The licensee shall notify the department of the name of any volunteer or member of the household who is on a court-supervised probation or parole or has been convicted of a felony. Notification must be within 48 hours of the licensee becoming aware.

R 400.625 Administrator.

Rule 625. Except for family homes, a facility shall have an administrator.

R 400.627 Licensee and administrator training requirements.

Rule 627. (1) A licensee and administrator shall complete annual training based on the license issue date, the educational requirements specified in subdivision (a) or (b) of this subrule, or a combination that totals 16 hours:

(a) 16 hours of training accepted by the department that is relevant to the licensee's admission policy and program statement.

(b) 6 credit hours at an accredited college or university in an area that is relevant to the licensee's admission policy and program statement as accepted by the department.

(2) A licensee and administrator shall complete the department training titled “AFC New Provider Training” within 6 months of the initial license being issued or within 6 months of being hired as applicable. If an individual has documentation of completing this training previously, they are not required to take this training again.

TECHNICAL ASSISTANCE

The division provides the “AFC New Provider Training” on an on-going basis. This virtual training is free. Upcoming training sessions are announced via GovDelivery. GovDelivery allows licensees and their staff to sign up for announcements and alerts. Sign up to receive announcements and alerts from BCHS!

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(3) The department may prescribe additional training if substantial noncompliance with the act or these rules is evident.

R 400.629 Direct care staff; qualifications and training

TECHNICAL ASSISTANCE

Licensees may utilize temporary staff obtained through an employment agency and/or volunteers to perform direct care functions. However, when temporary staff or volunteers are used in this capacity, the licensee is responsible for ensuring full compliance with all employee-related requirements regarding training, demonstrated competency, and completion of criminal history background checks. See also **MCL 400.734b** for statutory requirements related to criminal history checks.

For temporary staff obtained through an employment agency, the licensee must either:

- Obtain verification from the employment agency that a background check has been completed through the **Workforce Background Check System** or
- Conduct a Workforce Background Check independently.

Information regarding Workforce Background Checks for employment agency staff can be accessed through the **Workforce Background Check System** or by contacting the Workforce Background Check Program at **877-718-5542**.

For volunteers:

- If a volunteer is performing duties in the capacity of direct care staff, the licensee must conduct a Workforce Background Check.
- If a volunteer is not acting as direct care staff but will have unsupervised access to residents, a Workforce Background Check is still required.

Licensees are responsible for ensuring that all individuals providing care or having unsupervised access to residents have been properly screened in accordance with applicable requirements.

RECOMMENDATIONS

It is recommended that licensees view the division's Workforce Background Checks Provider Responsibilities video training.

Rule 629. (1) Direct care staff shall be at least 18 years of age and able to complete required reports and follow written and oral instructions that are related to the care and supervision of residents.
(2) Minor individuals who are 16 or 17 years of age may be considered as a direct care staff under subrule (1) of this rule and counted toward the staff-to-resident ratio if all the following criteria are met:

(a) The individual is under direct supervision of a fully trained direct care staff who is onsite at the facility and is at least 18 years of age.
(b) The individual does not provide transportation for the residents.
(c) The individual does not provide medication administration to the residents.
(d) The individual meets all the direct care staff training and requirements in these rules for the duties that the individual is assigned.
(e) The individual shall receive parent's consent as required to undergo a background check pursuant to section 34b of the act, MCL 400.734b.

RECOMMENDATIONS

It is recommended that licensees verify with the applicable pay source whether compensation is permitted for 16- and 17-year-old employees.

(3) Staff shall be individuals who are not residents.

INDICATORS

The consultant may review the resident register and employee records to determine the roles of all persons. Under no circumstances may a resident assist in the

administration of the home or care and supervision of other adult foster care residents.

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(4) Direct care staff shall possess all of the following qualifications before working independently:

(a) Be suitable to meet the physical, emotional, intellectual, and social needs of each resident.

(b) Be capable of appropriately handling emergency situations.

INDICATORS

Consultants may assure that the licensee has a method to assess that staff are capable of meeting the physical, emotional, intellectual, and social needs of each resident and capable of appropriately handling emergency situations. Examples may include, but are not limited to, an observation of staff and resident interactions during inspections and investigations, a review of available facility documentation, such as staff competency checklists, staff communication logs, Incident Reports, practice evacuations drill records, and employee performance evaluations, as well as feedback from residents and/or their responsible person or legal guardian.

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(5) A licensee or administrator shall provide in-service training or make training available through other sources to direct care staff. Direct care staff shall be trained and competent in all of the following areas before performing assigned tasks independently.

TECHNICAL ASSISTANCE

Training can be provided by the licensee or administrator, and they can use relevant training videos or other training resources. Exception is CPR. See the Technical Assistance under (c) Cardiopulmonary resuscitation.

The division's "Provider Training YouTube Channel" was created for providers to locate free resources and training videos/quizzes related to codes, rules, acts, and "best practices". Many of the videos come with quizzes, which are located in the information box below the videos.

The division also compiled an extensive list of Training Resources related to AFC. Training on these lists do not constitute an endorsement of any particular trainer, training company, or their consultative or other services, and can be located HERE.

The licensee must have a method to assure competency. The licensee is required to maintain written verification of completed training in the required areas of competence in each employee record. See Rule 400.639 (1)(e). Examples of methods to assure staff competency following training include, but are not limited to, the completion of Skills Demonstration and Competency Checklists, short tests or quizzes to reinforce

learning and to confirm understanding, the use of employee performance evaluations, and implementing shadowing and mentorship by pairing new staff members with experienced staff members to ensure knowledge is applied correctly.

Newly hired direct care staff can shadow a fully trained direct care staff person for on-the-job training purposes, as long as the fully trained direct care staff person is responsible for the assigned direct care tasks and the untrained staff person is never left alone with residents. Staff not performing direct care staff responsibilities are not required to be competent in areas of direct care.

(a) Reporting requirements.

TECHNICAL ASSISTANCE

Licensees may choose to use the AFC Division's **Mandatory Reporting Policy Template** to create a policy on Mandatory Reporting.
All training provided or made available by the licensee or administrator to direct care staff related to their reporting requirements must include:

- Public Act 519 of 1982, as amended, the Adult Protective Services Act.

Training should include the definition and responsibilities of a "mandated reporter". A mandated reporter is an individual, such as a teacher, healthcare professional, law enforcement officer, or Adult Foster Care staff member, who is legally required to report suspected child abuse and/or vulnerable adult abuse, neglect, or exploitation. Anyone licensed, registered, or certified to provide health, education, social welfare, mental health, or other human services, is a mandated reporter, as are employees of licensed agencies in these fields, regardless of their specific job title.

Training should indicate that mandated reporters are to contact law enforcement or the Michigan Department of Health and Human Services (855-444-3911) immediately when they have reasonable cause to suspect child and/or vulnerable adult abuse or neglect.

- Public Act 238 of 1975, as amended, the Child Protective Services Act, when minor children are in adult foster care per Section 36 or 37 of Public Act 218 of 1979, as amended, the Adult Foster Care Facility Licensing Act. Section 36 pertains to the concurrent licensure of an adult foster care family home as a foster family home or foster family group home for children. Section 37 pertains to the concurrent licensure of an adult foster care small group home as a child caring institution.

For homes that are dually licensed, the training must indicate that anyone working in the home is a mandated reporter and must report suspected child and/or adult abuse or neglect. Staff in dually licensed facilities must make an immediate oral report to the

Michigan Department of Health and Human Services (855-444-3911) and submit a written report within 72 hours, preferably using the DHS-3200 form at Michigan Online Reporting System

- The provisions contained in R400.693 as it related to the reporting procedures to be followed regarding incidents, accidents, illnesses, absences, and death. The provisions contained in R400.675 related to medications. The provisions contained in R400.647 (18) related to the reporting of property damage.

- For homes with 7 or more, Department of Licensing and Regulatory Affairs-Bureau of Fire Services-AFC facilities. Section 10 of 1979 PA 218, MCL 400.710

This training must include information regarding the Bureau of Fire Services administrative rule 400.18109 Fire reporting, which indicates that after the occurrence of a fire, the licensee shall immediately notify the local fire department and the bureau of fire services with all details of the fire (for facilities with 7 or more residents). Licensees may choose to use the following resources as part of their Reporting Requirements training:

AFC Division's Reporting Requirements videos/quizzes

Mandated Reporters and APS Fact Sheet

Learn more about abuse and neglect.

(b) First aid.

TECHNICAL ASSISTANCE:

Documentation is to be maintained by the licensee confirming that each direct care staff has completed training in basic first aid covering such areas as:

Emergency aid for someone who is choking, bleeding, or in shock, treating burns, bites, stings, trauma to eye, ear, or nose, aid for treatment for fractures, strokes, seizures, accidental drug overdose and poisonings, hypothermia and hyperthermia, and treatment for emergencies associated with diabetes.

Acceptable sources of training include but are not limited to videos, local public health departments, hospitals, the American Red Cross, a licensed physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), emergency medical technician (E.M.T.), or physician's assistant.

A list of training resources can be located at AFC Self-Study Training and On-Going Training

(c) Cardiopulmonary resuscitation, which includes a hands-on demonstration as part of the training.

TECHNICAL ASSISTANCE:

Competency in CPR is demonstrated by participation in and successful completion of a CPR training course. CPR training includes two essential components: **Knowledge** and **hands-on skill performance**. While the knowledge portion can be delivered effectively through online learning, the skills component must be completed in person to ensure accuracy, safety, and competency. Staff cannot work alone in the facility without being competent in CPR and first aid.

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

(d) Personal care, supervision, and protection.

TECHNICAL ASSISTANCE

Some training resources include, but are not limited to, nationally recognized online caregiver training programs such as Relias Learning or CareAcademy, Area Agency on Aging and Senior Service organizations, Provider Associations, Hospice & Healthcare Systems, and Community Mental Health agencies.

Training resources include, but are not limited to:

Intro to Adult Foster Care and Supervision, Protection, and Personal Care

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

If the facility's program statement includes the care of residents with Alzheimer's disease or related conditions, the facility must meet the provisions of the MCL 400.726b, which includes staff training and continuing education practices on personal care, supervision, and protection to residents with Alzheimer's disease or related conditions.

INDICATORS

The consultant will determine that the licensee has a training methodology in place that assures that all direct care staff are competent in providing the personal care, supervision and protection as identified in the facility's program statement and admission/discharge policy as well as the individual assessment plans, health care appraisals and resident care agreements.

(e) Resident rights.

TECHNICAL ASSISTANCE

Training resources include, but are not limited to:

AFC Division's Resident Rights videos/quizzes

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

INDICATORS

The consultant is to determine that the licensee's direct care staff training addresses resident rights as contained under Rule 400.681.

(f) Safety and fire prevention.

TECHNICAL ASSISTANCE

Training provided to staff should minimally address "knowledge of basic emergencies", including medical and weather emergencies and other disasters; knowledge of responsibilities during emergency situations; knowledge of the facility's emergency preparedness plan; knowledge of what to do to assist residents with special needs, knowledge of how to prevent and respond to common types of home fires, the proper operation of fire extinguishers, and how to "promptly" evacuate residents from the facility in the event of a fire.

According to the Bureau of Fire Services "prompt" means that a facility's evacuation capability is such that the facility can be evacuated in 3 minutes or less.

Training resources include, but are not limited to:

AFC Division's Safety and Fire Prevention videos/quizzes

A list of training resources can be located at AFC Self-Study Training and On-Going Training

INDICATORS

The consultant will determine that the licensee has a training methodology that assures direct care staff competency in the area of safety and fire prevention appropriate to the needs of the current resident population identified in the facility's program statement and admission policy.

(g) Prevention and containment of communicable diseases including recognizing signs of illness.

TECHNICAL ASSISTANCE

Acceptable sources of training may include but are not limited to, local health departments, American Red Cross, training by a licensed physician, registered nurse, hospitals, MDHHS/CMH training and training provided by the licensee utilizing appropriately related materials.

Training resources include, but are not limited to:

AFC Division's Prevention and Containment of Communicable Diseases videos/quizzes

Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings | Infection Control | CDC
CDC Infection Prevention and Long-Term Care Facility Residents

Influenza

An additional list of training resources can be located at AFC Self-Study Training and On-Going Training

INDICATORS

The consultant will determine that the licensee has a training methodology to assure that direct care staff are competent in prevention and containment of communicable diseases consistent with current OSHA guidelines on blood-borne pathogens. The training should address such areas as identification of situations where risk of exposure to blood-borne pathogens exists, recognize the need to keep work and room surfaces clean, orderly and in a safe and sanitary condition; know the purpose of universal precautions; know what precautions should be taken to prevent the spread of disease; and know correct hand-washing procedures.

(h) Food safety, which includes food storage, preparation, distribution, and serving in a safe manner.
(i) Nutrition and special diets.

TECHNICAL ASSISTANCE

Acceptable sources of training may include but are not limited to ServSafe, U.S Food and Drug Administration, U.S. Department of Agriculture, State and Local Health Departments, Michigan State University Extension, and Community Colleges. Licensees may choose to use the AFC Division's Nutrition Series as their training.

Other resources include, but are not limited to:

AFC Division's Nutrition and Special Diets videos/quizzes

MyPlate.gov | MyPlate Tools

A list of training resources can be located at AFC Self-Study Training and On-Going Training

INDICATORS

The consultant will determine that the licensee has a training methodology to assure that direct care staff are competent in food safety, as well as nutrition and special diets. The training should address food storage, preparation, distribution, and serving in a safe manner.

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(6) Training for subrule (5)(b) and (c) of this rule must be in accordance with these rules. The individual providing the training shall be trained in and follow nationally recognized standards.
(7) Documentation of training must be maintained in the staff's record to determine that the training has been completed and is current.

R 400.631 Health screenings.

Rule 631. (1) A licensee, staff, volunteers, and members of the household shall be in such physical and mental health as not to negatively affect the health or care of the residents.
(2) A licensee shall have on file a statement signed by a licensed physician or physician's designee attesting to the physical health of the licensee, staff, and members of the household. Statements for the licensee and administrator must be signed no more than 6 months before the issuance of a temporary license and at any other time requested by the department. Statements for staff and members of the household must be obtained within 30 days of employment start date, assumption of duties, or occupancy in the facility.

TECHNICAL ASSISTANCE

The statement attesting to an individual's physical health must be signed by a licensed physician or the physician's designee. A physician's designee is someone authorized by the physician to complete and sign the statement on the physician's behalf, within that person's professional scope of practice. A nurse employed by the AFC facility does not qualify as a physician's designee solely because the nurse is licensed or works at the facility.

Although subrule (2) specifically references staff, a volunteer who is performing duties equivalent to those of a direct care staff member must also comply with this requirement.

The department considers the function being performed, not simply the title of the individual. Therefore, when a volunteer is providing direct care, supervision, or assistance to residents in a manner similar to paid staff, that volunteer is effectively acting in the capacity of a staff member and must meet the same health screening requirements to ensure resident safety.

(3) A licensee shall ensure that the volunteer's physical and mental health will not negatively affect the residents or the quality of the residents' care.

TECHNICAL ASSISTANCE

Licensees must take reasonable steps to assess and monitor whether volunteers are physically and mentally capable of safely interacting with residents. Licensees should implement reasonable screening practices, observe volunteer interactions with residents, assign appropriate duties, and address health or behavioral concerns that could negatively affect resident care.

If a volunteer is acting in the capacity of a direct care staff, see technical assistance for R 400.631(2).

RECOMMENDATIONS

Some recommendations to assist in complying with this rule include, but are not limited to:

- Requiring volunteers to complete a health screening or self-disclosure form indicating that they do not have any physical or mental condition that would negatively impact resident care.
- Observing volunteers during their activities to ensure they demonstrate appropriate behavior, judgment, and physical ability.
- Assigning duties appropriate to the volunteer's abilities and health status.
- asking volunteers to reschedule or refrain from volunteering when ill.
- Providing orientation or training that informs volunteers of expectations regarding health and safety.

(4) A licensee shall annually review and maintain in the facility the health status of the staff and members of the household. Verification of annual reviews must be maintained for 2 years.

TECHNICAL ASSISTANCE

Although subrule (4) specifically references staff, a volunteer who is performing duties equivalent to those of a direct care staff member must also comply with this requirement.

The department considers the function being performed, not simply the title of the individual. Therefore, when a volunteer is providing direct care, supervision, or assistance to residents in a manner similar to paid staff, that volunteer is effectively acting in the capacity of a staff member and must meet the same annual review requirement to ensure resident safety.

Licensees may choose to use the division's Employee Annual Health Review Template to conduct annual health reviews for employees.

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(5) A licensee shall maintain documentation of a baseline screening for communicable diseases and records of illness on hiring. Staff who have direct physical contact with residents or resident food may perform those duties only when they are noninfectious or when proper precautions are taken to prevent the spread of a communicable disease. A licensee shall follow a staff's health care professional or local health department guidance on controlling the spread of a communicable disease when identified.

TECHNICAL ASSISTANCE

A "baseline screening for communicable diseases" is the initial health assessment conducted upon hiring, that determines whether an individual shows any signs, symptoms, or known exposure to infectious or contagious illnesses before they begin working, or providing services in a facility. Communicable diseases may include, but are not limited to, influenza, tuberculosis, measles, mumps, and hepatitis. A licensed physician, or physician's designee, may indicate that a baseline screening for communicable diseases was completed in the signed statement attesting to the physical health of a licensee, staff member, or member of the household. This statement must be obtained upon hire. Otherwise, the licensee is required to conduct their own baseline screening on staff on hire.

The AFC staff member conducting the baseline screening should use reasonable judgment when determining whether a staff member may need additional assessment by a licensed health care provider. The purpose of the screening is not to diagnose medical conditions, but rather to identify potential signs, symptoms, or risk factors that could indicate a communicable disease or other health concern that may affect the safety of residents or staff.

A referral for additional assessment may be appropriate when the person conducting the screening observes or becomes aware of information that suggests the employee

may have an active illness, may be contagious, or may not be medically able to safely perform their duties.

Although subrule (5) specifically references staff, a volunteer who is performing duties equivalent to those of a direct care staff member must also comply with this requirement.

The department considers the function being performed, not simply the title of the individual. Therefore, when a volunteer is providing direct care, supervision, or assistance to residents in a manner similar to paid staff, that volunteer is effectively acting in the capacity of a staff member and must meet the same baseline screening requirement to ensure resident safety.

Licensees may choose to use the division's **AFC Division- Baseline Screening** tool to conduct screenings for employees.

R 400.633 Staffing requirements

Rule 633. (1) A licensee shall always have sufficient direct care staff on duty for the supervision, personal care, and protection of residents and to provide the services specified in a resident's assessment plan, health care appraisal, and resident care agreement. At a minimum, the ratio of direct care staff to residents must not be less than 1 direct care staff to either of the following:

(a) 15 residents during waking hours or 20 residents during sleeping hours for large group homes and congregate facilities.
(b) 12 residents for small group and family homes.

TECHNICAL ASSISTANCE

A resident, the resident's designated representative, or a responsible agency may hire a contracted caregiver or home health aide to provide some personal care services. This caregiver cannot be counted when determining the adequacy of on duty direct care staff that are required in the home in order to provide the services specified by the home's resident assessments and resident care agreements or in determining the minimally required resident to staff ratio. For purposes of this rule "Sufficient direct care staff" is defined to mean the number of staff necessary to implement the care needs as indicated in the resident's assessment plan, health care appraisal, and resident care agreement.

Individuals receiving respite services within the facility's "licensed space" are considered residents.

In facilities where staff sleep overnight, this requirement may be met when the staff member remains responsible for resident supervision and is able to respond to resident needs as they arise. Staff must be capable of waking and providing

assistance during the night, including responding to emergencies, assisting residents who require nighttime care, and ensuring the overall safety and welfare of residents.

Licensees must evaluate the number of residents, their level of care needs, mobility, behavioral needs, and any nighttime services required when determining whether sleeping staff are sufficient. If residents require frequent assistance during the night, have significant medical or behavioral needs, or require continuous supervision, additional awake staff may be necessary to ensure that resident needs can be met in a timely manner.

“Floating” or “roaming” staff members may provide supplemental support or temporary assistance between two separate facilities. However, they cannot be counted as the required minimum staff for multiple facilities simultaneously. When a staff member is assigned to work in multiple licensed facilities at the same time and routinely leaves one facility to provide services or supervision in another, that staff member is not continuously available to meet the needs of residents in a single facility.

INDICATORS

To assist the consultant in determining whether the ratio of direct care staff is sufficient, the licensing consultant may review the following in addition to interview and observation of staff and residents:

- Program statement
- Admission policy
- Employee job descriptions
- Staffing patterns
- Current/past employee work schedules
- Resident assessment plans
- Resident care agreements
- Resident health appraisals
- Resident register
- Fire drill records
- Evacuation plans
- Medication procedures, if applicable
- Other relevant documents

When reviewing these documents, the consultant may look at the individual and total care needs of the population to be served. The number of staff that is adequate and sufficient is variable and specific to the needs of residents and the capabilities of staff at a given point in time. The number may change based on various factors such as:

- Physical layout of the facility including the ability of available staff to maintain visual and auditory monitoring of residents.
- The needs of residents if disaster or fire emergency plans require implementation.

- Number of residents needing two-person assistance or Hoyer lifts.
- Number of residents with chronic incontinence.
- Number of residents with elopement or aggressive behaviors.
- Number of residents with feeding needs.
- Number of new, inexperienced staff on duty.
- Number of new admissions, especially residents with dementia. Residents with increased anxiety or confusion require more staff attention especially during the initial transition period.
- Number of residents on hospice

The consultant should only determine if adequate staffing is being provided. Consultants should not attempt to determine how many additional staff persons are necessary to meet the "sufficient staff" requirement. The facility is responsible for providing individuals with needed services; how they meet that responsibility is up to the facility, not the consultant. The consultant should also review whether other assigned job responsibilities interfere with the provision of direct care services.

RECOMMENDATIONS

It is recommended that children under the age of 12 who are “temporarily” being supervised in the household (for example, a direct care staff member who brings his/her child to work), be considered residents for the purpose of staff ratio.

Children who are over the age of 12 and have special needs, who are “temporarily” being supervised in the household, may require additional supervision based on their individual abilities and support needs. Subsequently, that may be considered residents for the purpose of staff ratio.

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(2) Children under the age of 12 who are a member of the household count as residents for subrule (1)(a) and (b) of this rule.
(3) An individual, including a volunteer, cook, or private duty staff shall not be considered in determining the ratio of direct care staff-to-residents unless the individual meets the qualifications of a direct care staff member and is providing direct care to residents on behalf of the licensee.
(4) Direct care staff need not be in the facility during the day if all the residents of the facility are out-of-home as approved in the residents’ assessment plans. The licensee shall provide contact information to residents or responsible parties in case of emergency or if a resident wants to return to the facility.

SUBPART C: GENERAL FINANCIAL ABILITY AND COMPETENCE

R 400.635 Fiscal ability and competence.

Rule 635. (1) The department may request the following financial documents during initial licensure, licensure renewal, an inspection, or an investigation:
(a) Operational budget.

(b) Invoices.
(c) Purchase orders.
(d) Receipts.
(e) Other nonproprietary financial documents maintained in the normal course of business and that demonstrate the provision of care and services.

TECHNICAL ASSISTANCE

Other nonproprietary financial documents maintained in the normal course of business that demonstrate the provision of care and services include, but are not limited to, employee payroll records, vendor statements from pharmacies, medical equipment suppliers and grocery suppliers, bank statements, and ledgers or accounting summaries.

INDICATORS

The operational budget is the primary financial document reviewed during the standard application process. The other documents identified in subrule (1)—such as invoices, purchase orders, receipts, and other nonproprietary financial records—would not necessarily be requested in every case. They may be requested when the budget raises questions, or when there are complaints or observations about a licensee's ability to provide required care and services. The documents requested should be relevant and limited to what is necessary to evaluate the specific concern.

Examples may include but are not limited to:

- When a licensed home has utility shutoff notices, unpaid bills, or interruptions in essential services are reported or observed.
- When it has been determined that a home lacks adequate food, household supplies, medications, personal-care items, bedding, or other necessities.
- Instances when required repairs or maintenance have not been completed and the licensee indicates that funds are unavailable.
- When AFC staff report late or missed paychecks, insufficient staffing, or an inability to hire enough staff because of financial concerns.
- When vendors report unpaid invoices that could affect food delivery, utilities, transportation, maintenance, or other resident services.
- When there are concerns that resident funds intended for care or services may not have been used appropriately.
- When significant changes occur—such as a bankruptcy, foreclosure, or other circumstances that may affect continued operation.

(2) A request for financial documents in subrule (1) of this rule must be made only when the department requires the documents to evaluate the delivery of care and services for state licensing purposes.
(3) A licensee shall have the financial and administrative capability to operate a facility to provide the level of care and program stipulated in the program statement.

INDICATORS

Determination is based on the totality of the available information, including application materials, interviews, inspections, financial documents, staffing records, compliance history, and the applicant's/licensee's response to identified concerns. The overall evidence should demonstrate that the program can operate responsibly and consistently provide required resident care and services.

Financial capability may be demonstrated by:

- A realistic operational budget showing anticipated income and expenses.
- Sufficient funds to cover staffing, food, utilities, insurance, transportation, maintenance, resident supplies, and unexpected expenses.
- Timely payment of employees, utilities, vendors, and other operating costs.
- Financial records showing that required care and services are being provided.
- The ability to maintain the facility and promptly correct deficiencies.
- The absence of recurring shutoff notices, unpaid bills, payroll problems, or shortages of essential supplies.

Administrative capability may be demonstrated by:

- Adequate staffing, scheduling, training, and supervision systems.
- Complete accurate resident, employee, medication, incident, and financial records.
- Policies and procedures that comply with applicable licensing requirements.
- Effective systems for resident assessment, care planning, medication management, emergency response, and complaint handling.
- The ability to identify and correct violations and maintain ongoing compliance.
- Ability to complete the original licensing application process.

(4) This rule does not limit the department's authority to consider other relevant financial information from other governmental entities.
(5) The financial documents required by this rule must be maintained for 2 years.

R 400.637 Handling of resident funds and valuables

R. 637 (1) A licensee may accept resident funds and valuables to be held in trust on request from a resident or a resident's designated representative.

TECHNICAL ASSISTANCE

If a resident or resident's designated representative requests a licensee to manage the resident's funds or valuables, the licensee has the option to refuse that request.

INDICATORS

Consultants may determine through interview and review of the “Resident Care Agreements” and resident’s itemized funds and transaction forms, whether the licensee has agreed to manage and/or accept for safekeeping resident funds and valuables.

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(2) Resident funds or valuables that have been accepted for safekeeping must be treated as a trust obligation.

TECHNICAL ASSISTANCE

“Accepted by a licensee for safekeeping” means items specifically given to the licensee for storage or safekeeping, such as a diamond ring. Licensees are to complete and maintain a list of all funds and valuables for all residents. A department form is not required.

A licensee is not required to accept a resident's funds and valuables for safekeeping.

INDICATORS

The consultant may ask the licensee whether he/she has accepted a resident's funds and valuables for safekeeping and/or assists residents in handling their funds, or with banking transactions.

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(3) A licensee shall have a record of resident valuables for each resident that includes a written description of the items, the date received, and the date returned to the resident or the resident’s designated representative, and the record must be signed at the time of receipt and return by the facility and the resident or the resident’s designated representative.

TECHNICAL ASSISTANCE

Licensees may choose to use the division’s Resident Record of Valuables template or create their own.

INDICATORS

When a licensee accepts a resident's valuables for safekeeping, the consultant may review the record of valuables for the resident to determine whether the record is maintained as required by this rule. See R 400.601(1)(hh) definitions for “valuables”.

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(4) A licensee shall record in the resident record a resident funds and itemized transactions including payment for services provided for each resident.

TECHNICAL ASSISTANCE

Advanced care payments or deposits that are credited to the resident’s account upon admission must be recorded on the resident’s funds and itemized transaction form.

Licensees may choose to use the division’s Resident Funds and Transactions Template, or create their own. Electronic forms are acceptable.

INDICATORS

The licensing consultant may inspect resident records to determine that resident funds and valuables transaction forms have been completed for each resident. The licensee may choose to use department’s “Resident Funds” form or create their own. Electronic forms are acceptable.

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(5) Resident funds must be kept separate from funds of the licensee or facility.

TECHNICAL ASSISTANCE

The practice of depositing the resident's check into the home’s or licensee’s account and writing the resident a check or giving the resident cash for his/her portion of the check is not considered commingling, provided that the licensee forwards the resident’s remaining portion of the check to the resident within 5 working days. This should be documented in the resident care agreement and on the resident funds and transaction records.

If authorized in the Resident Care Agreement, a licensee may serve as an Authorized Signer, Convenience Signer, or Agent Signer on a resident’s account(s). In this capacity, the licensee may assist with activities such as writing checks, making deposits, withdrawing funds, and managing bill payments on behalf of the resident and has no controlling interest in the resident’s account(s). This is also not considered commingling.

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(6) Interest and dividends earned on resident funds must be credited to the resident.

(7) Except for bank accounts, a licensee shall not accept resident funds of more than $400.00, as defined in R 400.601(1)(y), for any resident of the facility after receiving payment of charges owed.

TECHNICAL ASSISTANCE

A licensee is considered in compliance with this rule when holding a resident's debit card solely for safekeeping purposes, such as preventing loss or theft, provided that:

- The licensee does not manage or control the resident's funds.
- The licensee does not have access to the resident's bank account.
- The licensee does not possess or know the resident's PIN number.

In this situation, the funds remain under the resident's control within their personal bank account and are not considered funds held by the licensee.

If a licensee **does manage or access a resident's funds** using the resident's debit card (e.g., making purchases, withdrawing cash, or otherwise handling funds on the resident's behalf), then:

- The licensee is considered to be holding and managing resident funds
- The licensee must ensure that no more than $400.00 per resident is accessible or managed at any given time after payment of charges owed

INDICATORS

The consultant may review resident funds and itemized transaction forms and the money on hand to determine compliance with this subrule.

RECOMMENDATIONS

Licensees are encouraged to clearly document whether a debit card is held for safekeeping only versus fund management, including written acknowledgment from the resident or their designated representative.

It is recommended licensees establish internal procedures to prevent unauthorized access to PIN numbers and bank accounts.

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(8) A resident shall have access to and use of their resident funds in reasonable amounts, including immediate access to not less than $40.00. A resident shall receive up to the full amount of resident funds at a time designated by the resident, but not more than 5 days after the request for the resident funds. Exceptions must be subject to the provisions of the resident's assessment plan.

INDICATORS

The consultant may review the resident record for an accounting of the resident's funds and compare the cash on hand with the balances indicated on the resident funds and itemized transaction form.

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(9) A resident fund transaction over the amount specified in the resident care agreement must require the signature of the resident or resident's designated representative and the licensee or administrator.

INDICATORS

The consultant may review the resident record to determine that resident transactions have been recorded and that proper signatures have been obtained in accordance with the resident care agreement.

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(10) A resident's account shall be individual to the resident. A licensee shall be prohibited from having any ownership interest in a resident's account and shall inform the resident or resident's designated representative of this in writing.

TECHNICAL ASSISTANCE

If authorized in the Resident Care Agreement, a licensee may serve as an Authorized Signer, Convenience Signer, or Agent Signer on a resident’s account(s). In this capacity, the licensee may assist with activities such as writing checks, making deposits, withdrawing funds, and managing bill payments on behalf of the resident.

The licensee’s name may appear on the account(s) solely for the purpose of providing assistance or convenience to the resident. However, the funds within the account remain the sole property of the resident, and the licensee may not claim legal ownership interest of the resident’s funds.

INDICATORS

The consultant may review the resident’s funds and itemized transaction records and account (savings, money market funds, checking, investment accounts etc.) statements to determine that the licensee does not have ownership interest in the accounts.

Consultants may review the Resident Care Agreement to determine whether the resident and/or their authorized representative and the licensee agreed to the licensee assisting with the management of the resident’s funds and their access to the resident’s financial account(s). If established a licensee has access to a resident’s account(s), the consultant may verify that the arrangement provides the licensee with access authority only and does not grant the licensee ownership interest in the

account(s) or the resident funds. Examples of acceptable arrangements may include the licensee serving as an Authorized Signer, Convenience Signer, or Agent Signer.

Consultants may request to review supporting documentation, such as:

- Bank signature cards or account documentation.
- Resident funds transaction records required under R 400.637(4)
- Receipts, invoices, or other documentation supporting withdrawals or expenditures made on behalf of the resident.

The consultant may review the documentation to ensure:

- The resident remains the owner of the account and funds.
- The licensee's role is limited to assisting with financial management.
- Resident funds are used solely for the resident's benefit.
- Transactions are appropriately documented and traceable.

The consultant may also interview the resident and/or their authorized representative, when appropriate, to determine whether they understand the arrangement and whether the resident has reasonable access to their funds.

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(11) A licensee, staff, volunteers, members of the household, and their family members cannot accept, take, or borrow money, resident funds, or valuables from a resident, even with the consent of the resident.
(12) A licensee or administrator shall obtain prior written approval from a resident or a resident's designated representative before charges are made to a resident's account.
(13) Charges against the resident's account must not exceed the agreed price for the services rendered and goods furnished or made available by the facility to the resident.

TECHNICAL ASSISTANCE

Adult foster care facilities providing domiciliary care or personal care to residents receiving supplemental security income (SSI) shall not require those residents to reimburse the home or facility for care at rates in excess of those legislatively authorized. To the extent permitted by federal law, adult foster care facilities serving residents receiving supplemental security income shall not be prohibited from accepting third-party payments in addition to supplemental security income if the payments are not for food, clothing, shelter, or result in a reduction in the recipient's supplemental security income payment. Concerns regarding payments about the Supplemental Security Income payment may be referred to the Social Security Administration, or adult services workers.

INDICATORS

The licensing consultant may verify that the licensee is not charging more than the amount agreed to in the "Resident Care Agreement". This can be done by comparing

the resident's funds and itemized transaction form, against the "Resident Care Agreement". Adult foster care payments must be documented on the individual resident's funds and transaction form.

The licensee may choose to use the department's "Resident Funds and Transaction form" template, or utilize their own resident funds and itemized transaction form. Electronic forms and records are acceptable.

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(14) A licensee shall provide a complete accounting on an annual basis and upon request, of all resident funds and valuables which are held in trust and in bank accounts or which are paid to the home, to the resident, or to his or her designated representative. The accounting of a resident's funds and valuables which are held in trust, or which are paid to the home shall also be provided, upon the resident's or designated representative's request, not more than 5 banking days after the request and at the time of the resident's discharge from the home.

INDICATORS

Residents' funds and itemized transaction records are to be inspected to determine that the licensee has maintained an accounting of resident funds, and has a method by which annual accountings to residents are made. The licensing consultant may review receipts for resident fund expenditures to assure they correspond to charges identified on the individual resident's funds and transaction form.

The licensee may choose to use the department's "Resident Funds and Transaction form" template, or utilize their own resident funds and itemized transaction form. Electronic forms and records are acceptable.

RECOMMENDATION

In addition to maintaining a record of accounting of resident funds, it is recommended licensees also maintain copies of receipts to verify their records.

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(15) A licensee shall have a written refund agreement with a resident or a resident's designated representative. The agreement must state under what conditions a refund of the unused portion of the monthly charge that is paid to the facility is returned to the resident or resident's designated representative.

TECHNICAL ASSISTANCE

The written refund agreement must be signed by the licensee and the resident or resident's representative.

The licensee may choose to use the AFC divisions **Resident Refund Agreement Template** to create their Resident Refund Agreement.

(16) A refund agreement must provide for refunds to a resident or the resident's designated representative under any of the following conditions:

(a) A resident's emergency discharge from the facility.

(b) A resident has been determined to be at risk or victim of abuse, neglect, or exploitation as defined in section 11 of the social welfare act, 1939 PA 280, MCL 400.11, and remaining in the home puts the resident at continued risk.

(c) A resident relocates on a determination the resident is at risk due to substantial noncompliance with the act or these rules that results in the department taking action to issue a provisional license or revoke or summarily suspend, or refuse to renew, a license.

(17) The amount of the monthly charge that is returned to the resident under subrule (16) of this rule must be prorated based on the number of days that the resident lived in the facility during that month.

(18) Personal property and belongings that are left at the facility after the discharge or death of a resident must be inventoried and stored by the licensee. A licensee shall notify in writing the resident's designated representative of the existence of the property and belongings and request disposition. Personal property and belongings that remain unclaimed or for which arrangements have not been made may be disposed of by the facility after 30 or more days from the date that written notification is sent.

TECHNICAL ASSISTANCE

Written notification may include email or text message correspondence, provided the licensee is able to produce verifiable documentation upon request.

SUBPART D: STAFF RECORDS AND SUPERVISION

R 400.639 Staff records.

TECHNICAL ASSISTANCE

Employee records must be made available for review at the facility at the time of an announced inspection. If an unannounced inspection is conducted and records are not available, the licensee is to make the records readily available to the consultant. Electronic records are acceptable as long as the consultant is given prompt access to the electronic records.

Rule 639. (1) A licensee shall maintain a record for each staff that contains all of the following:

(a) Name, address, telephone number, and Social Security number.

(b) Copy or number of a professional or vocational license, certification, or registration if staff provides professional or vocational services.
(c) A copy of a driver's license if staff provides transportation services.
(d) Verification of age.
(e) Verification of experience, highest level of education completed, and training.

TECHNICAL ASSISTANCE

Administrative licensing rules do not establish a minimum education requirement for direct care staff. The purpose of documenting the highest level of education completed is not to determine eligibility for employment but to maintain an accurate personnel record reflecting the staff member's background. Licensees are expected to make a reasonable effort to verify the highest level of education reported by the employee. Examples of acceptable documentation may include, but are not limited to:

- A copy of a high school diploma or GED.
- A copy of a college diploma, transcript, or certification.
- Documentation provided by the employee verifying completion of a training or educational program.
- A written statement signed by the employee attesting to the highest level of education completed if third-party verification cannot reasonably be obtained.

If a school is closed, records are unavailable, or verification cannot be obtained despite reasonable efforts, the licensee should document the attempts made to obtain verification and maintain the available documentation in the employee's personnel record.

The inability to obtain third-party verification of education for direct care staff does not automatically prohibit employment when no minimum education requirement exists for the position. However, the licensee is still responsible for maintaining documentation in the personnel file that reflects the employee's reported education level and any efforts made to verify that information. Maintaining documentation of the employee's reported education level, along with evidence of reasonable efforts to verify it when possible, would generally be considered sufficient to demonstrate compliance with the intent of the rule.

(f) Verification of not less than 2 reference checks. If reference checks cannot be obtained, documentation verifying reference checks were attempted must be maintained.

TECHNICAL ASSISTANCE

The licensee must have a process to verify reference checks of each potential employee prior to employment. Licenses should attempt to obtain professional

references. However, if employment at the facility is the potential staff member's first job, personal references are acceptable.

RECOMMENDATIONS

It is recommended that the licensee create a "reference check" form to conduct and confirm reference checks have been completed on potential staff members. It is recommended to ask the questions indicated on the division's **Sample Reference Check Form**

(g) Beginning and ending dates of employment or separation.

TECHNICAL ASSISTANCE

For purposes of this rule, "separation" refers to the point at which an employee's working relationship with the licensee ends. This may occur for a variety of reasons, including resignation, termination, retirement, or any other circumstance in which the individual is no longer employed by the facility.

(h) Health information as required by these rules.
(i) Verification of the receipt by the staff of personnel policies and job descriptions.
(2) Records identified in subrule (1) of this rule must be maintained for 2 years after the staff's ending date of employment.
(3) A licensee shall maintain for 90 days a daily work schedule and assignments that includes all of the following:
(a) Names of staff on duty.
(b) Job titles.
(c) Hours or shifts worked.
(d) Date of schedule.
(e) Scheduling changes when made.

R 400.641 Resident behavior interventions.

Rule 641. (1) A licensee shall ensure methods of behavior intervention are appropriate to the needs of the resident.
(2) Interventions must be specified in the resident's assessment plan and performed in accordance with that plan. Interventions must ensure that the safety, welfare, and rights of the resident are adequately protected. If an intervention is needed to address the unique programmatic needs of a resident, the intervention must be developed in consultation with, or obtained from, a professional or professionals licensed, certified, or registered in that scope of practice.

TECHNICAL ASSISTANCE

Interventions should be clearly outlined in resident assessment plans.

“Interventions” can be developed or written by professionals who are licensed or certified in behavior interventions, including, but not limited to: psychologists, psychiatrists, social workers. Licensees are to ensure they have enough staff on duty, at all times to implement resident interventions. Examples of interventions may include, but are not limited to, verbal and behavioral de-escalation, environmental modifications, proactive support and prevention, staff response techniques, enhanced supervision, PRN use, and physical management, such as techniques learned in Crisis Prevention Institute (CPI) training, or a similar training.

If applicable, licensees are to contact residents’ community mental health (CMH) agencies to request that interventions be outlined in residents’ CMH person centered plans and/or behavioral treatment plans.

INDICATORS

The consultant is to review the resident's assessment plan, health care appraisal, CMH person centered plan and/or behavior treatment plan (if applicable), staff schedules, daily logs and charts, accident and incident reports, and other relevant documents to determine that the methods of dealing with resident behavior are clearly addressed. The consultant is to review the resident record to determine that any "intervention" has been approved by a licensed or certified professional and that the safety, welfare, and rights of residents are adequately protected.

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(3) Staff responsible for implementing a resident's assessment plan must be trained in the applicable behavior intervention techniques and onsite at the facility during each shift.
(4) Intervention techniques must not be used to punish or discipline residents for the convenience of staff.
(5) Staff, volunteers, visitors, or other occupants of the facility shall not mistreat a resident. Mistreatment includes any intentional action or omission that exposes a resident to a serious risk, physical or emotional harm, or the deliberate infliction of pain by any means.

TECHNICAL ASSISTANCE

Yelling at or hitting residents, using abusive language, verbal intimidation or threatening residents are examples of behavior that a licensee, administrator, direct care staff, employees, volunteers who are under the direction of the licensee, visitors, or other occupants of the home may not use. Failure to intervene if a resident is being hit, sworn at, or threatened constitutes mistreatment of a resident. Neglecting a resident’s physical or emotional needs also constitutes mistreatment, by omission.

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(6) A licensee, staff, volunteers, or any person who lives in the facility shall not do any of the following:
(a) Use any form of punishment.

(b) Use any form of restraint without an order from an appropriately licensed heath care professional or physical force, other than physical restraint for crisis intervention.
(c) Restrain a resident's movement for the purpose of immobilizing the resident.
(d) Confine a resident in an area where egress is prevented.
(e) Withhold food, water, clothing, rest, or toilet use.
(f) Subject a resident to any of the following:
    I. Mental or emotional cruelty.
    II. Verbal abuse.
    III. Derogatory remarks.
    IV. Threats.
(g) Refuse entrance to the facility.
(h) Isolation.

R 400.643 Crisis intervention.

(1) Crisis intervention may be utilized when a resident has not previously exhibited a behavior creating the crisis or there has been insufficient time to develop an intervention plan to reduce the behavior causing the crisis. If the resident requires repeated or prolonged use of the crisis intervention, the licensee shall contact the resident's designated representative and responsible agency or, in the absence of a responsible agency, an appropriate licensed, certified, or registered professional to review and evaluate positive alternatives or the need for an appropriate intervention plan.

TECHNICAL ASSISTANCE

Staff must not use crisis intervention until he or she is trained in crisis intervention per subsection (8) of this rule. Crisis intervention should only be used when the resident displays a new behavior or a behavior the licensee could not reasonably anticipate. After crisis intervention, the licensee must take steps to obtain a plan to address the behavior in the future.

INDICATORS

When it has been determined that crisis intervention has occurred, the consultant is to determine if the intervention was consistent with the criteria contained in this rule. Questions to consider:

- What was the danger or threat?
- Is there a systematic pattern of incidents being called "emergencies" or "crisis interventions" in order to apply physical restraint without use of an approved program?
- Are repeated applications of physical restraint followed up with development of specialized interventions?

RECOMMENDATIONS

It is recommended that, based on the population served in the facility, the licensee provide training to direct care staff on crisis intervention, as part of their “new hire training”.

Training resources included, but are not limited to:

Trauma Informed Care, Restraint Free Approach - Ukeru Systems®

Crisis Prevention (CPI)

A list of additional training resources can be located at AFC Self-Study Training and On-Going Training

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(2) Crisis intervention may be used for any of the following reasons:
- (a) Provide for self-defense or the defense of others.
- (b) Prevent a resident from harming self.
- (c) Quell a disturbance that threatens physical injury to any individual.
- (d) Obtain possession of a weapon or other dangerous object that is in the possession or control of the resident.
- (e) Prevent serious property destruction.

(3) Crisis intervention must be used to the minimum extent and duration necessary and used only after less restrictive means of protection have failed.
(4) Crisis intervention must be employed to allow the resident the greatest possible comfort and to avoid physical injury and mental distress.
(5) Crisis intervention must not be used as a routine intervention.
(6) All uses of crisis intervention shall be noted in the resident's record. This notation shall include all of the following information:
- (a) The nature of the crisis intervention used and the duration of use.
- (b) Reasons for the use of the crisis intervention.
- (c) Types of less restrictive alternatives tried, duration, number of trials, and results.
- (d) Name of the individual who authorized the crisis intervention.
- (e) Times and dates crisis intervention was used and staff that implemented the intervention.

TECHNICAL ASSISTANCE

Crisis intervention should only be used when less restrictive procedures or methods have failed and only for the briefest time necessary to control severely aggressive or destructive behaviors that place the individual or others in imminent danger, when those behaviors reasonably could not have been anticipated. Less restrictive procedures or methods may include, but are not limited to, verbal de-escalation, active listening, offering choices, redirection, and environmental modifications.

INDICATORS

The consultant is to review available documentation of the use of less restrictive procedures.

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(7) A licensee shall make available reports of all uses of crisis intervention when requested by the resident, designated representative, or responsible agency.
(8) A licensee, administrator, or direct care staff shall not use crisis intervention until successful completion of crisis intervention training.

SUBPART E: SAFETY, CLEANLINESS, AND ADEQUACY OF PREMISES

R 400.645 Environmental health.

Rule 645. (1) The water supply must be of potable, reliable quality and from an approved source.
(2) A facility that does not have access to an approved community water system shall comply with the safe drinking water act, 1976 PA 399, MCL 325.1001 to 325.1023. A facility not on an approved community water system, or a facility on an approved community water system but that installs water treatment equipment, shall provide a total coliform, nitrate, and arsenic report documenting satisfactory water quality with the initial application and with all renewal applications. Satisfactory samples mean concentrations that do not exceed the primary maximum contaminant levels or action level. The department may require increased monitoring parameters and increased frequency based on local site conditions or other pertinent factors.

TECHNICAL ASSISTANCE

The local health authority determines rule compliance with all private water systems. The licensee should follow guidance from the local health authority on any issues identified.

INDICATORS

If at licensing renewal a new well is drilled, or at any other time, the water supply may be suspect, the consultant is to request a copy of the approval of the water analysis report from the local health authority.

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(2) A licensee shall provide hot and cold running water under pressure. A licensee shall maintain the hot water temperature for a resident's use at a range of 105 degrees Fahrenheit to 120 degrees Fahrenheit at the fixture.

TECHNICAL ASSISTANCE

The water temperature is to be tested by thermometer at multiple sites within the facility after the water has run long enough to reach maximum temperature. The temperature is not to be less than 105 degrees Fahrenheit and not to exceed 120 degrees Fahrenheit at any fixture accessible to residents.

If using mixing valves, licensees are to ensure they are adjusted properly to maintain proper temperature.

INDICATORS

The consultant is to determine how the licensee assures proper water temperature is maintained but should only cite if water is not maintained within the required range. Signs of low water pressure could include weak or minimal water stream or water drippling or trickling at faucets as water under normal pressure should come out at a steady flow. If there is mineral build-up on the fixture that restricts flow, that should be cited under maintenance of premises, R 400.647 (6).

RECOMMENDATIONS

It is recommended that licensees create and implement a “water temperature check log” to document regular water temperature checks in their facility.

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(4) Sewage must be disposed of in a public sewer system. In the absence of a public sewer system, sewage must be managed and discharged of in a manner of on-site wastewater treatment that is approved by department of environment, Great Lakes, and energy in compliance with part 31 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.3101 to 324.3134, or where applicable, the local health department.

INDICATORS

When consultants are conducting on-site inspections, they may observe whether there is evidence of septic/sewer failure. Toilets which back up or flush poorly may be an indication of septic failure. Flush toilets and turn on faucets to determine if plumbing fixtures drain properly. Evidence of sewage on the ground includes septic tank effluent that is very dark or black in appearance and extremely malodorous, or presence of dark colored standing water close to the septic system area. Wastewater from the laundry machine is considered sewage. Therefore, it must be discharged into the home’s sanitary sewer system. Any evidence of sewage on the ground surface or extremely saturated soil (ground is squishy) near the drain field location may be an indication that the sewage system is failing.

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(5) Garbage and rubbish that contains food waste must be maintained in leakproof, nonabsorbent containers. Containers must be covered with tight-fitting lids and removed from the facility daily and from the premises at least weekly.
(6) An insect, rodent, or pest control program must be maintained and carried out in a manner that continually protects the health of the residents.

TECHNICAL ASSISTANCE

Examples of effective control measures include but are not limited to:

- Keeping kitchen and food storage areas clean and free of excessive clutter. Not using loose paper for shelf liners. If contact paper is used, it must maintain its integrity.
- Eliminating potential places of harborage and avenues for entrance into the home, such as cracks and crevices in construction.
- Obtaining the services of a licensed pest control operator when necessary.
- Screening and sealing all openings to the outside.
- Maintaining yard areas to prevent attracting vermin. Where an Integrated Pest Management System is being used, the consultant may determine if the licensee has taken appropriate safeguards to protect residents. If poisons or traps are used, the licensee must assure that residents do not have access to them.
- Keeping copies of contracts with a pest control company can help demonstrate compliance.

Licensees can view the AFC Division's video training on Prevention & Management of Bed Bugs in AFC Settings

Other resources include, but are not limited to: Bed Bugs

INDICATORS

Consultants may look for copies of pest control contracts, to ensure the contract and services provided addressed issues timely. Consultants can view the AFC Division's video training on Prevention & Management of Bed Bugs in AFC Settings

Other resources include, but are not limited to: Bed Bugs

RECOMMENDATIONS

It is recommended that licensees hire professional pest control companies to conduct routine inspections in the facility, to treat any identified infestations, and to maintain a preventative plan.

It is also recommended that licensees publicly post in the facility, at the entrance, the presence of current infestation and plans for treatment.

(7) Poisons, caustics, and other dangerous materials must be stored and safeguarded in nonresident, non-food preparation areas, and storage areas.

INDICATORS

The consultant may determine that poisons, caustics and other toxic materials are properly stored so that they are not accessible to residents. Safeguarding may include locking the materials if necessary for protection of the home's resident population. Safeguarding can also include storing in an area where staff have a constant line of sight. The consultant may check labels of items to determine if they are poisonous, caustic or other toxic material.

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(8) A habitable room must have direct outside ventilation by means of windows, louvers, air-conditioning, or mechanical ventilation. From April to November, each door, openable window, or other opening to the outside that is used for ventilation purposes must be supplied with a standard screen of not less than 16 mesh.

TECHNICAL ASSISTANCE

Habitable rooms are all rooms that may be used by residents for living and sleeping. All habitable rooms are to have a direct source of ventilation year-round.

INDICATORS

The consultant may determine how each habitable room is ventilated. When mechanical ventilation systems are used, the consultant may check that the system is operating. Filters and ducts are to be kept clean.

Where the ventilation source is a window, it may be checked to determine that it is openable and operable, and is tight fitting when closed. Screening must be of a small enough mesh to prevent entry of insects.

If licensees claim that screens are not needed because the facility is equipped with central air, the consultant may interview residents and/or direct care staff to determine if windows are ever opened.

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(9) Hand-washing fixtures must be provided in both the kitchen and bathroom areas and include hot and cold water, soap, and individual towels.

TECHNICAL ASSISTANCE

Residents are not allowed to use common cloth towels; each towel must be used by only one person.

RECOMMENDATIONS

It is recommended that licensees provide paper towels for hand washing.

(10) When a resident is discharged, the resident's room and its contents must be thoroughly cleaned, and blankets and linens sanitized.
(11) The condition or operation of a swimming pool or spa equipment, structure, area, or enclosure must not jeopardize the health or safety of the individuals using or operating the pool or spa. A swimming pool or spa area must be completely enclosed by a wall, fence, or other protective enclosure.

R 400.647 Safety and maintenance of premises.

Rule 647. (1) A facility must be constructed, arranged, and maintained to provide adequately for the health, safety, and well-being of occupants.

TECHNICAL ASSISTANCE

Rule 400.601(1)(w) defines premises as the facility, grounds, and all other appurtenances.

Plumbing, lighting, ventilation, floor space, the minimizing of hazards and routine maintenance are to be adequate.

Oxygen Storage: A one (1) day supply (or one canister if the canister holds more than a one-day supply) is permitted in the room where it is being used. Oxygen in excess of a one (1) day supply is to be stored in a separate room used for no other purpose or storage. A rack or fastening device must be used to protect cylinders from accidental damage or from falling over.

INDICATORS

When evaluating compliance with this subrule, the licensing consultant may consider the entirety of the premises as it relates to the foster care needs of the population served. Any obvious hazards to residents must be cited and corrected.

Routine Maintenance: The consultant may assure proper maintenance of the interior and exterior of the facility by observing that the mortar is intact around brick or stonework; eaves troughs and down spouts are securely fastened and kept in good repair; rails and porch floors, exterior stairs and sidewalks are in good repair. The maintenance of auxiliary buildings and the yard are to be maintained in a manner that does not present a hazard to residents.

(2) Home furnishings and housekeeping standards must present a comfortable, clean, and orderly appearance.

(3) Living, sleeping, hallway, storage, bathroom, and kitchen areas shall be well-lighted and ventilated.

INDICATORS

Consultants may rely upon their initial impressions of the lighting when inspecting various areas of the facility. The citing of lighting violations in facilities should reflect various symptoms of the problem, such as the presence of dirt and debris, the existence of large shadow areas, and other indicators that the tasks to be accomplished by residents and staff have been made more difficult because of poor illumination.

Consultants will assure that there is adequate ventilation throughout the home. Means of ventilation includes windows and mechanical ventilation systems. When mechanical ventilation systems are used the consultant is to determine through observation that the system is operating. Indicators of adequate ventilation include:

- Steady, on-going air exchange.
- Control of odors.
- Absence of extreme humidity, dryness, mold, or mildew.

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(4) Roofs, exterior walls, doors, skylights, and windows must be weathertight and watertight and maintained in good repair.

INDICATORS

The consultant is to determine that the roof, exterior walls, doors, skylights, and windows are weathertight and watertight. Indicators that a facility may not be watertight may include, but are not limited to, water stains on ceilings or walls, buckled walls, peeling paint, squishy carpeting, sagging floors, and/or standing water in the basement.

Indicators that a facility is not weathertight include, but are not limited to, the consultant's ability to see through cracks to the outside or feel cold air entering from the outside by means not intended in the normal construction of a house.

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(5) Floors, walls, and ceilings must be easily cleanable, maintained clean, and in good repair.

TECHNICAL ASSISTANCE

Walls and ceilings must be free from holes, breaks, cracks, flaking paint or plaster, and other surfaces which make cleaning difficult. Floor moldings must be installed to fit both the floor and adjoining wall tightly. Wherever cracks or crevices of any size are

found, it is possible for cockroaches, other insects and, in extreme cases, mice or young rats to establish harborage.

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(6) Plumbing fixtures and water and waste pipes must be properly installed and maintained in good working condition.
(7) A water heater must be equipped with a thermostatic temperature control and a pressure relief valve, both of which must be in good working condition.

TECHNICAL ASSISTANCE

Flame-producing water heaters must be properly vented to the outside (see picture 1). The pressure relief valve discharge pipe must terminate within approximately 4 inches of floor level (see picture 2)



Picture 1



Picture 2

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(8) Water closet compartments, bathrooms, and kitchen floor surfaces shall be constructed and maintained to be reasonably impervious to water and allow the floor to be easily maintained in a clean condition.

TECHNICAL ASSISTANCE

Where carpet is used, it must be installed over areas that are impervious to water.

INDICATORS

Indications of problems include strong odors, cracked flooring, spongy flooring, evidence of leakage.

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(9) Stairways with more than 1 step must have sturdy and securely fastened handrails. Handrails must be 30 to 34 inches above the upper surface of the tread.

TECHNICAL ASSISTANCE



(10) On the effective date of these rules, new or renovated exterior and interior stairways and ramps must have handrails on the open sides and be constructed in accordance with and inspected and approved by the state or local building authority in accordance with the Stille-DeRosset-Hale single state construction code act ,1972 PA 230, MCL 125.1501 to 125.1531.
(11) Porches and decks that are 8 inches or more above grade must have deck railing in accordance with the local building code on the open sides.
(12) Stairway risers and treads must be a uniform and consistent size. Stairways that form a part of a required means of egress must change direction at landings only. Spiral staircases and staircases that incorporate wedge-shaped steps are not allowed as a part of a required means of egress. This subrule does not apply to family or congregate facilities licensed on or before promulgation of these rules that have been continuously licensed.

TECHNICAL ASSISTANCE

The term “continuously licensed” means a facility that has remained licensed without any lapse, closure, revocation, or period of operating unlicensed. This includes situations in which a new license was required due to a change in ownership, licensee, location, or licensure status, provided there was no interruption in licensure between the previous and subsequent license.

(13) Rugs on hard finished floors must have a nonskid backing.
(14) Handrails and nonskid surfacing must be installed in showers and bath areas.

TECHNICAL ASSISTANCE

Handrails must be properly fastened and secure. Showers or bathtubs constructed of nonskid materials from the manufacturer are acceptable. Removable rubber bathmats are unacceptable because they are easily removable. Nonskid surfacing and strips must be maintained and in good repair.





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(15) Sidewalks, fire escape routes, and entrances must be kept reasonably free of hazards, such as ice, snow, and debris.

TECHNICAL ASSISTANCE

The home's sidewalks, hallways, fire escapes, and entrances must be kept clear of anything that would present an obstacle to someone entering or leaving the building. Such obstacles may include, but are not limited to, snow, ice, trash containers in hallways, furniture which may protrude into a passageway, loose carpeting or floor tile, baby gates, doors not easily opened, and other obvious hazards.

When a garage is used as a fire escape route, the passageway through the garage itself is to be kept clear even when the garage is used for storage of autos, lawn equipment, power tools, etc.

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(16) Yard areas must be kept reasonably free from all hazards, nuisances, refuse, and litter.

TECHNICAL ASSISTANCE

Broken or uneven paved walks or driveways that present an obvious risk must be repaired or removed. Decorative pools, fishponds, and canals without barriers constructed around them could be hazardous. Depending upon the population served, if a yard has decorative pools, fishpond, is adjacent to a body of water, or has

severe elevation changes, it may be necessary to require the installation of a barrier to prevent injury to the resident. The licensee will need to be able to demonstrate how safety of residents will be maintained when hazards exist in the yard surrounding the facility.

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(17) Hot water pipes and steam radiators that are located in resident-occupied areas must be shielded to protect against burns.

TECHNICAL ASSISTANCE

An enclosure around hot water pipes and steam radiator could be a three-sided box with top that allows circulation of air and prevents touching the radiator surface.







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(18) A written report must be made to the resident's designated representative; responsible agency, if applicable; and the department within 24 hours from the occurrence of property damage that impacts the facility to provide adult foster care services or relocation of a resident to a different address or any fire.

R 400.649 Electrical service.

Rule 649. Electrical service must be maintained in a safe condition. Where conditions indicate a need for inspection, and on all new or remodeled projects, the electrical service must be inspected by a qualified electrical inspection service and a copy of the inspection report must be maintained for 2 years.

TECHNICAL ASSISTANCE

Routine electrical inspections are not required.

A "qualified electrical inspection service" is the Michigan Department of Licensing and Regulatory Affairs Bureau of Construction Codes Electrical Division, the local electrical inspection authority, an electrical contractor, or a licensed electrician.

A copy of a Home Inspection Report does not meet the requirements of this rule, as these reports only document the issues that are found by the inspector and not that the electrical system is in a safe condition.

INDICATORS

Conditions indicating a need for an inspection may include, but are not limited to, the age of construction, the need for extensive use of extension cords, bare, frayed, or spliced wiring, hot fuse boxes, regular brownouts, continually blown fuses, covers off receptacles and switches, and oversized fuses.

R 400.651 Living space.

Rule 651. (1) Common use areas of the facility must be accessible to all residents unless a resident has restrictions imposed in the resident's assessment plan or individual plan of service.
(2) The licensee shall provide not less than 35 square feet of indoor living space per occupant, excluding bathrooms, storage areas, hallways, kitchens, and sleeping areas.
(3) A resident shall be provided with storage space for storing personal belongings.
(4) A resident that has impaired mobility shall have access to the living, dining, bathroom, and the resident's bedroom. These areas must be located on the street floor level of the facility that contains the required means of egress.

TECHNICAL ASSISTANCE

"Impaired mobility" means physical or mental conditions that prevent a resident from walking or going up and down stairs without assistance.

INDICATORS

Indicators of impaired mobility may include, but are not limited to, the use of walkers, wheelchairs, crutches and canes, and the inability to follow staff direction.

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(5) Facilities that regularly accommodate residents with impaired mobility shall ensure the doorways to a living, dining, bathroom, and resident bedroom have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.
(6) A resident shall not be housed above the second floor of the facility. This subrule does not apply to those facilities licensed on or before May 24, 1994 that have been continuously licensed.

TECHNICAL ASSISTANCE

The term "continuously licensed" means a facility that has remained licensed without any lapse, closure, revocation, or period of operating unlicensed. This includes situations in which a new license was required due to a change in ownership,

licensee, location, or licensure status, provided there was no interruption in licensure between the previous and subsequent license.

(7) Living, dining, bathroom, and sleeping areas for residents must be contained within the facility.
(8) A licensee shall provide 1 or more multipurpose areas of adequate size for training, recreation, family-style dining, and other diversional and social activities.
(9) A licensee shall have dining space that can accommodate all residents at the same time.
(10) A facility licensed on or before May 24, 1994, that is not in compliance with subrule (2) of this rule, and the license remained in continuous effect, may apply for a variance.

R 400.653 Room temperature.

Resident-occupied rooms must be heated at no less than 68 degrees Fahrenheit. While air conditioning is not required, precautions must be taken to prevent prolonged resident exposure to noncirculating air that is at a temperature of 90 degrees Fahrenheit or above. Variations must be based on a resident's health care appraisal and addressed in the resident's assessment plan.

INDICATORS

The consultant may check the room temperature of several resident bedrooms and rooms generally occupied by residents with a thermometer to determine the temperature.

The consultant may also review the residents' Health Care Appraisal and written Assessment Plan for any special instructions related to the temperature recommendations for residents. Resident Care Agreements and Assessment Plans may be reviewed to determine whether preferences for variations from this rule requirement have been addressed and carried out.

RECOMMENDATIONS

Practical ways to keep air circulating when there is no air conditioning include, but are not limited to, using fans strategically, creating a cross-breeze, limiting heat sources, and using blinds and curtains.

R 400.655 Bathrooms

Rule 655. (1) Bathroom and toilet amenities with windows must open easily for ventilation. Amenities without a window must have forced ventilation to the outside.
(2) Toilets, bathtubs, and showers must provide for individual privacy.
(3) Bathrooms must have doors with positive-latching, non-locking-against-egress hardware. Hooks, bolts, bars, and other similar devices are prohibited on bathroom doors.

(4) A facility must have a minimum of 1 toilet, 1 sink, and 1 bathing fixture for every 8 occupants. Areas restricted for employee, household member or adult day care use only may not be counted in meeting this requirement.
(5) At least 1 toilet and 1 bathing fixture, and 1 sink must be provided on each floor that has resident bedrooms.

TECHNICAL ASSISTANCE

A resident bedroom that has a bathroom contained in it is to be considered available only to those occupants of the bedroom, including dual entry bathrooms.

RECOMMENDATION

It is recommended that licensees with residents who share a dual entry bathroom, sign an acknowledgment they agree to this bathroom arrangement.

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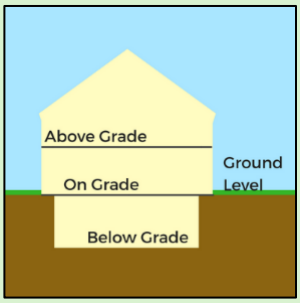
(6) A facility licensed on or before May 24, 1994, that does not have 1 bathing fixture in accordance with subrule (5) of this rule, and the license remained in continuous effect, can apply for a variance.

R 400.657 Bedrooms

Rule 657. (1) A room must not be used as a resident bedroom if more than 1/2 of the room height is below grade. This subrule does not apply to basement bedrooms previously approved before the promulgation of these rules.

TECHNICAL ASSISTANCE

"Below grade" means any portion of a room that is located lower than the surrounding ground level.





More than ½ of the bedroom's height is below grade. This would NOT be an approved resident bedroom.

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(2) Living rooms, dining rooms, hallways, or other rooms that are not ordinarily used for sleeping, or a room that contains a required means of egress, must not be used for sleeping purposes by anyone.
(3) A resident bedroom must be separated from halls, corridors, and other rooms by floor-to-ceiling walls that do not have openings, except for doorways.

(4) Interior doorways of a resident bedroom must be equipped with a side-hinged, permanently mounted door that is equipped with positive-latching, non-locking-against-egress hardware.

TECHNICAL ASSISTANCE

"Positive latching" means that a door's latch automatically engages and holds the door closed whenever it is pushed or pulled shut.

"Non-locking against egress hardware" means the door can be opened, unlatched, and unlocked in one releasing motion. The latch must secure the door without requiring a key, tool, or special knowledge to open it from the egress.

See examples of acceptable hardware below:







Pocket doors, barn doors, and bi-fold doors do NOT meet this rule requirement. See example pictures below:



Pocket Door



Barn Door



Bi-fold Door

(5) Traffic to and from any room must not be through a resident bedroom.
(6) For 2 adjoining rooms to be considered as 1 bedroom, there must be a 7-foot horizontal opening between the rooms.
(7) A resident bedroom must have at least 1 easily openable window. A window does not need to be openable if the room has air conditioning, has a ducted system that

provides fresh air, and staff and local authorities are able to break the window to rescue the residents in an emergency.
(8) Residents of different gender identities shall not occupy the same bedroom for sleeping purposes unless agreed to by both residents, designated representatives, or responsible agencies and documented in each resident's assessment plan.

TECHNICAL ASSISTANCE

Licensees are expected to evaluate roommate compatibility during the assessment process. The same general questions should be asked of every resident during the completion of resident assessment plans, and should include consideration of sleep habits, personality, cleanliness, medical needs, personal preferences, and comfort level with a proposed roommate arrangement, including circumstances in which residents may have different gender identities or may identify differently from the sex assigned to them at birth. Gender Identity is an individual's internal sense of being male, female, a blend of both, or neither.

Licensees are not required to disclose a resident's personal gender history; however, they should ensure that roommate placements are mutually agreeable and do not create situations where residents feel misled, unsafe, or uncomfortable.

If a resident expresses discomfort after learning information about their roommate, the licensee should assess whether continued cohabitation remains appropriate. The licensee must ensure no harassment or discrimination occurs and should consider alternative room arrangements if compatibility is no longer present. The goal is to find appropriate accommodation for both residents. Any changes must be documented in the residents' assessment plans.

RECOMMENDATION

While Michigan law protects against discrimination, it does not create a universal statute labeling gender identity as automatically confidential in all contexts. However, in care settings like AFC homes it is recommended that gender identity be treated as sensitive personal information and handled confidentially. It is recommended that a resident who identifies as transgender not be required to disclose their status to potential roommates, and that disclosure may only occur if the resident voluntarily chooses to share that information, or if the resident provides clear consent for the licensee to share it. It is recommended that licensees encourage voluntary disclosure in a supportive way, such as, *"If you would like to share information about yourself with a potential roommate, you are welcome to do so. That choice is entirely yours. We will respect your privacy either way."*

It is recommended that staff periodically reassess shared-bedroom arrangements through private conversations to ensure continued comfort and voluntary agreement.

It is recommended that the licensee maintain clear "*Anti-Harassment Procedures*" and ensure there is a documented process for addressing roommate conflicts or discriminatory behavior promptly and appropriately.

It is recommended that the licensee provides ongoing training to staff on confidentiality and inclusion, as well as gender identity terminology, privacy standards, anti-discrimination practices, and respectful communication.

R 400.659 Bedroom space; "usable floor space"

Rule 657. (1) Usable floor space means floor space that is under a ceiling that is not less than 6 feet, 6 inches in height, excluding closets and portable wardrobes. When determining usable floor space, an alcove or any other part of the room that does not have at least a 7-foot horizontal dimension must be excluded.

INDICATORS

The consultant may observe the home for slanted ceilings or other obstructions that could affect the amount of required usable floor space. If ceilings are sloped to less than 6' 6" from the floor, the consultant may need to establish at what point the ceiling meets the height requirement and measure floor space within that perimeter. The consultant shall exclude areas with less than 7 feet of horizontal space.

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(2) A single occupancy resident bedroom must have not less than 80 square feet of usable floor space, except for family homes, which require 65 square feet of usable floor space.
(3) A multioccupancy resident bedroom must have not less than 65 square feet of usable floor space per bed.
(4) A maximum of 2 beds are allowed in any multioccupancy bedroom, except as provided in subrule (5) of this rule.
(5) A maximum of 4 beds are allowed in any multioccupancy bedroom for a facility licensed on or before May 24, 1994 if the license has remained in continuous effect.

TECHNICAL ASSISTANCE

AFC Family Homes that were licensed on or before May 24, 1994, and whose license has remained in continuous effect through November 3, 2025, may apply for a variance to R 400.659(5). Licensees should continue to comply with the current rule requirements unless and until a variance has been formally approved by the department.

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(6) There must not be less than a 3-foot clearance between beds in a multioccupancy bedroom.

R 400.661 Bedroom furnishings.

Rule 661. (1) Bedroom furnishings must include all of the following:

(a) A bed that is not less than 36 inches wide and not less than 72 inches long with a foundation that is clean, in good condition, and provides adequate support.
(b) A mattress that is clean, in good condition, and not less than 5 inches thick or 4 inches thick if made of synthetic materials.
(c) Closet or wardrobe space.
(d) Dresser or equivalent.
(e) Chair.

TECHNICAL ASSISTANCE

"Closet or wardrobe space" is a designated storage area within a bedroom that is intended for keeping personal belongings and clothing. This space may be built into a structure or may be freestanding, such as an armoire. "Closet or wardrobe space" is not open shelving or open racks.

"Dresser or equivalent" is a piece of furniture designed to store personal clothing and belongings. It includes drawers, or compartments that allow a resident to organize and access their items easily. A "dresser or equivalent" is not a nightstand or bedside table, baskets, bins, or underbed storage containers.

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(2) The bed and mattress in subrule (1) of this rule can be removed from the bedroom if the resident or resident representative requests that it be removed, the resident's health care professional approves an alternative sleeping arrangement, and it is documented in the assessment plan.
(3) The licensee may allow the resident to use their own bedroom furnishings instead of the licensee provided furnishings listed in subrule (1) of this rule.
(4) Resident bedrooms must have lighting for reading and other activities, equipped with an accessible mirror appropriate for grooming, and provisions to allow a resident to mount pictures or decorative items on walls.

TECHNICAL ASSISTANCE

The mirror should be mounted at a height usable for the resident, accessible, and large enough to facilitate grooming. Non-breakable mirrors are available for situations where residents break mirrors. If a single bedroom has an adjoining single bathroom, the mirror in the bathroom is sufficient.

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(5) A resident shall not use any of the following for sleeping:

(a) Roll-a-way bed.
(b) Cot.
(c) Double-deck beds.
(d) Stacked bunks.
(e) Hide-a-bed.
(f) Daybed.
(g) Waterbed.

TECHNICAL ASSISTANCE

The following beds are NOT allowed:


Roll-a-way bed


Double-deck bed


Stacked bunks


Hide-a-bed


Daybed


Waterbed

SUBPART F: FOOD, CLOTHING, EDUCATIONAL OPPORTUNITIES, EQUIPMENT, AND INDIVIDUAL SUPPLIES

R 400.663 Nutrition; adopted by reference.

Rule 663. (1) A licensee shall provide daily a minimum of 3 nutritious meals to residents.

TECHNICAL ASSISTANCE

Meals served by the licensee must meet recommended daily allowances in subrule (4) of this rule.

INDICATORS

The consultant may conduct an unannounced onsite inspection/investigation at mealtime and/or observe meal preparation. The consultant may randomly select the licensee's menus and review them in order to determine that nutritional requirements have been met.

RECOMMENDATIONS

It is recommended that licensees involve residents in meal planning to promote choice, independence, engagement, and overall satisfaction with meals. Ways to involve residents in meal planning include, but are not limited to, conducting regular resident food preference surveys, holding monthly or biweekly meal planning meetings, using suggestion boxes for private feedback, offering choices with every meal, and providing culturally responsive meal options.

It is recommended that licensees consult with a dietician or nutritionist to assist in ensuring that meals provided to residents are healthy and nutritious.

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(2) Meals must be of proper form, consistency, and temperature.
(3) Not more than 14 hours must elapse between the evening and morning meal.

TECHNICAL ASSISTANCE

The consultant may review mealtimes with the licensee, staff and residents to determine compliance with the timing of menus.

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(4) Meals must meet the nutritional allowances recommended by the United States Department of Agriculture and the United States Department of Health and Human Services in the Dietary Guidelines for Americans (DGA), 2020-2025. The Dietary Guidelines for Americans 2020-2025 are adopted by reference and available to be viewed or downloaded from the U.S. Department of Agriculture and the U.S. Department of Health and Human Services at https://www.dietaryguidelines.gov at no cost at the time of adoption of these rules. A copy of these guidelines is available for inspection and distribution from the Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, at 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption of these rules.

TECHNICAL ASSISTANCE

The Dietary Guidelines for Americans (DGA) referenced in this rule are the 2020–2025 Dietary Guidelines for Americans. They were the most current version at the time when the administrative licensing rules were adopted. The United States Department of Agriculture (USDA) and the United States Department of Health and Human Services (HHS) periodically update these guidelines, and more recent editions may now be available.

For purposes of compliance with this rule, licensees are only required to follow the 2020–2025 Dietary Guidelines for Americans, as this is the version formally adopted by reference in the administrative rules. Licensees may choose to consult newer

editions for general nutritional guidance, but compliance determinations will be based on the 2020–2025 guidelines referenced in the rule.

RECOMMENDATIONS:

It is recommended that licensees and staff members view the division's training video Dietary Guidelines for Americans 2020–2025

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(5) A resident who has a prescribed diet by an appropriately licensed health care professional shall be provided that diet.

TECHNICAL ASSISTANCE

Special diets include, but are not limited to, weight reduction plans, diabetic diet plans, low sodium, low fat, modification of food consistency, or gastric tube feeding. Any food that is chopped, pureed, or whose consistency has been modified, including gastric tube feeding, is to be considered a special diet and is to coincide with a resident's prescribed special diet.

Staff are to ensure there are not multiple and or conflicting orders for special diets in resident records. Staff responsible for food preparation must be familiar with the prescribed diet. Equipment and information needed to follow special diets must be available to staff in the home. Food on hand must be consistent with the special diet. Licensees must be able to demonstrate how staff have been trained and are competent in providing special diets to residents.

INDICATORS

The consultant may review resident records for special dietary requirements. Special dietary requirements can generally be found on the resident's health care appraisal, on a prescription form or in a narrative statement from the health care professional. Documentation signed and dated by the health professional is to be maintained in the resident record.

The consultant may determine if and how a special diet is being provided.

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(6) Menus, excluding special diets, must be written at least 1 week in advance and posted. Any change or substitution must be documented.

TECHNICAL ASSISTANCE

The purpose of a menu is to ensure the residents' nutritional needs are met, to guide staff and assist with grocery planning, as well as facilitate communication between staff, residents, and visitors about the food being served and allow for feedback.

Licensees may choose to use the division's Weekly Menu Template or create their own.

INDICATORS

The consultant may check the food supply in the home's pantry to determine that it coincides with the menu.

RECOMMENDATIONS

It is recommended that licensees include residents in the creation of menus. It is also recommended that serving sizes be added to written menus, to ensure that residents receive consistent, nutritionally appropriate portions that meet dietary needs.

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(7) A licensee shall keep records of menus, including special diets, for 90 days.
(8) A facility that is licensed for 7 or more residents shall have a minimum of 1 staff who is qualified by training, experience, and performance to be responsible for food preparation. Additional food service staff shall be employed as necessary to ensure regular and timely meals.

TECHNICAL ASSISTANCE

In most cases staff responsible for food preparation should not be counted into the direct care staff to resident ratio. However, under certain circumstances, a person responsible for food preparation could be counted as a part of the staff to resident ratio if that person meets the qualifications of a direct care staff and the licensing consultant has determined that the care and supervision needs of the residents would not be jeopardized.

A "Food Handler's Card" is not required by this rule. Licensees are to assure that a person responsible for food preparation has experience and training that will enable them to carry out their duties.

INDICATORS

Some factors a consultant may take into account when making this determination include:

- The physical layout of the home.
- The location of the residents in the home at meal preparation and serving times.
- The number of residents in the home at mealtimes.
- The specific care needs of the residents.

R 400.665 Food Service.

Rule 665. (1) A facility shall be properly equipped to prepare and serve adequate meals.

TECHNICAL ASSISTANCE

Even if a commercial or fully equipped kitchen is available in a licensed facility on a campus of multiple licensed facilities, owned and operated by the same licensee, each facility must be minimally equipped to prepare meals, to keep food at required temperatures, and to adequately serve meals. This could include dishwashing facilities, stove, refrigerator, a food preparation area, and eating and cooking utensils.

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(2) Food must be from sources that are safe for human consumption and free from spoilage, adulteration, and misbranding.

TECHNICAL ASSISTANCE

Such products must be processed by a commercial food processor, as if for retail sales. Food that is not commercially packaged is prohibited, such as:

- home canned foods.
- packages of meat and poultry with no label or marked "not for sale" or "not for retail" (may indicate product was not commercially processed).

The following are acceptable:

- noncommercial fish and eggs.
- home grown fresh or frozen vegetables and fruit.

According to the Michigan Dept. of Agriculture and the USDA, powdered milk which is labeled grade A and pasteurized may be mixed with water and used as a beverage for residents and in cooking and baking. The container in which the milk is reconstituted must be covered and washed, rinsed and sanitized, between uses. Partially filled containers cannot be refilled until they are washed, rinsed and sanitized.

INDICATORS

The licensing consultant may inquire as to where the home obtains meat and poultry products if they do not have store labels.

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(3) Food must be protected from contamination while being transported, stored, prepared, and served.

TECHNICAL ASSISTANCE

Containers of food are to be stored off the floor, on clean racks, dollies, or other clean surfaces, in such a manner as to be protected from splash and other contamination.

Containers of food must not be stored directly below sewer or cold-water pipes unless effectively designed protection is installed under the pipes to prevent contamination by sewage leakage or water condensation on the containers of food. The licensee must not store food or food service utensils under sink drains. Light bulbs located above food preparation, food storage, dishwashing facilities and in refrigerators must be protected against breakage.

Food stored in open containers must be covered. Individual portions of food once served to a resident are not to be served again.

The requirements for storage and general protection against contamination apply to the transport of all food, as well.

INDICATORS

When an applicant/licensee proposes to or prepares food off site, the consultant is to request the health authority to inspect and approve the off-site facilities, including preparation, transportation and serving of food. A rule variance is not required when food is prepared off site.

If the consultant has questions about possible contamination, the consultant may contact the local health authority for technical assistance.

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(4) Food must be stored at temperatures that will protect against spoilage. Cold foods must be stored at 40 degrees Fahrenheit or below and hot foods stored at 140 degrees Fahrenheit or above until served to residents, except during periods that are necessary for preparation.
(5) Refrigerators and freezers must be equipped with thermometers.

TECHNICAL ASSISTANCE

Licensees may use digital thermometers/displays built into refrigerator/freezer if it shows precise temperature.

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(6) Food service equipment and utensils must be constructed of materials that are nontoxic, easily cleaned, and maintained in good repair. Food service equipment and eating and drinking utensils must be thoroughly cleaned and air dried after each use.

INDICATORS

The licensing consultant may inspect the food preparation areas for cleanliness, including:

Equipment - stoves, ranges, hoods, tables, pots and pans, counters, refrigerators, sinks, dishwashers, and any other equipment in the kitchen.

Tableware - multi-use eating and drinking utensils, including flatware (knives, forks, and spoons). A common use drinking cup/glass at a water fixture is not permitted. Tableware with worn surfaces cracks or chips are to be discarded, as they cannot be easily cleaned and are not in good repair.

Single-service articles - Aluminum foil baking utensils, such as those used when baking pies, and similar single-service articles, must not be used more than once. Paper or foam cups, or plates and plastic flatware must be stored in closed cartons or containers, which protect them from contamination. These articles are to be used only once.

Utensils - tableware and kitchenware used in the storage, preparation, conveying, or serving of food.

Regardless of the cleaning method employed, utensils must be air-dried. Towel drying may result in contamination.

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(7) When food is removed from its original packaging and stored, it must be clearly labeled to identify the prepared or opened date and an expiration or discard date. The discard date must be no more than 7 days on all perishable foods that are opened or if food is prepared and held at safe storage temperatures. The day of opening or day of preparation must be counted as day 1. If there are signs of spoilage, food must be discarded immediately. If any residents of the home have known food allergies, the label must also indicate that this food contains the food or ingredient that the resident is allergic to.

TECHNICAL ASSISTANCE

This does not include items such as ketchup, mustard, and other bottles of condiments. These items can be discarded on their expiration date, or before, if signs of spoilage are present.

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(8) Kitchen appliances must be properly installed and maintained according to the manufacturer's instructions.
(9) Kitchen hoods or canopies must be equipped with filters. Filters must be maintained in an efficient condition and always clean.
(10) Food preparation surfaces and areas must be clean and in good repair.

TECHNICAL ASSISTANCE

Food preparation surfaces, tables, countertops and cutting boards are to be reasonably smooth, washable, readily accessible for cleaning and of such material and in such repair as to be maintained in a clean and sanitary condition. Only cutting

boards in good condition are acceptable. Cutting boards with chips or cracks must be discarded.

Miscellaneous kitchen items - wall exhaust fans and any items that are essential to the kitchen operations are to be inspected for cleanliness and proper working order. Nonessential items that may contribute to poor sanitation must be kept out of the kitchen.

R 400.667 Laundry

A licensee shall provide for the laundering of a resident's personal laundry.

TECHNICAL ASSISTANCE

Off-site laundry services are permitted.

R 400.669 Linens.

Rule 669. (1) A licensee shall provide all of the following:

(a) Clean bedding in good condition that includes a minimum of a fitted sheet, top sheet, pillowcase, and blanket or comforter for each bed.

(b) At least 1 standard bed pillow that is comfortable, clean, and in good condition for each resident.

(c) Bath towels and washcloths.

(2) Bed linens must be changed and laundered at least once a week and towels and washcloths changed and laundered not less than twice weekly or more often if soiled.

(3) A licensee shall maintain a minimum linen supply for twice the number of licensed beds or more as required based on residents' needs.

SUBPART G: PROGRAM AND SERVICES

R 400.671 Resident care.

Rule 671. (1) Staffing shall be sufficient to meet the needs of the residents in accordance with each resident's assessment plan and individual plan of service.

(2) Care and services provided to a resident must be designed to maintain or improve a resident's physical and intellectual functioning and independence.

(3) A licensee shall ensure that interactions with residents promote and encourage cooperation, self-esteem, self-direction, independence, and normalization.

(4) A licensee shall provide supervision, protection, and personal care as specified in a resident's assessment plan. A hospice service plan, do-not resuscitate order, or any other advance directive must be included as an addendum to the resident assessment and maintained with the assessment plan in the resident's record.

(5) A licensee shall provide the following opportunities for a resident:

(a) Development for positive social skills.

(b) Contact with relatives and friends.

TECHNICAL ASSISTANCE

Opportunity for contacts with friends and relatives and to receive visitors in the home is to be provided. Any restrictions on visitation must be included in the assessment plan and agreed to by the resident, resident's designated representative, or guardian.

A licensee may establish house guidelines that govern the conduct of residents and visitors in the home, provided such guidelines are not in violation of applicable licensing regulations. If there are no limits placed on the activities of residents, the licensee is still responsible for assuring the safety and protection of residents from social, moral, and financial exploitation, as defined in mcl-Act-218-of-1979.pdf

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(c) Community-based recreational activities.
(d) Privacy and leisure time.

TECHNICAL ASSISTANCE

The home must have a method of arranging for resident's privacy including visits with case managers, family, friends, etc.

(e) Religious participation of choice.

TECHNICAL ASSISTANCE

Residents are to be afforded the opportunity to attend religious services and education of their choice, though religious participation cannot be required of residents.

INDICATORS

The consultant could determine whether religious preferences are honored, and preferences have been addressed by interviewing the resident and reviewing the resident's assessment plan.

(f) Direction and opportunity for growth and development as achieved through activities that foster independent and age-appropriate functioning, such as dressing, grooming, manners, shopping, cooking, money management, and the use of public transportation.

TECHNICAL ASSISTANCE

The specific services provided are to be identified in a resident's written assessment plan.

INDICATORS

The licensing consultant is to determine what the licensee is doing to assure that these requirements are being met according to the resident's assessment plan.

(g) Opportunity for involvement in educational, employment, and community activities.

INDICATORS

The consultant is to review the resident's written assessment plan to identify what educational employment and day program opportunities are and will be provided. The consultant can interview and observe residents and staff to determine how the licensee is fulfilling the requirements of this rule.

RECOMMENDATIONS

It is recommended licensees and staff members view the division's **Recreation Programs and Activities in AFC Homes** video training.

R 400.673 Use of assistive devices, therapeutic support.

Rule 673. (1) An assistive device or therapeutic support intended to achieve or maintain a resident's proper position to enhance mobility, physical comfort, safety, and well-being must be specified in the resident's assessment plan and agreed on by the resident or resident's designated representative.

TECHNICAL ASSISTANCE

Examples of assistive devices include, but are not limited to, walkers, canes, wheelchairs, gait belts, mechanical lifts, bedrails, grab bars and assist rails, body positioning wedges, and shower chairs or shower trollies.

Use of a half bed rail is generally preferred over a full bed rail. A full bed rail may be considered a potential restraint, if it is a means of confinement. (See Guidelines for Bedrail, Mattress & Headboard Measurements) Any device used solely for the purpose of restricting a resident's movement is not an assistive device and is prohibited because it is a restraint. The following questions can be used to determine if the item is a restraint or an assistive device:

(h) Can the resident remove or release the device? (if yes, assistive device).

(i) Would the resident harm himself/herself if the device was not used? For example:

- A harness to maintain an upright position while sitting in a wheelchair to prevent positional asphyxiation (if yes, assistive device).
- A lap belt for residents without torso control to prevent falling out of a wheelchair (if yes, assistive device).
- Time-limited use of posey/arm/leg restraints to prevent injury to surgical wound (if yes, assistive device).
- Does the device prevent the resident from getting up and wandering around when injury is not an issue? (if yes, restraint)
- Does the device appear to be for the convenience of staff, rather than for the protection of the resident? (if yes, restraint)
- Does the device increase the resident's independence? (If yes, assistive device)

When a device is used, there must be a plan of supervision developed by the licensee to assure that:

- The resident can obtain staff assistance as needed.
- Staff provide routine visual monitoring of the resident.
- Staff have been trained in the proper use, application and maintenance of the assistive device
- Staff been trained in the proper care and supervision of the resident when the device is in use

Guidelines for Use of Bed Rails

The following hazards related to improperly positioned bed rails, mattresses, or beds have been identified. It is recommended that the following be considered during inspections:

- A gap may be created if the mattress or mattress pad is ill-fitted or out of position. The resident may become asphyxiated if the resident slips into the gap with their face pressed against the mattress and is unable to extricate themselves.

- Rail and in-bed entrapment can occur when a side rail releases with the resident's head lodged between side rail bars resulting in compression of the resident's neck and throat.

- Rail and off-bed entrapment can occur when a small person is trapped in the space between the mattress and headboard, mattress and footboard, or a resident could slide out of bed and become trapped between the raised side rail and the bed frame.

- Increased risk of serious injury or death also occurs when the resident's size and/or weight are inappropriate to the bed's capacity or dimensions.

NOTE: Bed rails must be used in accordance with the requirements of Rule R 400.673(1). The licensee must document use of the bed rail in the assessment plan and ensure that direct care staff are instructed in the use of bed rails as follows:

- Resident supervision
- Bed and bed rail safety
- The risks and benefits of bed rail use
- Bed rail maintenance

RECOMMENDATIONS

It is recommended licensees and staff members view the division's Assistive Devices in AFC Homes video training.

It is recommended that only bed rails which were designed and sold for use in health care facilities and that meet the following criteria be used:

- The bed rail is mechanically sound, firmly attached to the bed frame, and the latches are in good working order.
- The distance between the slats (the horizontal or vertical supports between the perimeter of the rail itself) or the bed rail is small enough to prevent the resident's head/leg or arm, from becoming accidentally entrapped between the slats.
- Bed rail protective barriers that do not obstruct the resident's view from the bed may be used to close off open spaces between the slats, such as netting or clear padding.
- Padded bed rail covers that obstruct the resident's view may be used for residents who are prone to seizures or who are extremely agitated. The covers should be soft enough to prevent injury, but rigid enough to prevent a resident from becoming entrapped.
- Any space between bed rail and mattress and between mattress and head or footboard is to be filled with foam wedges.
- When the bed is occupied, the top surface of the mattress must be higher than the bottom of the bed rails.

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(3) An assistive device or therapeutic support must be authorized in writing by an appropriately licensed health care professional, and the authorization must state the reason for and the term of the authorization.

TECHNICAL ASSISTANCE

Obtaining a reason for an assistive device is crucial for ensuring the device meets the resident's specific needs, improves the resident's quality of life, and provides clear justification for the recommendation. It confirms the assistive device will improve function, increase independence, and is the right fit for the resident's specific challenges.

Documenting the term of authorization for the device is crucial for re-evaluation of potential medical necessity and ensures the assistive device remains appropriate for the resident's changing needs and conditions.

Licensees must ensure they obtain authorizations for any devices that residents bring with them, or were provided with by family/designated representative at the time of admission.

RECOMMENDATION

It is recommended the licensee review assistive device use and obtain authorizations during the residents' annual physical.

R 400.675 Resident medications.

(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.

TECHNICAL ASSISTANCE

"Medications" include over the counter medications.

When a resident brings medication into the facility upon their admission, staff should follow careful step by step procedures to ensure the resident's safety. Staff should collect all medications immediately upon admission. This includes, but is not limited to, prescription bottles, over the counter medications, inhalers, creams and ointments, and "as needed" (PRN) medications. Staff should check all prescription labels for accuracy, and compare the medications to the resident's medication orders. Staff should not administer any medication with a missing or unreadable label, conflicting instructions, someone else's name, or outdated or discontinued orders. If anything is unclear, staff should contact the pharmacy or prescriber before administering medication. Staff should compare each medication to the written physician's order, hospital discharge paperwork, and/or the resident's previous medication administration records, if available, to identify duplications, missing medications, medications the resident no longer takes, and new medications recently added. Issues discovered during admission should be communicated to the resident and/or their designated representative, if applicable, as well as their care team(s). Any discrepancies must be clarified before medication administration.

In 2016, Michigan passed a naloxone standing order law. This allows a pharmacist to dispense naloxone without an individual prescription and without identifying a particular patient. With this, the "prescription" comes from the standing doctor's order from the State. Although individual doctor prescriptions still work for this, as an alternative, family, friends, or others can now obtain naloxone to use in an emergency without an individual prescription. More information on Naloxone can be located here: Naloxone

INDICATORS

The consultant may review the label instructions and medication logs to determine that they are consistent with one another. When discrepancies are observed or alleged, it may be necessary to have the licensee/staff do a medication count in the presence of the consultant.

RECOMMENDATIONS

It is recommended that the licensee create and implement a checklist to be used to inventory resident's medications upon admission.

If staff members take verbal or telephone orders, it is suggested the licensee create a policy and procedure on taking verbal/telephone orders. Licensees can view the division's **Sample Policy Verbal Telephone Orders**

If residents use medication bubble packaging, it is strongly recommended that staff members write the date on each resident's medication bubble pack at the time it is first opened. Dating the bubble pack helps ensure accurate tracking of when the medication supply was started, supports timely refill requests, promotes accountability, and reduces the risk of medication errors.

It is recommended that two staff members "together" conduct a narcotic (controlled substance) medication count during each shift change period. This helps to ensure accurate tracking of controlled medications, prevents discrepancies, supports accountability among staff, and protects residents of the home from potential medication errors or diversion.

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(2) Prescribed medication must be kept in the original pharmacy container and labeled for a specific resident. Over-the-counter medication must be kept in the original manufacturer's container. Prescription and over-the-counter medication must be kept in a locked cabinet or drawer and refrigerated if required. Equipment necessary to administer a medication must be easily accessible and used only for the resident for whom it is prescribed unless generally used for all residents.

TECHNICAL ASSISTANCE

The placing of medications in containers that are not the original pharmacy supplied container with its label, (e.g. weekly pill containers, “pre-setups,” etc.) or the original manufacturer’s container, is prohibited. In situations where medication samples have been provided, physician-supplied pharmacy samples of medication may be used in the home if the medication is accompanied by written instructions which pertain specifically to the residents to whom it was supplied. Medications stored in the refrigerator must be in locked box or in separate locked refrigerator designated for medications.





When a pharmacy dispenses insulin pens in a pharmacy-labeled box and does not label each pen individually, the individual pen may be removed from the box for storage at the manufacturer-required temperature. The in-use pen must be clearly identified for the specific resident, kept locked, and readily traceable to the original pharmacy-labeled box maintained at the facility. The facility should also document the date the pen was opened and its required discard date.

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(3) Giving, taking, or applying of prescription medications must be supervised by a licensee, administrator, or direct care staff unless otherwise directed by an appropriately licensed health care professional in writing.

TECHNICAL ASSISTANCE

A resident’s appropriately licensed health care professional’s statement approving a resident to self-administer medication must be available in the resident record, and approval must be addressed in the resident’s written assessment plan.

Although a resident may self-administer medications unsupervised, the licensee has a responsibility to safeguard the medication and to remind a resident to maintain his/her medication schedule, as directed by the resident's physician.

INDICATORS

If the consultant determines a resident is self-administering medications unsupervised, they must confirm there is a written directive from the resident's licensed health care professional available in the resident's record.

RECOMMENDATIONS

It is recommended that staff members conduct periodic assessments of residents who self-administer medications without supervision. Regular assessments help ensure that the residents continue to demonstrate the ability to safely manage their medications, follow instructions, recognize dosage schedules, and understand when to request assistance. Ongoing monitoring also allows staff to identify any changes in condition, physical ability, or judgment that may affect medication safety. This practice supports a resident's independence while maintaining a safe and compliant medication management program within the facility.

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(4) A licensee, administrator, or direct care staff shall comply with the following when supervising the taking of medication by a resident:

(a) Be trained in the proper handling and administration of medication.

TECHNICAL ASSISTANCE

Training must include, in part, the "6 R's" of medication administration:

- Right resident.
- Right medication.
- Right time.
- Right route
- Right dosage.
- Right documentation.

The division provides an ongoing "Medication Administration Rules and Best Practices in AFC Homes" Training. This is a free virtual training opportunity for licensees, administrators, and direct care staff members. Upcoming training sessions are announced via GovDelivery. GovDelivery allows licensees and their staff members to sign up for announcements and alerts. Sign up to receive announcements and alerts from BCHS!

Licensee may also use the division's **Medication Skills Training & Competency Training Checklist** as part of their staff training.

INDICATORS

The consultant may review the licensee's training and procedures for the administration of medications.

RECOMMENDATIONS

It is recommended that facilities create detailed medication administration policies and train AFC staff members on the following topics specific to medication administration:

- Medication orders, including telephone orders and how orders are taken and processed. Licensees may use the division's **Sample Policy Verbal Telephone Orders** to create this policy.

- Medication packaging and the process used in the facility. Licensees may use the division's **Medication Packaging and Storage Policy** to create this policy.

- Medication administration by staff including specific procedures and documentation. Licensees may use the division's **Medication Administration Policy Template** to create this policy.

- Monitoring for side effects. Licensees may use the division's **Monitoring for Medication Side Effects Policy Template** to create this policy.

- Medication errors.
- Medication storage, including storage and accountability for controlled substances. Licensees may use the division's **Medication Packaging and Storage Policy** to create this policy.

- Medication disposal. Licensees may use the division's **Medication Disposal Policy Template** to create this policy.

It is recommended that licensees and staff members who administer medications attend the division's "Medication Administration Rules and Best Practices in AFC Homes" Training. This is a free virtual training opportunity for licensees, administrators, and direct care staff members. Upcoming training sessions are announced via GovDelivery. GovDelivery allows licensees and their staff members to sign up for announcements and alerts. Sign up to receive announcements and alerts from BCHS!

(b) Complete an individual medication log that contains all of the following:
i. The medication.
ii. The dosage.
iii. Label instructions for use.

TECHNICAL ASSISTANCE

Medication label instructions and medication logs must be consistent with one another. However, when a prescriber changes the dose, frequency, or administration time of a medication that has already been dispensed, the pharmacy should not be expected to issue a replacement label for the existing medication container. The licensee must obtain a clear, written prescriber's order that includes the new instructions and authorizes continued use of the medication already dispensed. The medication administration record must be updated to reflect the new order. The existing pharmacy label may continue to reflect the original

instructions until the medication is refilled. Staff must follow the current prescriber's order and updated medication administration record. The pharmacy label must not be removed, altered, or replaced by the licensee or staff. When the medication is next dispensed, the new pharmacy label should reflect the current order.

iv. Time to be administered.
v. The initials of the person who administers the medication, which shall be entered at the time the medication is given.
vi. A resident's refusal to accept prescribed medication or procedures.

(c) Record the reason for each administration of medication that is prescribed on an as needed basis.

TECHNICAL ASSISTANCE

Staff are to indicate on the individual resident medication logs when residents are on a leave of absence, or admitted to the hospital.

This rule requires staff to record the "reason" for each administration of an "as needed", or PRN medication. For this reason, PRN medication orders should be written with specific guidelines that include the minimum and maximum number of doses, the number of days the medication may be used, under what condition(s) the medication is prescribed, and any other directions specific to the resident.

PRN medication orders for pain medication should specify what kind of pain: for example, chest pain, back pain, tooth pain, headache, stomach pain, joint pain, etc. All medication orders, including PRN medication orders, should match the labeling instructions and the instructions on the medication log.

INDICATORS

The medication logs are to be reviewed to determine that they are being completed according to the rule requirements and that administration is consistent with the label information. The consultant may review the employee work schedules to verify the employee's initials on the medication log are consistent with the staff on duty.

(d) Initiate a review process to evaluate a resident's condition if a resident requires the repeated and prolonged use of a medication that is prescribed on an as-needed basis. The review process must include the resident's prescribing licensed health care processional and resident, resident's designated representative, and the responsible agency if applicable.

TECHNICAL ASSISTANCE

A "review process" is a documented evaluation conducted when a resident relies heavily on a PRN medication. "Prolonged use" means a resident is using a PRN

medication frequently or over an extended period, indicating a potential change in their condition and the need for a medical review.

The purpose of a review process is to ensure the resident's safety, confirm the medication remains appropriate, and prevent the misuse or overuse of "as needed", or PRN, medication. The review process includes collaboration with the prescribing health care professional to review the pattern of PRN use, assess whether the medication should continue, evaluate if the resident requires a new diagnosis, a dose adjustment, or a scheduled (routine) medication instead of PRN use. Staff must thoroughly document the reason the review was initiated, feedback from the prescriber, and any new orders, interventions, or required follow-up.

INDICATORS

If frequent administration of "PRN" medication is noted, the consultant is to request verification the licensee initiated a review process to evaluate the resident's condition and need for the medication.

RECOMMENDATION

When a PRN medication is administered, it is suggested that the AFC staff member who administered the medication complete a follow up check in 30-45 minutes, which involves talking to, and observing the resident for the intended effect, and then document the effectiveness.

(e) Not adjust or modify a resident's prescription medication without instructions from a physician, physician assistant, advanced practice nurse, or a pharmacist who has knowledge of the medical needs of the resident. A licensee shall record in writing any instructions regarding a resident's prescription medication.

TECHNICAL ASSISTANCE

Changes in prescription medication are to only be made by a person licensed to prescribe medication (i.e., physician, dentist, podiatrist). Directions regarding a change in prescription medication should only be accepted from the individual prescribing the medication or a licensed medical professional (i.e., nurse, physician's assistant, pharmacist) acting as a representative of the person prescribing the medication.

This rule also means no crushing or mixing medications in food, unless that direction is on the pharmacy label, or is indicated in the accompanying information, or there is a signed order from the prescribing health care provider indicating that it is okay to mix or crush a medication. By crushing or mixing, the efficacy of some medications could unintentionally be compromised.

INDICATORS

If the consultant observes that the pharmacy label instructions/dosage is different than that contained on the medication log, the consultant is to review the licensee's documentation of the change instructions.

(f) Contact the resident's licensed health care professional or the appropriately licensed health care professional who prescribed the medication when a medication error occurs.

TECHNICAL ASSISTANCE

A Medication Error is when a medication is administered in any way other than how it was prescribed, including when a medication was not administered to a resident.

This rule does not specify an exact timeframe for contacting the licensed health care professional. Subsequently, expectations are generally guided by resident safety, clinical urgency, and professional judgment rather than a fixed clock. The department's expectation is that contact with a licensed health care professional occurs within a time frame that is reasonable and clinically appropriate based on the circumstances. For example:

- If the medication is critical (e.g., insulin, seizure medication, cardiac medication, antibiotics for active infection, etc.), contact should occur **immediately** or as soon as possible due to potential health and safety risks.

- If the medication is non-critical (e.g., vitamin supplement, non-urgent routine medication), contact may occur within a reasonable timeframe, which in many situations could be the same day or the next business day, provided the resident is not placed at risk.

RECOMMENDATIONS

It is recommended licensees and staff members view the division's Medication Errors in AFC Homes video training.

It is recommended that following contact with a resident's licensed health care professional regarding a medication error, that the licensee document the following:

- Any instructions or recommendations provided by the health care professional.
- Actions taken by the facility in response to the instructions provided.
- Any monitoring completed or follow-up observations related to the resident's condition.

(g) Contact the appropriately licensed health care professional when a resident refuses a prescribed medication or procedure. A licensee, administrator, or staff shall document and follow the instructions given by the licensed health

professional. Documented instructions may include procedures to follow when a resident refuses medication or procedures in the future.

TECHNICAL ASSISTANCE

Residents have the right to refuse medications or medical treatment and to be made aware of the consequences of refusal.

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(5) A licensee, administrator, or direct care staff shall ensure that the resident or the individual who assumes responsibility for the resident has the appropriate information, medication, and instructions when the resident is out of the facility but still requires medication during that period.

TECHNICAL ASSISTANCE

When a resident is outside the facility and requires medication during that period, the licensee, administrator, or direct care staff must provide the resident or the individual assuming responsibility for the resident with the appropriate medication and clear instructions for its administration.

While subrule (2) requires medications to remain in their pharmacy-labeled containers at the AFC home, subrule (5) does not prohibit the facility from preparing the needed doses in another suitable container when a resident will be temporarily away from the facility. If another container is used, it should be appropriate for medication storage and clearly identify the resident, medication, dose, route, and administration time.

INDICATORS

Licensing consultants may determine compliance by:

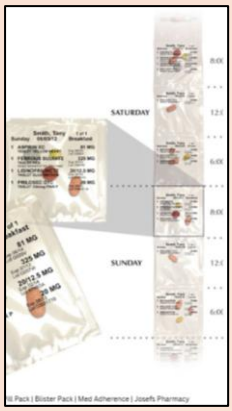
- Interviewing the licensee, administrator, or direct care staff about the facility's process for sending medications with residents who are temporarily away.
- Reviewing the facility's medication policies and procedures, including how medications and instructions are provided, documented, and reconciled upon return.
- Interviewing residents or individuals who have assumed responsibility for residents, when appropriate, to verify that they received the necessary medication and instructions.
- Observing the facility's preparation of medications for an upcoming absence, when the opportunity is available.

RECOMMENDATIONS

Transferring medication from its original container for use outside the facility may increase the risk of medication errors, misidentification, contamination, loss, or incorrect administration. Licensees are encouraged to work with residents' pharmacies on medication packaging options that would assist in maintaining

compliance with subrule (5) without transferring medication from its original container into another container.

There are several medication packaging options available, for example, Strip Packaging or Tear Off Blister Pack Containers.







It is strongly recommended that licensees have a method for residents, and the person who is assuming responsibility for the resident when the resident is outside the home, to provide written confirmation they received the resident's medication and provided them to the facility upon the resident's return.

(6) Prescription medication must not be used by a person other than the resident for whom the medication was prescribed.
(7) Prescription medication that is no longer required by a resident must be properly disposed of.

INDICATORS

The consultant is to determine how prescription medication is disposed of in the facility. The requirements of this subrule also apply in the event of a resident death if the resident's next of kin does not take them.

RECOMMENDATION

Proper drug disposal is important because it helps protect human health and our environment. Unwanted drugs should not be flushed down the drain.

Medications should be kept secure when in the home to prevent unlawful use and regularly disposed using the steps shared in this video: **EGLE Classroom - Drug Disposal Minute**

Licensees may use the division's **Medication Disposal Policy Template** to create a policy on medication disposal in their facility.

R 400.677 Resident hygiene, clothing.

Rule 677. (1) A licensee shall offer a resident appropriate opportunity, access to, and instructions for the following daily:

(a) Bathing or showering, or both.
(b) Shaving.
(c) Oral care.
(d) Grooming.
(e) Peri-care.

(2) A licensee shall ensure the resident receives or has access to all of the following:

(a) Bathing at least weekly.

TECHNICAL ASSISTANCE

Examples of bathing include, but are not limited to, independent bathing with staff oversight, supervised bathing, partial assistance bathing, full assistance bathing, and sponge baths or basin baths. If the licensee is unable to ensure that a resident maintains proper hygiene, even if due to a resident's refusal, discharge may be appropriate.

(b) Toileting as needed.
(c) Assistance with resident hygiene as needed.
(d) Availability of all the following resident hygiene supplies:

i. Deodorant.
ii. Feminine hygiene products.
iii. Razors and shaving cream.
iv. Shampoo.
v. Soap.
vi. Toothpaste.
vii. Toothbrushes.
viii. Toilet paper.

TECHNICAL ASSISTANCE

When residents are unable to independently obtain items indicated in rule R 400.677(2)(d)(i)-(viii), licensees may assist in several ways, including but not limited to the following:

- Purchasing items on behalf of the resident using the resident's personal funds, with proper documentation when required.
- Assisting the resident during shopping trips, including transportation to stores where hygiene supplies can be purchased.
- Ordering items online or through catalogs at the resident's request.

- Coordinating with family members, guardians, or designated representatives to ensure needed hygiene supplies are provided.
- Maintaining commonly used hygiene supplies in the home that residents may access when needed, particularly for residents who do not independently manage personal purchases.

- Reminding or prompting residents when supplies are running low and assisting them in replacing the items.

The intent is to ensure residents have consistent access to the basic hygiene supplies necessary to maintain personal cleanliness and dignity, while supporting the resident's independence and personal choice whenever possible.

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(3) A licensee shall assist the resident in obtaining clothing that fits, is clean, and is seasonally appropriate.

TECHNICAL ASSISTANCE

When a resident is not able or refuses to do his/her own laundry, the licensee is responsible for assuring that clean clothing is available. The licensee must have laundry soap available for resident use.

R 400.679 Resident recreation.

Rule 679. (1) A licensee shall provide and promote activities and the use of leisure and recreational equipment that are appropriate to the number, care, needs, age, and interests of residents.
(2) Any equipment provided must be safe, clean, maintained, and easily accessible.

RECOMMENDATIONS

It is recommended that licensees and staff view the division's Recreation Programs and Activities in AFC Homes video training.

SUBPART H: RIGHTS OF RESIDENTS

R400.681 Resident rights; licensee responsibilities.

Rule 681 (1) A resident shall be treated with dignity and respect, free from exploitation, and protected and safe.

INDICATORS

The consultant is to determine whether the home has methods in place to assure residents are free from threat to their physical and psychological health and safety. The consultant is to review assessment plans, health care appraisals, service contracts, health care chronological, incident reports, etc. to assure resident's protection.

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(2) Work that is performed by a resident must be in accordance with the resident's assessment plan.

TECHNICAL ASSISTANCE

Residents are not to be used to provide a source of labor for a home against their will or in opposition to the objectives of the resident's assessment plan. Regular participation in the resident's activities of maintaining the resident's own bedroom that can lead to the resident's greater functional ability to perform independent household tasks is also not considered "work" for the home. Shared duties are common and appropriate when agreed to in the resident's assessment plan.

INDICATORS

The consultant is to determine whether a resident is performing work in the home.

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(3) A licensee and staff shall respect and safeguard all of the following resident rights to:

(a) Be free from discrimination based on race, religion, color, national origin, sex, gender identity, age, physical or mental impairment, marital status, or source of payment in the provision of services and care.

TECHNICAL ASSISTANCE

"Source of payment" refers to Supplemental Security Income, private pay, social security, etc. The intent of referencing "source of payment" is to assure that residents are treated equally, including the basic services provided, regardless of source of payment. This does not preclude the provision of additional services for additional compensation.

(b) Exercise individual constitutional rights including right to vote, right to practice religion of choice, freedom of movement, and freedom of association.

TECHNICAL ASSISTANCE

Residents have the right to freedom of movement, which means they must be able to enter and leave the home and access outdoor areas without unreasonable physical barriers or restraints. Locked fences around the entire facility create a barrier that prevents residents from moving freely and limits their ability to access the community or outdoor environments. A locked fence acts like a locked perimeter, which turns the home into a secured facility, a level of restriction that is not allowed in adult foster care homes without a rule variance approval.

While the division allows for the installation of delayed egress systems that are properly integrated with the fire alarm system in accordance with the National Fire Protection Association (NFPA 101, 2006 edition), in AFC facilities, other state and local entities with regulatory oversight, such as the Michigan Department of Health and Human Services (specifically Home and Community Based Services enforcement), local Community Mental Health authorities, and the Office of Recipient Rights may consider delayed egresses to be restrictive interventions, which could limit or prohibit their use in AFC facilities depending on resident rights and service requirements.

RECOMMENDATIONS

It is recommended that licensees consult with their assigned licensing consultant, and all residents' responsible agencies when considering the installation of a delayed egress system in their facility.

(c) Attend or refuse participation in religious practices.
(d) Write, send, and receive uncensured and unopened mail at the resident's own expense.
(e) Have reasonable access to a telephone for private communications, but a licensee may charge a resident for the cost of long-distance telephone calls.

TECHNICAL ASSISTANCE

Either a "land-line" or cellular telephone provided by the licensee and accessible to residents is acceptable.

(f) Be afforded the means to present grievances to the facility licensee and administrator.
(g) Voice grievances and present recommendations pertaining to the policies, services, and facility rules without fear of retaliation.
(h) Associate and have private communications and consultations with their health care provider, attorney, or any person of choice.
(i) Participate in social and community group activities of choice.
(j) Use advocacy agency services and attend community services of choice.

(k) Have reasonable access to and use of personal clothing and belongings.

TECHNICAL ASSISTANCE

"Reasonable access" means a resident's access to a supply of personal clothing that is sufficient for a variety of occasions and seasons. The written assessment plan must address any restrictions to access of personal clothing or belongings and be agreed upon by the resident or his/her guardian. Residents should not be prohibited from access to their personal possessions because of the behavior of others.

(l) Receive visitors at a reasonable time. Exceptions or visitor restrictions must be covered in the resident's assessment plan. Special consideration must be given to visitors coming from out of town or whose hours of employment warrant deviation from usual visiting hours.
(m) Employ the services of a health care professional of choice for obtaining medical, psychiatric, or dental services.
(n) Refuse treatment and services, including taking of medication, and to be made aware of the consequences of refusal.

TECHNICAL ASSISTANCE

The licensee may inform the resident that refusing medication, treatment or services could result in a negative outcome to their physical or mental health, and may result in discharge of the resident, if the licensee is no longer able to meet the needs of the resident, and/or assure their safety and protection.

(o) Request and receive assistance from the responsible agency in relocating to another living situation.
(p) Be treated with consideration and respect with due recognition of personal dignity, individuality, and need for privacy.

TECHNICAL ASSISTANCE

In common areas of a facility, non-recording visual cameras can be used to assist with monitoring. Recording in common areas can be done only if the residents, authorized representatives, and legal guardians are made aware and provide written confirmation acknowledging they exist.

Cameras that the licensee installs in resident rooms should be for a medical or behavioral reason and would require a rule variance approval. Cameras installed in resident bedrooms at the request of a resident and/or their legal guardian is permitted, unless it is infringing on a roommate’s privacy in a semi-private bedroom, or is not allowed per facility policy

Note: The Office of Recipient Rights typically does not allow any cameras in a facility.

While cameras may be used in limited circumstances for safety and monitoring, they can never be a substitute for proper staff supervision in the facility. Cameras are a supplemental tool, and not a replacement for staffs' presence, and immediate response.

(q) Access their bedroom at their own discretion.
(r) Have confidentiality of records.

(4) A licensee shall provide to a resident or resident's designated representative a copy of the resident's rights at time of admission.

(5) A licensee shall provide contact information to file a complaint with the department, adult protective services, and the state ombudsman office. The licensee shall allow the resident to meet privately with the above agencies.

SUBPART I: RIGHTS OF LICENSEES

R 400.683 Applicant and licensee rights.

Rule 683. (1) An applicant or licensee shall be informed when the department is conducting either an initial or renewal inspection or a complaint investigation and be afforded an exit conference opportunity at the conclusion of an inspection or investigation. An applicant or licensee may provide comments during the exit conference, which may be added to the licensing inspection or complaint report.

(2) A licensee or an applicant shall have the right to bring to the attention of the supervisor of the licensing representative any alleged misapplication of enforcement of regulations by a licensing representative or any substantial differences of opinion between the licensee or the applicant and any licensing representative concerning the proper application of the act or these rules. A meeting with the supervisor must be afforded on request. A licensee or an applicant may contact any other official of the department regarding issues relating to the licensing activities of the department. Any contact with the supervisor or any other departmental official must not result in any retaliation by the licensing representative.

(3) The department shall provide advice and technical assistance to a licensee or an applicant to assist the licensee in meeting the requirements of the act and these rules. The department shall offer consultation on request in developing methods for the improvement of service.

(4) A licensee or an applicant shall have the right to provide a written response to the findings of the licensing representative or other department official if a licensing investigation report or a complaint investigation report is issued. The written response must become a part of the department's official licensing record and be public information according to the provisions of the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

SUBPART J: ADMISSION, PROGRESS, HEALTH, AND DISCHARGE RECORDS

R 400.685 Resident admission; resident assessment plan; health care appraisal.

Rule 685. (1) A licensee shall not accept or care for a resident who requires continuous nursing care. Continuous nursing care does not include a resident who becomes temporarily ill while in the facility or a resident that is receiving care from a licensed hospice program.

(2) A licensee shall not accept or care for a resident until a written assessment has been completed. A written assessment plan must include all of the following:

(a) The amount of personal care, supervision, and protection required by the resident that is available at the facility.

(b) The services, skills, and physical accommodations required by the resident that are available at the facility.

(c) The resident is compatible with other residents, assigned roommate, and members of the household.

(3) A licensee shall not accept or retain a resident who requires isolation or restraint, excluding crisis intervention.

(4) A written assessment plan must be completed with and signed by the resident or the resident's designated representative, responsible agency if applicable, and the licensee at the time of admission and annually thereafter. A licensee shall maintain a copy of the resident's most recent assessment plan on file at the facility for up to 2 years after discharge.

TECHNICAL ASSISTANCE

If the responsible agency refuses to sign the resident's written assessment plan, this should be noted on the assessment plan.

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(5) If a resident is referred for emergency admission and the facility accepts the resident, the resident's assessment plan must be completed within 7 calendar days after the emergency admission.

TECHNICAL ASSISTANCE

"Emergency admissions" are those admissions when a resident requires immediate placement into an AFC without the advantage of comprehensive pre-placement planning. An APS placement is one example of an emergency admission.

The licensee must complete an initial written assessment of the resident at the time of the emergency admission to ensure that the resident meets the admission criteria before the admission is accepted. If the licensee accepts a resident for admission then determines they are unable to meet the resident's needs, they must comply with the discharge rules.

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(6) A licensee shall complete a written resident care agreement at the time of a resident's admission that includes all of the following:

TECHNICAL ASSISTANCE

Electronic records of the resident care agreement are acceptable if the consultant has access to the electronic records.

(a) A statement that the facility is licensed to provide foster care to adults.
(b) The services to be provided and the fee for those services.
(c) Any additional costs in addition to the basic fee that is charged.
(d) A resident's rights policy.
(e) A discharge policy.
(f) Transportation services provided for a basic fee and services that are provided at an extra cost.

TECHNICAL ASSISTANCE

The licensee is responsible for "assuring transportation services" which may or may not be included in the basic fee, as long as that is specified in the Resident Care Agreement. Regardless of how transportation is provided or paid for, the licensee must assure transportation is available if it is needed. Transportation may be provided by a number of sources, including, but not limited to the following:

- The licensee.
- A family member.
- A volunteer.
- Public transportation.

MDHHS budget boilerplate Sec. 608 states that adult foster care facilities providing domiciliary care or personal care to residents receiving supplemental security income shall not require those residents to reimburse the home or facility for care at rates in excess of those legislatively authorized. To the extent permitted by federal law, adult foster care facilities serving residents receiving supplemental security income shall not be prohibited from accepting third-party payments in addition to supplemental security income provided the payments are not for food, clothing, shelter, or result in a reduction in the recipient's supplemental security income payment. Complaints related to the amount a licensee is charging an SSI recipient should be referred to the resident's responsible agency.

(g) A refund policy.
(h) A resident's funds and valuables policy.

(i) An agreement by the licensee to provide care, supervision, and protection to the resident and to ensure transportation services as indicated in the resident's assessment plan and resident care agreement.
(j) An agreement by the licensee to respect and safeguard the resident's rights.
(k) An agreement by the licensee and resident or the resident's designated representative to follow the facility's discharge policy.
(l) An agreement by the resident, resident's designated representative, or responsible agency to provide necessary intake information, including health-related information, at the time of admission.
(m) An agreement by the resident or the resident's designated representative to provide a current health care appraisal.
(n) An agreement by the resident to follow written house rules if any.

(7) A licensee shall use the department resident care agreement form, or a facility substitute form that includes the same information as the department form.

(8) A resident care agreement must be signed by all applicable parties. A copy of the signed resident care agreement along with copies of the policies listed in subrule (6) of this rule must be provided to the resident or the resident's designated representative and maintained in the resident's record.

TECHNICAL ASSISTANCE

The signature of all applicable parties, including the resident's responsible agency, helps demonstrate that all parties acknowledge their role in the resident's care and service planning, agrees to provide necessary intake information at the time of admission, is aware of the services the facility will provide, and understands the terms of the agreement that impact the resident's placement and ongoing support needs. If the responsible agency refuses to sign a resident's care agreement, this should be noted in the agreement.

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(9) A licensee shall review the written resident care agreement with the resident, resident's designated representative, or responsible agency at least annually or more often if necessary. Any changes to the resident care agreement must be re-signed by all applicable parties. If the annual review results in no changes to the resident care agreement the resident care agreement does not need to be re-signed but the licensee shall document that all applicable parties were contacted and agreed that no changes were necessary.

TECHNICAL ASSISTANCE

Obtaining signatures from all applicable parties, including a resident's responsible agency, helps document all parties' participation in the review of changes to the agreement and supports accountability among all parties involved in the resident's care. Obtaining signatures also provides documentation that the licensee made reasonable efforts to involve all parties in the resident's care arrangements. If the

responsible agency refuses to sign a resident's updated care agreement, this should be noted in the agreement.

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(10) A resident or resident's designated representative shall provide a written health care appraisal or a medical discharge summary by an appropriate health care professional that is completed within the 90-day period before admission. A written health care appraisal must be completed at least annually thereafter. If a written health care appraisal is not available at the time of an emergency admission, a licensee shall require that the appraisal be completed no later than 30 days after admission.
(11) A licensee shall contact a resident's health care professional for instructions as to the care of the resident if the resident requires the care of a health care professional. The licensee shall record in the resident's record any instructions for the care of the resident.

R 400.687 Resident admission and discharge policy; house rules; change of residency; provision of resident records.

Rule 687. (1) A licensee shall have a written admission and discharge policy and shall make it available to a resident and resident's designated representative.

TECHNICAL ASSISTANCE

The licensee is to have a copy of the admission and discharge policy available upon request. If the admission or discharge policy changes, the licensee must inform the consultant within 10 business days after the change occurs.
Applicants/licensees may view the division's Admission & Discharge Policies in AFC Homes video training.

Licensees may use the division's **Admission Policy Template** and **Discharge Policy Template** to create these policies for their facility.

INDICATORS

Prior to issuance of the original license, the consultant is to review the home's admission and discharge policy to assure that it does not conflict with any administrative rules.

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(2) A licensee may establish house rules on the expectations for resident conduct that do not conflict with the act or these rules. If established, a licensee shall provide the rules in writing to the resident, resident's designated representative, or responsible agency on admission to the facility and when modified.
(3) A licensee shall have a written policy on visitation that includes if overnight visitors are allowed. A roommate shall consent to have an overnight visitor spend the night if in a resident semi-private room. An overnight visitor is considered an occupant. The facility cannot exceed the occupant capacity in accordance with R 400.613(3).

(4) A licensee shall provide a resident and resident's designated representative with a 30-day written notice before discharge from the facility. The notice must state the reasons for discharge and a copy of it be sent to the resident's designated representative and responsible agency. The provisions of this subrule do not preclude a licensee from providing other legal notice as required by law.

TECHNICAL ASSISTANCE

This rule does not preclude a licensee from beginning formal eviction procedures. To demonstrate compliance, a copy of the written notice of discharge is to be maintained in the resident record.

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(5) The licensee may discharge a resident before the 30-day notice when it has been documented that there is a substantial risk or occurrence of any of the following:

(a) An inability to meet the resident's needs.
(b) An inability to provide adequate safety and well-being of others.
(c) Self-destructive behavior.
(d) Serious physical assault.
(e) Destruction of property.

(6) A licensee shall take all of the following steps before discharging a resident under subrule (5) of this rule:

(a) A licensee shall notify the resident, resident's designated representative, responsible agency, and the adult foster care licensing consultant not less than 24 hours before discharge in writing and include all of the following:
(b) Reason for discharge including the specific nature of the risk.
    i. Alternatives to discharge that have been attempted by the facility.
    ii. Location where the resident will be discharged, if known.
(c) A licensee shall notify adult protective services in the department of health and human services not less than 24 hours before discharge if the resident does not have a resident's designated representative or responsible agency.
(d) A resident shall not be discharged until an appropriate setting that meets the resident's immediate needs is located.
(e) If the department finds that a resident was improperly discharged, the resident has the right to return to the first available bed in the facility.

(7) A licensee shall not discharge a resident to a setting without an address or to a hospital emergency department.

TECHNICAL ASSISTANCE

A licensee cannot discharge a resident to any location that does not have a specific, safe, and identifiable address. This means residents cannot be released to homelessness, to the streets, or to any other place where they would not have an actual residence. In addition, the licensee cannot discharge a resident by sending them to the hospital emergency department for the purpose of placement. Emergency

rooms are not considered appropriate discharge destinations and cannot be used as a substitute for proper planning or coordination of services.

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(8) A licensee shall not admit a resident to another location without the written approval of the resident, resident's designated representative, and responsible agency if applicable.
(9) A licensee shall not restrict a resident's ability to make their own living arrangements.
(10) A licensee shall provide copies of resident records when requested by the resident and resident's designated representative. A fee that is charged for copies of resident records must not be more than the cost to make the copies.

R 400.689 Resident health care.

Rule 689. (1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
(2) Refusal by a resident to follow the instructions and recommendations must be recorded in the resident's record.
(3) In case of an accident or sudden adverse change in a resident's health condition, a facility shall obtain needed health care immediately.

TECHNICAL ASSISTANCE

Under no circumstance is the licensee or the licensee's staff to delay or refrain from obtaining necessary care. For example, staff should not be expected to contact management or a resident's family prior to obtaining needed care.
Cardiopulmonary resuscitation (CPR) is specifically meant for individuals whose hearts have stopped beating and/or individuals who are not breathing normally, or not breathing at all. It is not appropriate to perform CPR on an individual whose heart and breathing are still functioning.

A Do Not Resuscitate (DNR) order is a legal medical order that instructs individuals, including AFC staff members, not to perform CPR, if the resident stops breathing or their heart stops and that resident is wearing a do-not-resuscitate identification bracelet or that individual has notice of the resident's do-not-resuscitate order in accordance with MCL 333.1061 (3).
The Do-Not-Resuscitate Procedure Act defines "resuscitate" as performing cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, including, but not limited to, any of the following:

(i) Cardiac compression.
(ii) Endotracheal intubation or other advanced airway management.
(iii) Artificial ventilation.
(iv) Defibrillation.
(v) The administration of a cardiac resuscitation medication.
(vi) Another related procedure.

Note: Providing abdominal thrusts (formally known as the Heimlich Maneuver) is not considered resuscitation. Use of NARCAN for a suspected drug overdose is also not considered resuscitation as it is given when a resident is still breathing (although it may be shallow breaths that are difficult to detect).

AFC homes must honor DNR orders.

The AFC home must:

1. Identify residents who have a valid DNR and verify authenticity (signatures, form date, expiration)
2. Have DNR orders immediately accessible if a crisis occurs
3. Inform all staff of DNRs and include DNR status in residents' AFC assessment plans as required by administrative licensing rule R400.14[15]301(4)

Start CPR if the resident is unresponsive and does not have a DNR:

1. Is not breathing, or only gasping (agonal breathing=abnormal, ineffective breaths).
2. Has no pulse

Call 911 immediately, or instruct someone else to call, and begin CPR right away.

Do NOT start CPR if the resident:

1. Is conscious and talking or moving
2. Is breathing normally, even if unconscious
3. Has a pulse and is breathing normally
4. Has a valid DNR order pursuant to the Michigan Do-Not-Resuscitate Procedure Act (even if the resident is unresponsive, does not have a pulse and/or is not breathing)

Make the resident comfortable, and call 911 to report the situation.
If the resident has a verified DNR and experiences respiratory or cardiac arrest, AFC staff should calmly advocate comfort measures (monitoring, positioning), immediately call 911, and refrain from CPR in accordance with Michigan law and the AFC Facility Licensing Act.

If the resident is enrolled in a licensed hospice program and has a DNR included in their AFC assessment plan, the AFC home may directly contact the hospice provider instead of emergency first responders.

MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT 193 of 1996

1998 Michigan Attorney General opinion # 6986

INDICATORS

The consultant may review accident and incident reports and resident records to determine if timely medical care was obtained.

RECOMMENDATIONS

It is strongly recommended that licensees do the following:

1. Audit current resident records: verify and record DNR status in assessment plans
2. Educate staff on legal definitions and procedures via annual training
3. Simulate mock emergency drills to practice DNR response protocols
4. Update documentation, such as notification logs
5. Communicate with resident families, guardians, and/or responsible agencies about DNR policies and practices

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R 400.691 Resident records.

(1) A licensee shall complete and maintain a separate record for each resident that includes all of the following:

(a) Personal information including all of the following:

I. Resident's full name.
II. Social Security number.
III. Date of birth.
IV. Marital status.
V. Veteran's status.
VI. Gender identity.
VII. Former address.
VIII. Name, address, and contact information of identified contact or designated representative.
IX. Name, address, and contact information of the person and agency responsible for the resident's placement in the facility.
X. Funeral provisions, preferences, and contact information.
XI. Resident's religious preference.

(b) Date of admission.

(c) Date of discharge and address to where the resident moved.

TECHNICAL ASSISTANCE

Licensees may choose to use the division's AFC Resident Information and Identification Record template, or create their own.

(d) Health care information including all of the following:
Instructions for emergency care and advanced medical directives.

I. Health care appraisals.
II. Medication administration record.
III. Name, address, and contact information of the preferred health care professional and hospital.
IV. Medical insurance.
V. Statements and instructions for supervising prescribed medication including dietary supplements and medical procedures.
VI. Instructions for emergency care and advanced medical directives.

TECHNICAL ASSISTANCE:

When a resident has requested "no medical intervention" in writing, the licensee should maintain the request in the resident's record. The licensee is to provide this written request to attending emergency medical and/or any other medical personnel, when applicable.

A hospice service plan for a resident who is enrolled in a licensed hospice program that includes a do-not-resuscitate order or any other form of advance directive is to be included as an addendum to the resident's assessment plan and maintained with the assessment plan in the resident's record. See TA for Rule 400.689 (3) for more info on advance directives and DNRs.

(e) Resident care agreement.
(f) Assessment plan.
(g) Admission and monthly weight record.

TECHNICAL ASSISTANCE

Licensees may choose to use the division's Resident Weight Record template, or create their own.

(h) Incident reports.
(i) Resident funds and valuables record and resident refund agreement.
(j) Resident grievances.
(k) Resident discharge notice.

(2) A resident's grievance must be maintained and include the nature of the grievance, the date of the grievance, and a statement indicating how the grievance was addressed.
(3) Resident records must be kept on file in the facility for 2 years after the date of resident discharge unless a shorter retention is specified elsewhere in these rules.

SUBPART J: FILING REPORTS

R 400.693 Incident notification, incident records.

Rule .693 (1) If a resident has a representative identified in writing on the resident's care agreement, a licensee shall report to the resident's representative within 48 hours after any of the following:

(a) Unexpected or unnatural death of a resident.

TECHNICAL ASSISTANCE

Expected and natural deaths of residents, including residents enrolled in a licensed hospice program and/or expected and natural deaths of residents that do not occur at the facility, do not require the submission of an incident report to the resident's identified representative.

(b) Unexpected and preventable inpatient hospital admission.

TECHNICAL ASSISTANCE

Any unexpected illness and/or accident that requires hospitalization, as referenced in this rule, means any unexpected and preventable sudden adverse change in a resident's condition or any preventable accident that resulted in an unplanned inpatient hospitalization. Hospitalization, as used in this rule, is not defined as an emergency room visit, but is defined as any time a resident is admitted to a hospital due to an unexpected and preventable illness or accident.

(c) Physical hostility, self-inflicted harm, or harm to others resulting in injury that requires outside medical attention or law enforcement involvement.

(d) Natural disaster or fire that results in evacuation of residents or discontinuation of services greater than 24 hours.

(e) Elopement from the facility if the resident's location is unknown.

(2) If an elopement occurs, facility staff shall conduct an immediate search to locate the resident. If the resident is not located within 30 minutes after the initiation of the search, staff shall contact law enforcement.

(3) An incident must be recorded on a department-approved form, or a facility form that contains the same information, and retained in the facility for 2 years.

TECHNICAL ASSISTANCE

Licensees may locate the department-approved Incident/Accident Report form HERE. Licensee may choose to use their own form for recording resident incidents and accident. The licensee's form must contain the same information as the department-approved form.

(4) The department may review incident reports during a renewal inspection or special investigation. This does not prohibit the department from requesting an incident report if determined necessary by the department. If the department requests an incident report, the licensee shall provide the report in electronic form within 24 hours after the request. The department shall maintain and protect these documents in accordance with state and federal laws, including privacy laws.

R 400.695 Complaints.

Rule 695. (1) When a complainant files a complaint with the department pursuant to section 24(1) of the act, MCL 400.724, the complaint must be filed within 12 months after the alleged violation. If it is not filed within 12 months after the alleged violation, the department may investigate the complaint if the complainant shows good cause for the delay in filing the complaint.
(2) The department shall determine if a complaint allegation or allegations warrants an investigation. An investigation of an allegation or allegations is not required if any of the following are true:

(a) The allegation or allegations do not violate a law or rule regulated by the department.
(b) The allegation or allegations do not provide specific information to allow the department to investigate the allegation or allegations. Specific information at a minimum should include, but is not limited to, identification of the facility, resident or residents involved, staff involved, dates, times, or location within the facility.
(c) The allegation or allegations have been previously reviewed or investigated and the facility has been found compliant or has an approved corrective action plan specific to the allegation being made.

SUBPART K: TRANSPORTATION SAFETY

R 400.697 Resident transportation.

Rule 697. (1) A licensee shall ensure the availability of transportation services as provided for in a resident care agreement. A licensee shall provide or arrange transportation for residents in a certified facility.

TECHNICAL ASSISTANCE

“Ensuring the availability of transportation services” means the licensee must make sure that transportation options exist and are accessible to residents when needed. It does not mean the licensee is required to drive residents, schedule rides, or physically provide transportation.

"Providing or arranging transportation" means the licensee must actively take steps to either drive residents directly, or schedule, call, coordinate, or secure transportation for residents.

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(2) A licensee shall ensure all of the following when providing transportation services:
(a) The vehicle is in good operating condition and insured.
(b) The vehicle carries a basic first aid kit.

TECHNICAL ASSISTANCE

"First aid kit" means a kit containing, at a minimum, all of the following: sterile gauze pads of assorted sizes, a roll of gauze, adhesive bandages of assorted sizes, adhesive cloth tape, an elastic bandage, tweezers, scissors, and any emergency supplies needed for residents with specific medical needs.

(c) The vehicle operator has a valid driver's license. This may include a chauffeur and a commercial driver license (CDL) if transporting 16 or more people including the driver.
(d) The vehicle has been inspected in accordance with the provisions of section 715a of the Michigan vehicle code, 1949 PA 300, MCL 257.715a, if the vehicle has a manufacturer's rated seating capacity of 12 or more individuals.

PART 3. REQUIREMENTS FOR FAMILY HOMES

R 400.699 Administrator not required.

Rule 699. Family homes are not required to have an administrator.

PART 4. Requirements for small group homes, large group homes, and congregate facilities

R 400.701 Required personnel policies

(1) A licensee shall have written policies and procedures that include all of the following:
(2) Written policies and procedures must be given to staff and volunteers at the time of hire or appointment. A verification of receipt of the policies and procedures must be maintained in the individual's personnel record.
(3) The licensee shall have a written job description for each position. The job description must define the tasks, duties, and responsibilities of the position. Each staff and volunteer shall receive a copy of their applicable job description. Verification of receipt of a job description must be maintained in the individual's personnel record.
(4) Work assignments shall be consistent with job descriptions and the level of training, experience, and education of the employee or volunteer.

INDICATORS

The licensing consultant may review the job descriptions and verification of receipt of the job descriptions. The consultant may also ask the employee(s) to explain their job responsibilities and whether they have received a copy of that job description. The consultant may compare what has been observed and/or described in the written job descriptions available and then determine whether the job description is consistent with the described or observed staff assignments. The consultant may review personnel records for documentation that staff have the appropriate level of training and education to carry out their duties.

PART 5. REQUIREMENTS FOR SPECIAL CERTIFICATION

TECHNICAL ASSISTANCE

Special certification means a program of services provided in an AFC facility that is designed to meet the unique programmatic needs of the residents of that home and for which the facility receives special compensation. Facilities may apply for a certification for specialized programs for the mentally ill, developmentally disabled, or both populations. This certification is only required to contract with community mental health agencies.

R 400.703 Application process.

Rule 703. (1) A licensee seeking certification as a specialized program shall apply to the department and include all of the following information:

(a) Facility license number.
(b) Current and proposed licensed capacity.
(c) Type of certification being requested.
(d) The ratio of direct care staff to residents that will be employed and present on each shift.
(e) The types of residents to be served and the services to be offered.

(2) The department may issue any of the following certifications:

(a) A regular certification for up to 2 years to a facility that is in full compliance with the act and these rules or in substantial compliance operating under a department-approved plan of corrective action.
(b) A provisional certification for a period of up to 3 months and renewed for 1 additional 3- month period to a facility that is operating under a department-approved plan of correction to address items of noncompliance that have been determined to seriously compromise program operations or performance.
(c) A temporary certification for a period of up to 6 months to a facility that has applied and has not been previously certified under these rules. A temporary certificate may not be renewed.

R 400.705 Certification inspections.

Rule 705. (1) A newly certified facility that has temporary certification shall notify the department when the number of residents reaches 50% of the licensed capacity. On notice, the department shall conduct an onsite review of the specialized program.
(2) A written report of the review must be provided to the licensee.
(3) Based on the report, the department may issue a regular, provisional, or temporary certification.
(4) If a certified facility voluntarily relinquishes its license or has its license revoked, suspended, or not renewed, the facility is decertified as a matter of law.

R 400.707 Staff training.

Rule 707. (1) Staff who work with residents shall have successfully completed training that provides basic concepts required in providing specialized dependent care before working independently. Staff shall show the ability to comprehend and be competent to deliver each resident's individual plan of service as written. Training must include all of the following before working independently:

(a) An introduction to community residential services and the role of direct care staff.
(b) Understanding and carrying out individual plans of service for residents.
(c) An introduction to the special needs of residents that have developmental disabilities or have been diagnosed as having a mental illness and is specific to the needs of residents to be served by the facility.
(d) Protecting and respecting the rights of residents in accordance with chapter 7 of the mental health code, 1974 PA 258, MCL 330.1700 to 330.1758, including providing resident orientation to written facility policies and procedures.
(e) Non-aversive techniques for prevention and treatment of challenging behavior of residents in accordance with an individual plan of service.

(2) Training must be obtained from individuals or organizations acceptable to the placing agency that contracts with the facility.
(3) Documentation of training must be maintained in the staff records to demonstrate that training has been completed and is current.

R 400.709 Transferability of certification.

Rule 709. Certification is issued to a specific licensee and location and is nontransferable.

R 400.711 Suspension, denial, or revocation of certification.

Rule 711. (1) After giving notice to a licensee, the department may suspend, deny, revoke, or reduce to provisional status a certification for failure to comply with the act or these rules.
(2) The department shall send a notice by certified mail or by personal service. The notice must specify the reasons for the proposed action and fix a date, not less than 30 days after the date of service, on which the licensee must be afforded a hearing.

R 400.713 Hearing opportunity.

Rule 713. A licensee that has been issued a provisional certification or certification proposed for suspension, revocation, or reduction to provisional; or has been denied renewal shall be provided an opportunity for a hearing in accordance with sections 71 to 92 of the administrative procedures act of 1969, 1969 PA 306, MCL 24.271 to 24.292, and R 792.10101 to R 792.10137.

PART 6. REQUIREMENTS FOR FIRE SAFETY OF FACILITIES WITH SPECIAL CERTIFICATION

R 400.715 Facility environment; fire safety, adoption by reference.

Rule 715. (1) A facility that has a capacity of 4 to 6 residents shall be equipped with an interconnected multi-station smoke detection system that is powered by the facility's electrical service. When activated, the system must initiate an alarm that is audible in all areas of the facility. The smoke detection system must be installed on all levels, including basements, common activity areas, and outside each sleeping area, excluding crawl spaces and unfinished attics, to provide full coverage of the facility. The system must include a battery backup to ensure that the system is operable if there is an electrical power failure and accommodate the sensory impairments of residents living in the facility, if needed. A fire safety system must be installed in accordance with the manufacturer's instructions by a licensed electrical contractor and inspected annually. A record of the inspections must be maintained at the facility for 2 years.

TECHNICAL ASSISTANCE
Annual inspections of the fire safety system must be conducted by a licensed electrical contractor.
INDICATORS
Consultants may inspect the system to ensure alarms are securely mounted and undamaged, and appear operational. Consultants may confirm that batteries are present and functional, if required. Consultants may test the system to confirm interconnected alarms activate simultaneously and that there are no alarms disabled or removed.

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(2) Instead of the interconnected multi-station smoke detection system being powered by the facility's electrical service, a wireless system in compliance with section 29.10.8.1 to 29.10.8.2.5 of the National Fire Protection Association (NFPA) 72, National Fire Alarm and Signaling Code, 2019 edition is accepted. The other requirements in subrule (1) of this rule still apply. NFPA 72, National Fire Alarm and Signaling Code, 2019 edition, is adopted by reference and available to purchase on the National Fire Protection Association website at https://www.nfpa.org at a cost of $163.00 for nonmembers of the NFPA and $146.70 for NFPA members at the time of adoption of these rules. A copy of NFPA 72 is available for inspection and distribution from the

Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption of NFPA 72.

TECHNICAL ASSISTANCE

Wireless smoke alarm systems are acceptable when all alarms are listed and compatible as part of the same wireless interconnected system, activation of any alarm triggers all alarms throughout the home, alarms meet the same location requirements as hardwired systems, and units are properly installed, powered, and maintained.

INDICATORS

A consultant may verify that a wireless smoke detection system is not a random collection of wireless alarms, and is a listed household fire warning system designed to work together by checking the following:

- A UL / ETL listing mark on the smoke alarm.
- The manufacturer labeling confirming it is a wireless interconnected system.
- Documentation indicating devices are compatible components of the same system.



Consultants may activate one smoke detector to confirm that it transmits an alarm signal to all interconnected devices, without noticeable delay. They may verify that the system is capable of generating a trouble signal if communication between devices is lost by reviewing listing information, manufacturer documentation, and system indicators. Typical language may include:

- “Loss of communication will generate a trouble signal.”
- “System supervision monitors device connectivity.”
- “Interconnected alarms provide fault indication.”

Consultants may inspect wireless smoke detection devices to ensure they are powered by batteries or approved power sources consistent with listing.

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(3) The capability of the residents to evacuate a facility in the event of a fire must be assessed using methods described in chapter 7 of the 2022 edition of NFPA 101A, Guide on Alternative Approaches to Life Safety. NFPA 101A. Guide on Alternative

Approaches to Life Safety, 2022 edition, is adopted by reference and available to purchase on the National Fire Protection Association website at https:// www.nfpa.org at a cost of $157.00 for nonmembers of the NFPA and $141.30 for NFPA members at the time of adoption of these rules. A copy of NFPA 101A is available for inspection and distribution from the Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption by reference of NFPA 101A.

(4) Evacuation assessments must be conducted within 30 days after the admission of each new resident and at least annually after the admission of the last new resident. A licensee shall forward a copy of each completed assessment to the responsible agency and retain a copy in the facility for 2 years. A facility that is assessed as having an evacuation difficulty index of "impractical" using appendix f of the 2021 edition of NFPA 101, Life Safety Code, which is adopted by reference in subdivision (b) of this subrule, shall have a period of 6 months after the date of the finding to do either of the following:

(a) Improve the score to at least the "slow" category.

(b) Bring the facility into compliance with the physical plant standards for "impractical" facilities contained in chapter 33 of the 2021 edition of NFPA 101, Life Safety Code. NFPA 101, Life Safety Code, 2021 edition is adopted by reference and available to purchase on the National Fire Protection Association website at https:// www.nfpa.org at a cost of $168.00 for nonmembers of the NFPA and $151.20 for NFPA members at the time of adoption of these rules. A copy of NFPA 101 is available for inspection and distribution from the Bureau of Community and Health Services, Department of Licensing and Regulatory Affairs, 611 West Ottawa Street, P.O. Box 30664, Lansing, Michigan 48909 at a cost of 15 cents per page as of the time of the adoption by reference of NFPA 101.

RECOMMENDATIONS

It is recommended that licensees and staff members view the division's **Calculating Evacuation Scores E Scores** video training.

PART 7. FIRE SAFETY REQUIREMENTS FOR FAMILY HOMES AND SMALL GROUP HOMES WITH 6 OR LESS RESIDENTS LICENSED AFTER MARCH 27, 1980

R 400.717 Facility construction.

Rule 717. All occupied rooms must be constructed of standard 1/2-inch drywall or its equivalent.

TECHNICAL ASSISTANCE

"Occupied rooms" means all rooms used in the facility for activities of daily living; e.g., sleeping, dining, cooking, recreation, etc. This rule refers to construction, not to interior finish. Mobile homes converted to adult foster care homes must comply with all fire safety requirements the same as homes of conventional construction.

R 400.719 Interior finishes.

Rule 719. (1) Interior finishes must be at least class C materials throughout the facility. (2) Interior finish materials must be securely attached to, or furred out not more than 1 inch from, walls or ceilings that are drywall, plaster, masonry, or natural solid wood that are not less than 3/4 of an inch thick.

TECHNICAL ASSISTANCE

Interior finish materials are to be a minimum Class C throughout the home. The term “throughout” as used in this requirement means the entire home including all rooms, basements, and attached garages. Any materials covering the basic interior construction, such as wood or vinyl paneling, ceiling tiles, or the like, must minimally meet the class "C" classification. Documentation from the manufacturer's literature provided by the licensee may meet compliance with this requirement, or it may be stamped on the material.

Wallpaper is permitted, if the applicant/licensee is able to provide verification the wallpaper meets class “C” classification.

The coating of paneling to achieve a Class “C” finish is prohibited for applicants, change of ownership, new construction or conversions, since it is not possible to determine whether the coating was applied and maintained in a manner that would achieve a Class “C” rating. Interior finishes that have been coated with a fire-retardant coating and previously approved that are in existing licensed homes are acceptable. For those homes, licensees must be able to provide information as to what has been done to maintain the coating at each interim and renewal inspection.

Generally, fire retardant coatings do not maintain their effectiveness when washed or when brushed up against often, to wear off the coating. Fire retardant coatings are to be reapplied on a routine basis as required by the manufacturer’s specifications.

INDICATORS

Consultants will make observations to assure that roof leaks have not caused the fire-retardant coating to become wet, that it is not peeling off, that it has not become faded or dull in appearance, and that the coating was adequately applied to cover the interior finish, all of which could reduce the integrity of the coating.

Where conditions indicate that an applied fire-retardant coating has become wet or has been washed, has begun to peel off, has not been applied to completely cover the area needing coverage, etc., reapplication of the same approved fire retardant coating as originally applied would be acceptable. If this is not possible, the interior finishing needs to be covered or replaced with an approved interior finish material meeting a minimum class "C" interior finish rating on its own i.e.: without the application of an approved fire-retardant coating. To assure that the fire-retardant coating was applied in accordance with the manufacturer's instructions, the consultant must read the label of the product applied, as well as keep a copy of label and manufacturer's instructions in the facility file.

RECOMMENDATION

It is strongly recommended licensees keep all documentation of interior finishes, class ratings, and fire-retardant finish materials used in the facility.

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(3) Attaching of interior finish materials, other than drywall, plaster, or natural solid wood that is not less than 3/4 of an inch thick, directly to wall studs or to floor or ceiling joists is prohibited. Suspended ceilings constructed of a class A material that is 1/4 inch or greater in thickness and are installed in accordance with manufacturer specifications are allowed.

TECHNICAL ASSISTANCE

Only natural solid wood that is at least 3 /4 of an inch, dry wall or plaster can be attached directly to wall studs or to floor or ceiling joists. The 3 /4 of an inch requirement applies to natural wood. When observing interior finish materials, special attention should be given to finished basements that may have been remodeled or constructed by the homeowner.

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(4) Class A, B, and C materials are interior finish materials that have the following minimum characteristics:

Class	Flame Spread	Smoke Developed
A	0-25	0-450
B	26-75	0-450
C	76-200	0-450

INDICATORS

Consultants will request documentation from the applicant/licensee during the enrollment process verifying finished materials meet requirements, and keep this documentation in the facility file.

R 400.721 Interior finishes prohibited materials.

Rule 721. The following materials must not be used as an interior finish in a facility unless they are at least class C rated:

(a) Asphalt paper.
(b) Cork.
(c) Cardboard.
(d) Carpeting, even if treated with fire retardant.
(e) Foam plastics.
(f) Plastic materials.
(g) Other finish materials that contribute to the rapid spread of fire or give off dense smoke or toxic gases.

TECHNICAL ASSISTANCE

The use of plastic materials as interior finish in a home may be acceptable if they meet the interior finish requirements of R 400.721 of these rules and provided they are installed as directed by the manufacturer.

Documentation from the appropriate testing laboratory provided by the licensee to the consultant may confirm compliance.

Plastic Kydex wall covering could be used in an adult foster care home if that wall covering had at least a Class C rating. Plastic Kydex is a hard dense plastic similar to what is used for airplane walls and is typically used in an adult foster care facility to protect walls from damage.

The materials mentioned in this rule, and any other like materials, are not to be used for wall, window, or ceiling coverings or be used in place of the usual finishing materials, such as paneling or dry wall.

R 400.723 Fire extinguishers.

Rule 723. (1) A minimum of one 5-pound multi-purpose fire extinguisher or equivalent must be provided for use on each occupied floor and in the basement.

TECHNICAL ASSISTANCE

Fire extinguishers must be present and operable. The licensee and direct care staff must know how to operate the extinguisher(s). See R 400.623(5)(b) & 400.629(4)(b)

"Occupied floor" means those areas of the home containing bedrooms, dining rooms, and recreation/activity rooms occupied by residents or members of the household.

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(2) Fire extinguishers must be examined and maintained as recommended by the manufacturer.

R 400.725 Means of egress.

Rule 725. (1) A means of egress must be considered the entire way and method of passage through the facility and out an exit door to free and safe ground outside the facility and must be arranged and maintained to provide free and unobstructed egress from all parts of the facility.

TECHNICAL ASSISTANCE

An egress window is considered an “emergency escape” and is not an approved means of egress.

A means of egress is an unobstructed passageway from anywhere in the building leading to safe ground outside the building. Such obstacles may include trash containers in hallways, furniture which may protrude into a passageway, loose carpeting or floor tile, baby gates, locked doors, and other obvious hazards.

Note: Partial doorways (i.e., “Dutch door arrangements” or gate, etc.) that are constructed for an open stairway(s) must not interfere with the pathway to the exit. For example, a gate or doorway would have to open into the stairwell and not obstruct the exit by opening into a foyer.

One of the required exits can be through the garage, but only through a service door. The passageway through the garage itself is to be kept clear, even when the garage is used for storage of automobiles, lawn equipment, power tools, dog kennels, etc.

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(2) Where basements are regularly utilized for resident activities, there must be 2 approved means of egress, 1 of which leads directly outside**.**

TECHNICAL ASSISTANCE

A basement is defined as that floor or story of a home below the street floor, that has more than 50% of its floor to ceiling dimension below grade for more than 50% of the perimeter of the home.

When a basement is regularly used by residents for recreation, workshops, classes, watching TV, lounging, etc., the basement must have two acceptable ways out. Regular use does not include occasional entry by a resident to the basement for a short period of time to do laundry, to obtain something from storage, etc. Basements used in times of emergency, and related drills, by AFC residents does not constitute regular use and would not require two means of egress when used for those circumstances. One of the two means of egress may be an interior stairway that

terminates on the floor above. The two means of egress are to be as far apart as feasibly possible.

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(3) Doors that form a part of a required means of egress must be equipped with positive-latching, non-locking-against-egress hardware and have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.

TECHNICAL ASSISTANCE

Exiting Out of the Garage: If a required means of egress passes through a garage, the door used must be a positive-latching door equipped with non-locking against egress hardware.

Exiting Through Sliding Glass Doors: The rules do not prohibit the use of exterior sliding glass doors as a means of egress. However, sliding glass doors must be equipped with positive-latching, non-locking against egress hardware. If unable to open the glass door with a single motion, the sliding glass door cannot be considered a means of egress. The door may not be secured by wedges, charlie bars, key locking mechanisms, dead bolts, etc. This would also apply to exiting from a garage.

Doors with delayed egress system: The AFC Division and BFS consider doors with delayed egress systems that are properly integrated with the fire alarm system in accordance with the National Fire Protection Association (NFPA 101, 2006 edition), to be compliant with this administrative rule. However, Rule R 400.681(3)(b) protects a resident's right to freedom of movement, which includes the ability to access the community when the resident has been assessed as capable of doing so safely without supervision. Subsequently, installing such systems to all exit doors may unduly restrict residents' ability to leave the facility. This could be considered a violation of the resident's right to freedom of movement under this rule.

Other state and local entities with regulatory oversight, such as the Michigan Department of Health and Human Services (specifically Home and Community Based Services enforcement), local Community Mental Health authorities, and the Office of Recipient Rights may consider delayed egress/locking mechanisms to be restrictive interventions, which could limit or prohibit their use in AFC facilities depending on resident rights and service requirements.

Doors designated exclusively for employee use or service access (e.g., supply, maintenance, or utility areas) may be kept locked, provided they are not part of a required means of egress. Such doors must not impede or restrict a resident's ability to exit the facility in an emergency. Licensees are responsible for ensuring that all required egress routes remain readily accessible, unobstructed, and compliant with applicable life safety requirements at all times.

RECOMMENDATIONS

It is recommended that licensees consult with their assigned licensing consultant, and all residents' responsible agencies when considering the installation of a delayed egress system in their facility.

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(4) The first floor of the facility must have not less than 2 separate and independent means of egress leading to the outside.

TECHNICAL ASSISTANCE

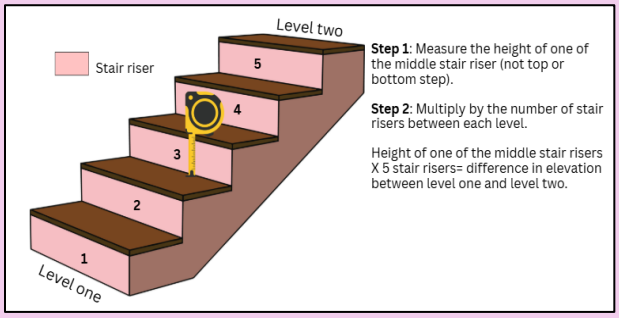
Means of egress are independent and separate when reasonably remote from each other to enable one to proceed to safe ground in more than one direction. The first floor of the home is defined as the "street floor" per R 400.601(1)(dd).

Two Exits Required: If the first floor has more than two exits, the third exit may not be subject to the rules regarding exiting or the rules regarding hardware because only two exits are required. However, the evacuation plans mandated by these rules must designate which are the required exits to be used.

Split Level Homes: In the case of bi-levels, tri-levels, or quad-level homes, two different levels will be considered one story if the difference in elevation between the two levels does not exceed four (4) feet.

INDICATORS

For split level homes, consultants measure the height of one of the middle stair riser (not top or bottom step) and multiply by the number of stair risers between each level to determine if the elevation difference between two levels exceeds four feet.



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(5) Facilities that accommodate residents who regularly require wheelchairs must be equipped with ramps located at 2 approved means of egress from the first floor. Ramps constructed before the effective date of these rules must not exceed 1 foot of rise in 12 feet of run. Ramps constructed on or after the effective date of these rules must comply

with R 400.647(10). A ramp is not required when an egress door is level with the walkway.

R 400.727 Smoke detection equipment for family home and small group home with 6 or less residents after March 27, 1980.

Rule 727. (1) At least 1 single battery-operated smoke alarm must be installed in the following locations:

(a) Between the sleeping areas and the rest of the facility. In facilities with more than 1 sleeping area, a smoke alarm must be installed to protect each separate sleeping area.

(b) On each occupied floor, in the basement, and in areas of the facility that contain flame- or heat-producing equipment.

TECHNICAL ASSISTANCE

A single-station smoke detector is an independent unit that is generally more effective when mounted on a ceiling. Such a unit requires no special wiring; it may be plugged into an ordinary A-C outlet or may be battery powered.

INDICATORS

The consultant will confirm that smoke detectors are present in the areas specified in subrule (1)(a)(b), have batteries, are operable, and are in good working order (clean, not cracked or broken exterior, etc.).

Consultants may ask the licensee/applicant to test the detectors to demonstrate that they are operable. Smoke detectors located in areas of the home that contain flame or heat producing equipment are to be located in accordance with the manufacturer's recommendations. This subrule only applies to homes licensed prior to March 27, 1980 that have been continuously licensed.

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(2) Approved heat detectors may be installed in the kitchen and in other areas of the facility containing flame- or heat-producing equipment in lieu of smoke alarms.

TECHNICAL ASSISTANCE

A heat detector may be used in place of a smoke detector in areas of the home containing heat-or flame producing equipment where dust particles and extreme temperature and humidity changes could interfere with a smoke detector's efficiency. Areas of the home where heat detectors could be installed include the kitchen, furnace room, garage, or in some cases, the bathroom. If heat detectors are used, they must be operable and in good working order (clean, not cracked, or broken exterior, etc.).

INDICATORS

Consultant may request that the license/applicant test the unit to confirm that it is operable. Heat detectors in areas of the home that contain flame or heat producing equipment are to be located in accordance with the manufacturer's recommendations.

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(3) If batteries are used as a source of energy, the batteries must be replaced in accordance with the recommendations of the alarm equipment manufacturer.

INDICATORS

Consultants may look for signs of chirping or beeping every 30-60 seconds. Other indications that batteries need to be replaced may be that upon pressing the alarm's test button, the alarm does not sound or is weak or quiet, or a normally red or green indicator light switched to a blinking pattern, signaling a low battery.

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(4) Detectors must be tested and examined as recommended by the manufacturer.
(5) Detectors that are mounted on ceilings must be spaced 6 inches or more away from walls. Detectors that are mounted on walls must be between 6 and 12 inches away from the ceiling. A smoke detector must not be mounted where ventilation systems or other obstructions keep smoke away.

TECHNICAL ASSISTANCE

The top of wall-mounted detectors must be at least 6 inches from the ceiling and the bottom not more than 12 inches from the ceiling.

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(6) For new construction, conversions to an adult foster care facility, and changes of adult foster care licensing type, approved smoke alarms must be installed in accordance with the requirements contained in the national fire protection association entitled NFPA 101, Life Safety Code, 2021 edition, powered from the building's electrical system, and, when activated, initiate an alarm that is audible in all sleeping rooms with the doors closed. Smoke alarms must be installed on all levels, including basements, but excluding crawl spaces and unfinished attics. Additional smoke alarms must be installed in living rooms, dens, dayrooms, and similar spaces. NFPA 101, Life Safety Code, 2021 edition, is adopted by reference in R 400.715(4)(b).

TECHNICAL ASSISTANCE

All new AFC applicants/enrollments are required to install a smoke detection system into their building's electrical system.

This subrule applies to homes that fall under new construction, conversion, change of category or change of licensee. Any changes in licensee, regardless of whether the facility has been continuously licensed or not, is a conversion, and requires the installation of the smoke detection system into the building's electrical system.

For additions added to existing licensed homes, only the addition needs to meet the requirements of Rule 400.727(6). Battery operated smoke detectors may remain in the existing portion of the home.

- When required, smoke detection devices must be installed at the following locations: On all levels of the facility including basements, (does not include crawl spaces or unfinished attics).
- Outside but in the immediate vicinity of each separate sleeping area.
- In living rooms, dens, day rooms and similar spaces.

INDICATORS

Consultants may inspect the system to ensure alarms are securely mounted and undamaged, and appear operational. Consultants may confirm that batteries are present and functional, if required. Consultants may test the system to confirm interconnected alarms activate simultaneously and that there are no alarms disabled or removed.

Most compliant smoke alarms contain a permanent label on the back or side of the unit. Licensing consultants can confirm that smoke alarm systems are listed and approved by a nationally recognized testing laboratory (NRTL), such as Underwriters Laboratories (UL), by gently rotating or removing the alarm from its mounting bracket (if safe to do so) and looking for a certification mark from a recognized testing laboratory. The label is usually molded into the plastic housing or printed on a manufacturer sticker. Example text that may appear on the unit:

- "UL Listed Smoke Alarm"
- "Conforms to UL 217"
- "ETL Listed – Smoke Alarm"



If the marking is difficult to locate, consultants may also verify listing through:

- Manufacturer instructions
- Product manuals

- Packaging retained by the facility

Potential Non-Compliance Indicators include:

- No listing mark is visible
- The alarm appears to be a novelty device or decorative unit
- The device lacks manufacturer identification
- The alarm appears altered or damaged

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(7) Instead of the approved smoke alarms being powered by the facility's electrical service in subrule (6) of this rule, a wireless system in compliance with section 29.10.8.1 et seq. of NFPA 72, National Fire Alarm and Signaling Code, 2019 edition, is accepted. The other requirements in subrule (6) of this rule still apply. NFPA 72, National Fire Alarm and Signaling Code, 2019 edition, is adopted by reference in R 400.715(2).

TECHNICAL ASSISTANCE

Wireless smoke alarm systems are acceptable when all alarms are listed and compatible as part of the same wireless interconnected system, activation of any alarm triggers all alarms throughout the home, alarms meet the same location requirements as hardwired systems, and units are properly installed, powered, and maintained.

INDICATORS

A consultant may verify that a wireless smoke detection system is not a random collection of wireless alarms, and is a listed household fire warning system designed to work together by checking the following:

- A UL / ETL listing mark on the smoke alarm
- The manufacturer labeling showing it is a wireless interconnected system
- Documentation indicating devices are compatible components of the same system



Consultants may activate one smoke detector to confirm that it transmits an alarm signal to all interconnected devices, without noticeable delay. They may verify that the system is capable of generating a trouble signal if communication between devices is

lost by reviewing listing information, manufacturer documentation, and system indicators. Typical language may include:

- “Loss of communication will generate a trouble signal.”
- “System supervision monitors device connectivity.”
- “Interconnected alarms provide fault indication.”

Consultants may inspect wireless smoke detection devices to ensure they are powered by batteries or approved power sources consistent with listing.

R 400.729 Heating equipment.

Rule 729. (1) Heat must be provided by an approved central heating plant or a permanently installed electrical heating system that is approved by a nationally recognized testing laboratory that uses acceptable testing methods.

TECHNICAL ASSISTANCE

An approved heating plant is defined as a central heating system that disperses heat throughout the building via pipes or ducts. This central heating system can be fueled by oil, gas, electricity, or solid fuel (wood or coal).

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(2) A furnace, water heater, heating appliances, pipes, wood-burning stoves and furnaces, and other flame- or heat-producing equipment must be installed in a fixed or permanent manner and in accordance with a manufacturer's instructions and maintained in a safe condition. Clothes dryers must be properly vented to the outside using permanent metal duct work.

TECHNICAL ASSISTANCE

Applicants/licensees must replace any plastic or metal foil, accordion-type ducting material on dyers, as plastic is not approved for dryer use. Some metal foil ducts may not be approved, either. Applicants/licensees must replace these ducts with rigid ducts or corrugated semi-rigid metal ducts. Most dryer manufacturers specify the use of a rigid or corrugated semi-rigid metal duct, which provides maximum airflow. Flexible plastic ducts are flammable, and they, along with foil-type accordion ducts, more easily trap lint, and are more susceptible to kinks and crushing, which greatly reduces or obstructs the dryer air discharge.



(3) Where conditions indicate a need for inspection, heat-producing equipment must be inspected by a qualified inspection service. A copy of the written approval from the qualified inspection service must be submitted to the department on request.

TECHNICAL ASSISTANCE

If there is reason to believe there may be a problem with the heating equipment, an inspection by a licensed HVAC technician and/or certified chimney sweep must be obtained.

The licensee must be able to demonstrate chimney safety has been maintained. Frequency of chimney cleaning is dependent on the frequency of use. Fireplaces of masonry construction or factory-built fireplaces will be acceptable as a means of supplemental heat only if they are equipped with an approved spark screen or glass shield. The installation or construction or use of fireplaces in sleeping areas or hazardous areas will not be approved.

Fireplace Defined: A fireplace is generally defined as a unit composed of a hearth, a fire chamber or similar prepared place and a chimney. There are two basic kinds:

Factory-Built – a fireplace composed of factory-built components which have been tested by a recognized testing laboratory, such as Underwriters' Laboratories or Factory Mutual, assembled in accordance with the terms of the manufacturer's recommendations. Free standing wood-burning stoves have installation directions permanently affixed to their exterior.

Masonry Fireplace – a hearth and fire chamber of solid masonry units such as brick, stoves or reinforced concrete, provided with a suitable chimney.

(4) Portable heating units are allowed if they are Underwriters Laboratories (UL) listed and equipped with a tip over sensor and a temperature overheat sensor. Portable heating units must not be plugged into an extension cord or power strip and must be

used in accordance with manufacturer's recommendations and guidelines. Documentation showing compliance with these requirements must be maintained at the facility and available for inspection. When determining if use and placement of a portable heating unit is appropriate, the resident population served and ensuring their safety must be taken into account.

TECHNICAL ASSISTANCE

The use of heating blankets and heated mattresses, in accordance with manufactures' instructions, is permitted.

R 400.731 Flame-producing equipment; enclosures.

Rule 731. (1) If the heating plant is in the basement, standard building material may be used for the floor separation. Floor separation must also include at least 1-3/4-inch solid core wood door or equivalent equipped with an automatic self-closing device to create a floor separation between the basement and the first floor.

TECHNICAL ASSISTANCE

If the heating plant is in the basement, floor separation can be created either at the top of the stairs leading to the basement or at the bottom of the stairs leading to the basement.

A fully stopped wood or steel door frame equipped with an automatic self-closing device and positive latching hardware ("fire door") is part of a fire-rated door assembly designed to close and latch without staff intervention. The door stops help the door close in the proper position, and the latching hardware keeps it closed. The door and frame must be properly installed and maintained so that gaps do not compromise their fire and smoke protection.

An automatic self-closer is a mechanical device installed on the door that closes the door automatically after it has been opened. This ensures the door returns to the closed position every time, even if someone forgets to close it. The self-closer can be pneumatic, spring hinge closer, spring-loaded hinge, weighted closer, or other closing devices that will accomplish the purpose of closing and latching the door when it is released from any position. A coiled screen door spring is not an acceptable closer.

A 20-minute fire-rated door may be accepted as equivalent to a solid-core wood door, provided the door is at least 1¾ inches thick and meets the requirements for the frame, self-closing device, and positive latching hardware.



(2) Heating plants and other flame-producing equipment located on the same level as the residents must be enclosed in a room that is constructed of material that has a 1-hour-fire-resistance rating and has a door made of 1-3/4-inch solid core wood. The door must be hung in a fully stopped wood or steel frame and must be equipped with an automatic self-closing device and positive-latching hardware.

TECHNICAL ASSISTANCE

This subrule also applies to heating plants in a basement that is regularly used for resident activities.

When heat plants are required to be enclosed, sufficient clearance must be provided for servicing on all sides. Such rooms are to be constructed of at least one (1) hour fire resistance rated construction. Partitions and ceilings must be tightly fitted around doors, pipes, ducts, etc., and all joints sealed to be fire and smoke-tight. Caulking used to ensure partitions and ceilings are tightly fitted around doors must be “fire caulk” or “firestop sealant”.

While heating plant rooms located on the same level as residents, OR in basements that are regularly used for resident activities, must be constructed of materials with a 1-hour fire-resistance rating, national recognized fire-safety standards accept a labeled 20-minute fire-rated door as equivalent to a 1¾-inch solid-core wood door. Accordingly, the department will also accept this alternative.

INDICATORS

At the time of inspection , the consultant should observe the furnace room door to assure proper operation, that no modifications to the enclosure have been made, and that the enclosure materials have not deteriorated. Caulking used to ensure partitions

and ceilings are tightly fitted around doors “fire caulk”, or firestop sealant must be used.

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(3) A permanent outside vent that cannot be closed must be incorporated in the design of heating plant rooms so that adequate air for proper combustion is assured.

TECHNICAL ASSISTANCE

The combustion air must be directly from the outside through noncombustible ductwork with a permanently opened vent and ducted to approximately 12" off the floor. If the heat plant room contains an outside wall, adequate combustion air may be provided through a louvered permanent opening or a permanently opened window. Combustion air openings must be at least equal to the combined diameter of all exhaust vent openings for the flame-producing equipment in the enclosure, or at least one (1) square inch of opening for each 4,000 BTU's produced, or as specified by the manufacturer.

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(4) Combustible materials must not be stored in rooms that contain heating equipment, water heater, incinerator, or other flame-producing equipment.

TECHNICAL ASSISTANCE

Combustible materials refer to those materials which catch fire, burn, or smolder, when subjected to various degrees of heat. Such materials would include, but are not limited to, flammable liquids, paper, cloth, wood, plastic, vinyl, leather, etc. Storage of combustibles is not permitted in one-hour rated enclosures. If there is no heat plant enclosure and the heat plant and/or flame-producing water heater is in an open area in the basement, then any storage of combustible materials must be located as far away from the units as possible but no closer than 4 feet to that heating unit or water heater.

PART 8. REQUIREMENTS FOR FIRE SAFETY OF FAMILY HOMES AND SMALL GROUP HOMES WITH 6 OR LESS RESIDENTS LICENSED ON OR BEFORE MARCH 27, 1980, AND IN ACCORDANCE WITH SECTION 21 OF THE ACT

R 400.733 Facility construction.

Rule 733. All occupied rooms must be constructed of standard ½-inch drywall or its equivalent.

TECHNICAL ASSISTANCE

Examples of “equivalent construction” include but are not limited to include dry wall on studs, wet plaster on lath, 3/4” wood, masonry.

"Occupied rooms" means all rooms used in the facility for activities of daily living, e.g., sleeping, dining, cooking, recreation, etc. This rule refers to construction, not to interior finish.

Mobile Homes: Mobile homes converted to adult foster care homes must comply with all fire safety requirements the same as homes of conventional construction. Full compliance with this rule is necessary prior to the issuance of an original license.

R 400.735 Interior finishes and materials.

Paper, cardboard, asphalt paper or other highly flammable material shall not be used for the interior finish of a facility.

TECHNICAL ASSISTANCE

These materials and any other like materials are not to be used for wall, ceiling, or floor covering or to be used in place of the usual finishing materials used in the construction of a room such as wood studs, paneling, lath and dry wall, etc.

Carpeting is not to be used as a wall covering.

R 400.737 Means of egress.

Rule .737 (1) A means of egress must be considered the entire way and method of passage through a facility and out an exit door to free and safe ground outside the facility. Means of egress must be maintained in unobstructed travel condition.

TECHNICAL ASSISTANCE

A means of egress is that passageway from anywhere in the building leading to the ground level outside the building. Passageways should be at least 30 inches wide and are to be kept clear of anything that would present an obstacle to someone leaving the building. The 30 inches refers to the dimensions of the door itself. Such obstacles may include trash containers in hallways, furniture which may protrude.

The passageway through a garage itself is to be kept clear, even when the garage is used for storage of automobiles, lawn equipment, power tools, dog kennels, etc.

(2) Where basements are regularly utilized for resident activities, there must be 2 acceptable means of egress, 1 of which must lead directly to the outside.

(3) Doors that form a part of a required means of egress must be equipped with positive latching, non-locking-against-egress hardware and have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.
(4) Doors that form a part of a required means of egress must be equipped with positive-latching, non-locking-against-egress hardware and have a width to allow for residents requiring wheelchairs or other devices to easily navigate through doorways.

TECHNICAL ASSISTANCE

Doors which are part of a required means of egress, include resident occupied areas. These doors must be equipped with hardware that can be opened with a single motion, such as a turn of a knob or push of a handle, even if the door itself is locked. Positive latching non-locking against egress hardware: means the door can be opened, unlatched, and unlocked in one releasing motion. The latch must secure the door without requiring a key, tool, or special knowledge to open it from the egress.

Types of Locks Prohibited: Chain locks, dead-bolt locks, hook-and-eye locks, and other assorted paraphernalia which may be used to secure doors which are a part of a required means of egress.

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(5) In additions or remodeled facilities, corridors shall lead directly to the outside or to required stairways having egress directly outside at grade level.

TECHNICAL ASSISTANCE

Means of egress are independent and separate when reasonably remote from each other to enable one to proceed to safe ground in more than one direction.

Exiting Through Garages: If a required means of egress passes through a garage, the door used must be a positive-latching door equipped with non-locking against egress hardware. The passageway through the garage itself is to be kept clear, even when the garage is used for storage of automobiles, lawn equipment, power tools, dog kennels, etc.

If the first floor has more than two exits, the third exit may not be subject to the rules regarding exiting or the rules regarding hardware because only two exits are required. However, the evacuation plans mandated by these rules are to designate which are the required exits to be used.

Split Level Family Home. In the case of bi-levels, tri-levels, or quad-level family homes, two different levels will be considered one story if the difference in elevation between the two levels does not exceed four feet.

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(6) Facilities accommodating residents who regularly require wheelchairs must be equipped with ramps located at primary and secondary means of egress. Ramps constructed prior to the effective date of these rules must not exceed 1 foot of rise for every 12 feet of run. Ramps constructed on or after the effective date of these rules must comply with R 400.647 (10).

R 400.739 Heating.

Rule 739. (1) A facility shall be heated by an approved heating plant. If the heating plant is in the basement of the facility, standard building material is sufficient for the floor separation that must include at least 1 3/4-inch solid wood core door or equivalent to create a floor separation between the basement and the first floor. If the heating plant is on the same level as the residents, the furnace room must be separated from the remainder of the facility with materials that will afford a minimum 1 hour protected enclosure. A permanent outside vent that cannot be closed must be incorporated in the design of heating plant rooms so that adequate air for proper combustion is ensured.

TECHNICAL ASSISTANCE

If the heating plant is in the basement, floor separation can be created either at the top of the stairs leading to the basement or at the bottom of the stairs leading to the basement.

If the heating plant is in a basement where residents reside and/or regularly used for resident activities, in addition to floor separation at the top OR bottom of the stairs as indicated in subrule, the heating plant must also be enclosed. Sufficient clearance must be provided for servicing on all sides. Partitions and ceilings must be tightly fitted around doors, pipes, ducts, etc., and all joints sealed to be fire and smoke-tight.

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(2) Portable heating units are allowed if they are UL listed and equipped with a tip over sensor and a temperature overheat sensor. Portable heating units must not be plugged into an extension cord or power strip and must be used in accordance with manufacturer’s recommendations and guidelines. Documentation showing compliance with these requirements must be maintained at the facility and available for inspection. When determining if use and placement of a portable heating unit is appropriate, the resident population served and ensuring their safety must be taken into account.
(3) Factory mutual and underwriters' laboratories approved permanent, fixed type electrical heating, such as recognized panel or baseboard fixed type may be utilized in any location. In existing facilities where an American gas association (AGA) approved sealed combustion wall heater has been installed in accordance with both the AGA and the manufacturer's recommendations, approval is given if the unit is located on an outside wall, obtains combustion air directly from the outside, and vents products of combustion directly to the outside.
(4) Flame producing water heaters or incinerators shall be installed with the same protection as a heating plant.

(5) Storage of combustible materials is prohibited in rooms containing the heating plant, water heater, or incinerator.

TECHNICAL ASSISTANCE

Combustible materials refer to those materials which catch fire, burn, or smolder, when subjected to various degrees of heat. Such materials would include, but are not limited to, flammable liquids, paper, cloth, wood, plastic, vinyl, leather, etc.

Storage of combustibles is not permitted in one-hour rated enclosures. If there is no heat plant enclosure and the heat plant and/or flame-producing water heater is in an open area in the basement, then any storage of combustible materials must be located as far away from the units as possible but no closer than 4 feet to that heating unit or water heater.

R 400.741 Fire extinguishers.

Rule .741 A minimum of one 5-pound multi-purpose fire extinguisher or equivalent shall be provided for use in a facility on each occupied floor and in the basement.

TECHNICAL ASSISTANCE

"Occupied floor" means those areas of the home occupied by residents or members of the household.

Fire extinguishers must be present and operable. The licensee and direct care staff must know how to operate the extinguisher(s), as required by Rule 400.629(5)(f). A 5-pound multi-purpose fire extinguisher is equivalent to an extinguisher with a rating of 2A 10BC.

R 400.745 Smoke detection equipment for family and small group home with 6 or less residents on or before March 27, 1980.

Rule 745. (1) At least 1 single battery-operated smoke alarm must be installed in the following locations:

(a) Between the sleeping areas and the rest of the facilities. In facilities with more than 1 sleeping area, a smoke alarm must be installed to protect each separate sleeping area.

(b) On each occupied floor, in the basement, and in areas of the facility that contain flame or heat-producing equipment.

(2) Approved heat detectors may be installed in the kitchen and in other areas of the facility containing flame- or heat-producing equipment instead of smoke alarms.

(3) If batteries are used as a source of energy, the batteries must be replaced in accordance with the recommendations of the alarm equipment manufacturer.

(4) Detectors must be tested and examined as recommended by the manufacturer.