Proposed New Rules for Licensed Residential Facilities
Pre-Clearance Period: April 10-24, 2015
Feedback with Department's Responses

Comment	By Whom	DODD's Response
5123:2-3-01 (B)(13): The definition of "supervisory staff" is unclear. Is this just for staff who work in the home? Only in an office? Both?	Anita Allen, Vice President, Ohio Provider Resource Association	"Supervisory staff" is defined as "employees of the residential facility who provide direction or exercise supervision over one or more employees in **direct services positions**." "Direct services position" is defined in paragraph (B)(3) of the rule to have "the same meaning as in section 5123.081 of the Revised Code and includes staff who provide habilitation services."
5123:2-3-01 (B)(14): The definition of "support staff" has been changed from the current definition in existing rule 5123:2-3-01 (HH) which referenced support staff "means those personnel employed by the residential facility who are not habilitation staff or professional staff, including, but not limited to, secretaries, clerks, housekeepers, maintenance and laundry personnel." We need to make sure that we have not impacted who can be counted toward direct and indirect staff in an Intermediate Care Facility or inadvertently impact cost reporting by changing this definition.	Anita Allen, Vice President, Ohio Provider Resource Association	The definition of "support staff" has no effect on cost reporting.
5123:2-3-01 (C)(3): The Department has added a requirement that providers become compliant with the Americans with Disabilities Act (ADA). This is a new section and not otherwise required. Is the Department now requiring all licensed facilities to be ADA compliant? Please explain.	Anita Allen, Vice President, Ohio Provider Resource Association	Compliance with the ADA is not a new requirement. The reference has been removed as we do not want anyone to think it is a new requirement.
5123:2-3-01 (D)(2): The requirement for "RAPBACK" for all employees. Previous rule required the Bureau of Criminal Identification and Investigation (BCII) check, not RAPBACK. Although a better system, RAPBACK is more expensive. Is the intent that all current employees get a RAPBACK or just for new employees as of the implementation of this rule? In order to go back and get a RAPBACK on all current employees, it would cost the provider about $27 per employee because the BCII fingerprints are only good for one year if you are adding the RAPBACK. A couple of ideas: grandfather the BCII fingerprints previously required until the next time they come up for the 5-year recheck then require the RAPBACK addition, or grandfather the RAPBACK requirement to just any new employee as of the implementation of this rule.	Debbie Leibig and Carol Slight, Value and Faith Alliance	Good catch. New paragraphs (D)(2)(a) and (D)(2)(b) have been added so that providers can phase-in RAPBACK for existing staff when the next required Bureau of Criminal Identification and Investigation (BCII) criminal records check is due in accordance with the existing five-year schedule. At a cost of $5 per year per employee, phasing in RAPBACK in this manner is expected to be cost-neutral and ensures the provider receives notification when an employee is charged or convicted of a disqualifying offense. Although RAPBACK is in early stages of implementation, neither we nor BCII are aware of any problems with access. A panel convened in 2014 to review and make recommendations about health and safety systems recommended: "There is a fee to participate [in RAPBACK] and DODD should require that all agencies participate." The panel was comprised of representatives of providers, county boards, and advocates. The Department accepted this recommendation.
5123:2-3-01 (D)(2): Although RAPBACK is positively perceived and used by many of our members, it is a new unfunded mandate that will increase both real (as in fees) and administrative costs. It is a system that needs to be monitored and maintained. As written, all current staff will have to be entered into the system and paid for. Some members utilize other services such as WebCheck, while others choose to run the required background checks on a schedule. Members who wish to utilize RAPBACK have been reporting problems with getting signed up through the portal. It does not appear that the system is completely functional yet. We would like for RAPBACK to remain voluntary. OPRA was very supportive of RAPBACK, through the planning, pilot, and implementation phases. Our support was based in large part, in RAPBACK being voluntary and we made that clear.	Anita Allen, Vice President, Ohio Provider Resource Association	

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5123:2-3-01 (D)(7): The statement, "The operator shall maintain a written record, which may include an electronic record…" Our members would like to begin using more electronic files, but are not sure what must be kept on paper and what may be electronic.	Debbie Leibig and Carol Slight, Value and Faith Alliance	Paragraph (D)(7) refers to training records; any training records may be maintained electronically.
5123:2-3-01 (E)(2)(f): Provision (E)(2)(f) contains a grandfather clause for Administrators. Does the grandfather clause apply to other requirements such as (E)(2)(g), (E)(2)(h), (E)(2)(i), and (E)(2)(j)?	Anita Allen, Vice President, Ohio Provider Resource Association	**Former (E)(2)(g):** Paragraph (E)(2)(g) in the draft you reviewed has been stricken because it was redundant; background investigations are adequately addressed in paragraphs (D)(1) and (D)(2). As is currently the case, all staff, including Administrators, are subject to background investigations in accordance with rule 5123:2-2-02. **Former (E)(2)(h) - now (E)(2)(g):** The paragraph has been reworded to make clear that a person who is employed as the Administrator when the new rule goes into effect will not be required to complete the Orientation for Administrators of Residential Facilities. **Former (E)(2)(i) - now (E)(2)(h):** The paragraph has been reworded to make clear that a person who is employed as the Administrator when the new rule goes into effect will not be required to complete the initial training in Service Documentation, Fiscal Administration/Billing for Services, Internal Compliance Programs, Rights, and Rule 5123:2-17-02. **Former (E)(2)(j) - now (E)(2)(i):** Once the rule becomes effective, all Administrators will be required to annually complete the specified training.
5123:2-3-01 (E)(2)(h): "department provided web-based initial overview for administrators of residential facilities," is this now available, or when will it be available?	Debbie Leibig and Carol Slight, Value and Faith Alliance	The online training (which has been renamed "Orientation for Administrators of Residential Facilities") is under development and will be available by the time the new rule goes into effect.
5123:2-3-01 (E)(4): "plan and efforts to employ a replacement within thirty days" This is not a reasonable time frame. Most senior management positions take longer than 30 days to fill.	Anita Allen, Vice President, Ohio Provider Resource Association	The paragraph has been revised as indicated: The operator shall report in writing to the department within fourteen days when the administrator or operator serving as administrator leaves the residential facility's employ. The notification shall ~~describe the residential facility's plan and efforts to employ a replacement within thirty days~~ indicate when the operator anticipates filling the position and to whom executive authority has been delegated in the interim.
5123:2-3-01 (F): There are new requirements relative to training. We are not sure from where they are derived and current licensure provisions have been changed. There is also a reference to the Provider Certification rule. How will the Provider Certification training requirements relate to licensed facilities? It is not clear.	Anita Allen, Vice President, Ohio Provider Resource Association	As discussed at the Residential Facility Rules Workgroup meetings, to the extent possible, requirements for provider staff are being aligned across the service delivery system. The parenthetical references to the Provider Certification rule in the draft you reviewed were included merely to indicate that a similar requirement exists for certified providers of services. The references have been removed.
5123:2-3-01 (F): It appears that the Department has taken out the currently existing section found in 5123:2-3-08 (C)(3) where an employee is deemed to have met the requirements of 5123:2-3-08 (C) under training requirements if they are scheduled for training and have completed the training within 30 days. Has this been replaced somewhere?	Anita Allen, Vice President, Ohio Provider Resource Association	In response to your comment, a new paragraph (F)(2) has been added: An employee, contractor, or employee of a contractor engaged in a direct services position shall be deemed to have met the annual training requirements set forth in paragraph (F)(1)(i) of this rule if he or she is scheduled for training and the training is completed within thirty days of the deadline.

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5123:2-3-01 (F)(1)(d): This [high school diploma or GED] is a new requirement for Intermediate Care Facilities and eliminates potential staff hires in an already tight labor market.	Anita Allen, Vice President, Ohio Provider Resource Association	As discussed at the Residential Facility Rules Workgroup meetings, to the extent possible, requirements for provider staff are being aligned across the service delivery system.
5123:2-3-01 (F)(1)(e): Our membership has a question regarding the requirement of eight hours of training; is that intended to be inclusive of all training done with a new employee or only regarding (F)(1)(e)(i) through (F)(1)(e)(vi)? For example could it include the information required in (F)(1)(f) also?	Debbie Leibig and Carol Slight, Value and Faith Alliance	The eight-hour training should cover the topics listed in paragraphs (F)(1)(e)(i) through (F)(1)(e)(vi). The training specific to each individual served required in paragraph (F)(1)(f) is above and beyond the eight hours. The duration of the training specific to each individual served is not specified as it will vary depending on the number and needs of individuals served.
5123:2-3-01 (F)(1)(h): Regarding staffing, the Department has made a change. Under current law, at least one staff on shift in a direct service position shall hold American Red Cross or equivalent certification in First Aid or Cardiopulmonary Resuscitation (CPR). The Department has changed this to a requirement for all staff. Please explain the change. CPR/First Aid are not required in Intermediate Care Facilities (ICFs) where there are nurses on site 24/7. This presents an unreasonable hardship and is meaningless as only nurses are permitted to administer CPR. We request language that exempts ICFs with 24/7 nursing services.	Anita Allen, Vice President, Ohio Provider Resource Association	This was discussed extensively by the Residential Facility Rules Workgroup. We understand that not everyone agreed but feel it is an important safety standard wherever individuals receive services. When properly trained, staff other than nurses are permitted to administer CPR.
5123:2-3-01 (F)(1)(h): requiring First Aid/CPR for all employees within 30 days of hire. We still would like to see some provision for facilities that have 24-hour nursing on site; it is cost prohibitive to get all employees trained. Additionally, our members have asked if the requirement could be extended to 60 days of hire for facilities without 24-hour nursing.	Debbie Leibig and Carol Slight, Value and Faith Alliance	
5123:2-3-01 (G)(2): Supervisors who perform direct service in Intermediate Care Facilities (ICFs) do not need training in Billing Requirements. In addition, in many facilities they do very little in the way of managing individual's funds. This requirement is unnecessary and does not take into account the various ways ICFs are structured. There should be separate language for ICFs.	Anita Allen, Vice President, Ohio Provider Resource Association	Paragraph (G) has been revised as indicated: The operator shall ensure that within ninety days of becoming a supervisor, supervisory staff successfully complete training in accordance with ~~standards established by the department in~~ the residential facility's policies and procedures regarding: (1) Service documentation; (2) ~~Billing requirements~~ Fiscal administration and/or billing for services, as applicable; and (3) Management of individuals' funds.
5123:2-3-01 (G)(2): Why in an ICF is there a requirement for supervisors to be trained in Billing Requirements? ICF supervisors do not have anything to do with the billing.	Debbie Leibig and Carol Slight, Value and Faith Alliance	
5123:2-3-01 (I)(3): The definition of a volunteer is no longer included, through our stakeholder meetings, we had discussed that ONLY a volunteer that works directly with residents needed the background checks/training that the rule outlines. Can we make this clear in the rule; our membership has several volunteers that do mission work, clerical work, landscaping, volunteer to play the piano for worship, etc., who should not need to have the background checks and training as they are not working directly with the residents.	Debbie Leibig and Carol Slight, Value and Faith Alliance	The definition/concept of "volunteer" formerly in paragraph (B) has been moved to paragraph (I) where the requirements for volunteers are delineated. In response to your comment, paragraphs (I)(3) and (I)(4) have been revised as indicated to make clear that the requirements for training and background investigations apply to volunteers who work directly with residents for more than 40 hours during a calendar year. The operator shall ensure that volunteers who provide more than forty hours of service working directly with residents during a calendar year...

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5123:2-3-01 (I)(4): We would like to suggest that background checks be done on volunteers who spend unsupervised time with individuals. The need for the check is not necessarily the number of hours involved, but in the tasks performed.	Anita Allen, Vice President, Ohio Provider Resource Association	Existing rule 5123:2-3-07 (*Employment and Staffing*) requires volunteers to be supervised by facility staff. Even so, it is reasonable that volunteers who spend considerable time with individuals undergo background checks. We included a threshold of 40 hours so that background checks are not required for one-time or occasional volunteers.
5123:2-3-02 (C)(9): We request that the bedroom limit language in House Bill 64 be included in the rule.	Anita Allen, Vice President, Ohio Provider Resource Association	It is not necessary to repeat the statute in the rule.
5123:2-3-02 (C)(11): Please define "adult."	Anita Allen, Vice President, Ohio Provider Resource Association	"Adult" is defined in paragraph (B)(1) to mean an individual age 18 and older.
5123:2-3-02 (C)(11): Our membership wants clarification on the requirement of a bedroom being occupied by an adult and child. If people are roommates for several years and one turns 18 before the other (even a couple of years) would they have to be separated? Or is the intent for people of significant age difference, or becoming new roommates? Is there a way to capture so that those who have grown up together do not have to separate when one turns 18?	Debbie Leibig and Carol Slight, Value and Faith Alliance	The situation you describe could be remedied by requesting a waiver of this provision in accordance with proposed new rule 5123:2-3-10.
5123:2-3-02 (D)(4): What if an individual chooses a futon and wishes to purchase one for his/her own use? Is this prohibited if it is a choice?	Anita Allen, Vice President, Ohio Provider Resource Association	Existing rule 5123:2-3-10 (*Physical Environment Requirements*) requires the licensee to provide each individual with a bed that is sturdy, safe, and in good condition and sets forth that "hideaway beds and rollaway beds shall not be used." The Department has always regarded futons and sleeper sofas as "hideaway beds" and thought it helpful to say so in paragraph (D)(4) of proposed new rule 5123:2-3-02. Nothing in the rule prohibits an individual from purchasing a futon.
5123:2-3-02 (D)(5): This [providing closet and drawer space] is not practical for individuals who require total care and assistance with Activities of Daily Living. How will this standard be evaluated?	Anita Allen, Vice President, Ohio Provider Resource Association	This requirement is in paragraph (F)(6) of existing rule 5123:2-3-10 (*Physical Environment Requirements*).
5123:2-3-02 (E): Has the fire drill schedule been intentionally removed?	Anita Allen, Vice President, Ohio Provider Resource Association	Good catch; this was an inadvertent omission. New paragraph (E)(10) has been added to require the operator to conduct a fire safety drill at least three times in a twelve-month period: <u>The operator shall conduct and document at least three fire safety drills in a twelve-month period with one conducted during the morning, one conducted during the afternoon or evening, and one conducted during the time when individuals are routinely asleep.</u>
5123:2-3-03 (C): We request that language that the individual's choice of where to reside is noted and honored.	Anita Allen, Vice President, Ohio Provider Resource Association	Paragraph (C) is general language describing decision-making.

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5123:2-3-03 (C)(5): This provision governs service providers not guardians. How is this to be enforced? Who is responsible for enforcing? Who decides if the guardian's decision is in "the best interest?" What if a determination is made by someone that the decision is not "in the best interest?" Providers cannot be held responsible for guardian decisions.	Anita Allen, Vice President, Ohio Provider Resource Association	These are general principles regarding decision-making authority of which all providers should be aware. We agree; providers cannot be held responsible for actions of guardians. The Department recently hosted a webinar on the role of guardians that you may want to share with your members: https://sites.google.com/site/doddworkspace/home/training#bbrec
5123:2-3-03 (E)(1): The rule makes no mention of federally mandated requirements in Intermediate Care Facilities (ICFs). ICFs must complete certain assessments, attempt medication reductions, and insure proper dietary care, for example. These requirements are in place to insure a minimum level of health and safety and cannot be over-ridden by guardian or individual decisions. We ask that the rule reflect federal requirements.	Anita Allen, Vice President, Ohio Provider Resource Association	Paragraph (E)(1) reflects the essence of person-centered planning which we believe all stakeholders endorse. Person-centered planning is compatible with federal regulations governing ICFs. Paragraph (C)(3) of proposed new rule 5123:2-3-01 sets forth that residential facilities must comply with all federal, state, and local regulations; we are not repeating federal regulations in our administrative rules.
5123:2-3-04 (B)(1): Why does the definition of "community participation" include daytime and evening activities and not just say "activities?"	Anita Allen, Vice President, Ohio Provider Resource Association	Based on discussion at meetings of the Residential Facility Rules Workgroup, this wording is intentional, to shift the service delivery culture to consideration of each individual as a whole person and the comprehensive supports necessary to enrich the individual's life.
5123:2-3-04 (C)(1)(c): While we understand the importance of this provision, we had questions on its meaning. Is the provider expected to know sign language if the individual uses it? What about individuals who are non-verbal or non-communicative? What is the standard for evaluation of this provision?	Anita Allen, Vice President, Ohio Provider Resource Association	The provider needs a way to exchange information about what is important to and important for the person being served. The mode of communication may vary based on the specific needs of the individual.
5123:2-3-04 (E)(2)(c): This provision [obtaining driving record and persons with 6 or more points are prohibited from providing transportation] will be difficult to comply with. Should state 30 days, not 14.	Anita Allen, Vice President, Ohio Provider Resource Association	The requirements in this paragraph align with requirements for drivers set forth in existing rules 5123:2-2-02 (*Background Investigations for Employment*), 5123:2-9-24 (*Transportation*), and 5123:2-9-18 (*Non-Medical Transportation*).
5123:2-3-04 (E)(2)(e): This [ensuring vehicles used to transport individuals are accessible to the individuals and maintained in a safe manner] is impossible for a provider to insure in Homemaker/Personal Care transportation. The additional cost and administrative time is prohibitive. Are direct support professionals expected to have vehicle inspections? By what entity? Who bears the cost?	Anita Allen, Vice President, Ohio Provider Resource Association	Paragraph (E)(2)(e) is worded generally to permit flexibility for the provider to determine a vehicle used for transportation is safe. We suggested this approach in lieu of adopting wording from existing rules (e.g., rule 5123:2-9-18 governing Non-Medical Transportation requires that a vehicle used shall, at a frequency of at least once every twelve months be inspected by the Ohio State Highway Patrol safety inspection unit or a certified mechanic and be determined to be in good working condition).
5123:2-3-04 (F)(1) & (F)(2): These two provisions [offer meals and snacks that meet individuals' preferences and prepare and serve modified or specially-prescribed diets in accordance with instructions] could actually be in conflict with one another. Some food preferences might be in conflict with dietary restrictions. Language should be added that recognizes this fact.	Anita Allen, Vice President, Ohio Provider Resource Association	These concepts are in paragraph (B) of existing rule 5123:2-3-12 (*Food, Clothing, and Personal Items*).
5123:2-3-04 (F)(3): This provision [meals planned and prepared by individuals with support of staff] differs from the current rule and does not take into account the ability of an individual to actually prepare food. In addition, larger Intermediate Care Facilities have dietary departments that prepare meals according to specialized diets. Language should be included that recognizes these situations.	Anita Allen, Vice President, Ohio Provider Resource Association	
5123:2-3-04 (H)(2): Currently, this provision provides an exception for community participation if it would be contraindicated. It has been changed to medically contra-indicated only. This is a very narrow exception and we do not recall any discussion about this. Community participation is sometimes behaviorally contra-indicated and language is needed that recognizes this.	Anita Allen, Vice President, Ohio Provider Resource Association	The planning process for individuals who require behavioral support strategies must address how to support the individual in all settings, including settings that foster community participation.

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5123:2-3-04 (H)(3): Our membership is concerned about the how open-ended this requirement is written. Since the ICF has to pay for the day services, and the requirement is that individuals have access to day activities offered by others, could something be added in terms of "reasonable cost" for day services? As it is written now it is open to the individual being able to choose a day program regardless of the cost.	Debbie Leibig and Carol Slight, Value and Faith Alliance	In response to your concerns, paragraph (H)(3) had been revised as indicated: The operator shall ensure that individuals have access to a variety of day activities ~~offered by other providers and information in formats the individuals understand about day activities offered by other providers~~. Please note that paragraph (H)(1) has been revised as indicated: The operator shall ensure that ~~individuals routinely have~~ each individual routinely has information in formats the individual understands about day activities offered by other providers and opportunities to explore and experience community participation in accordance with ~~each individual's~~ his or her individual plan and ~~the individual's~~ desired outcomes as they relate to community employment in accordance with paragraph (D) of rule 5123:2-2-05 of the Administrative Code.
5123:2-3-04 (H)(3): This [day activities offered by other providers] is not feasible in the way the active treatment rate is currently structured and should not apply to Intermediate Care Facilities (ICFs). Under federal and state law, ICFs are responsible for active treatment 24/7. Free choice of provider does not apply. As you know, many ICF residents were once served by other day service providers until the active treatment rate no longer covered the costs. The active treatment component of the rate has not changed and inflationary pressures have made the situation worse. There are very few day service providers willing to serve ICF residents for the funding available. This pressure resulted in many ICF agencies developing their own day programs. An increase in funding would open up more options.	Anita Allen, Vice President, Ohio Provider Resource Association	
5123:2-3-04 (H)(4): This provision attempts to change the rules regarding day services and proximity to Intermediate Care Facilities (ICFs). First of all, this section refers to "day activities" and there is no definition as to what that is. Will you use the definition that exists today in 5123:2-3-24? Please explain and define. Second, the Department is broadening the definition of prohibited "day activities." Today, the ICF day array services cannot be provided 1) in the same building as the ICF, 2) in any residential facility, and c) within 200 feet of the building housing the ICF (5123:2-3-24). This change would broaden the prohibition to require that no day array services may be provided within 200 feet of any ICF, not just the licensed ICF building where the residents reside. Please explain. This will increase the cost of providing services for many ICFs.	Anita Allen, Vice President, Ohio Provider Resource Association	Our intent is not to change the meaning. To make that clear, paragraph (H)(4) has been revised as indicated: Day activities shall not be provided in an intermediate care facility or within two hundred feet of ~~an~~ the intermediate care facility except that an intermediate care facility that was providing day activities in or on the grounds of the intermediate care facility prior to July 1, 2005 may continue to provide day activities at that same location.
5123:2-3-04 (I)(1)(e) & (I)(1)(f): There is some concern about the requirement for medications and/or treatment records for the most recent twelve months to be maintained at the facility. Currently, some facilities keep previous medication administration records off-site at a nursing department to ensure the nursing staff has access to the information when contacting the doctor. These records and the Major Unusual Incident records both would be better included in (I)(2) as maintained in an accessible location.	Debbie Leibig and Carol Slight, Value and Faith Alliance	Paragraph (I) has been restructured to emphasize maintaining critical current records on-site and the provisions formerly in paragraphs (I)(1)(e) and (I)(1)(f) have been relocated to paragraph (I)(2). Paragraph (I)(2) allows for records to be made available at the time of the review in a manner mutually agreed upon between the Department and the provider (which may include accessing electronic records, facility staff bringing records to the facility at the time of the review, or DODD staff reviewing records at the administrative office as long as it is in reasonable proximity to the facility being reviewed).
5123:2-3-04 (I)(1)(f): Many liability insurance companies require Major Unusual Incident and Unusual Incident records to be kept off of the actual residential site and in a separate office. This provision will conflict with liability insurance standards and might put liability coverage at risk.	Anita Allen, Vice President, Ohio Provider Resource Association	
5123:2-3-04 (I)(2)(f): Regarding reconciliations and personal funds, will this rule apply to Intermediate Care Facilities?	Anita Allen, Vice President, Ohio Provider Resource Association	If you are asking if proposed new rule 5123:2-2-07 (*Personal Funds of the Individual*) will apply to Intermediate Care Facilities, the answer is "yes."

Comment	By Whom	DODD's Response
5123:2-3-05 (B)(4): Regarding an emergency, the new language appears to require the operator to document attempts to provide, obtain, and/or coordinate the services necessary to ensure the health and safety of the resident, other residents and staff at the facility. The requirement for documentation of previous occurrences fails to take into account situations where an emergency may present itself but there were no previous occurrences which lead to the emergency situation. For instance, if someone has a stroke and they are no longer appropriate for the Intermediate Care Facility, we assume that this would be an emergency situation. In sum, the definition of emergency appears to require documentation of previous events which may not be related to the emergency situation that presents itself.	Anita Allen, Vice President, Ohio Provider Resource Association	Nothing in the rule prohibits a resident from going to the hospital for a medical emergency. If the resident is ultimately discharged, however, absent an emergency, the residential facility would be required to give 30-day advance notice.
5123:2-3-05 (D)(4): If an individual is admitted to a nursing home for six weeks for a specific medical intervention or therapy, is this considered an emergency and not subject to a 30-day notice?	Anita Allen, Vice President, Ohio Provider Resource Association	Admission to a Nursing Facility would require a determination that the individual requires the level of services provided by a Nursing Facility in accordance with rule 5123:2-14-01 (*Preadmission Screening and Resident Review for Nursing Facilities*). The individual would have to be discharged from the residential facility in order for Medicaid to pay for the individual's care at a Nursing Facility. The definition of "emergency" in paragraph (B)(4) of rule 5123:2-3-05 has been revised as indicated so that situations in which an individual moves to another setting due to a change in the individual's level of care would not require 30-day advance notice: "Emergency" means either a situation in which~~, despite~~: (a) Despite the operator's documented attempts to provide, obtain, and/or coordinate the services necessary to ensure the health and safety of the resident, other residents, and/or staff of the residential facility, there still exists a significant risk of substantial harm to the resident, other residents, or staff that cannot be met in the current environment such that action must be taken immediately~~.~~ ; or (b) Through a level of care determination in accordance with rule 5123:2-8-01 of the Administrative Code or a preadmission screening for developmental disabilities in accordance with rule 5123:2-14-01 of the Administrative Code, the individual is determined to require a level of services provided in another type of setting (e.g., a nursing facility).
5123:2-3-06 (F)(1) & (G)(3): (F)(1) discusses three-year terms only, but (G)(3) includes both one-year and three-year terms.	Anita Allen, Vice President, Ohio Provider Resource Association	The Department may issue a one-year license when, after the Department initiates proceedings to refuse to renew the license, the licensee submits and implements a satisfactory plan of correction. The paragraphs have been reordered and fees are now addressed in paragraph (J). Paragraph (J)(3)(b) has been revised as indicated to make clear that a one-year license would be issued only in the situation described in paragraph (G)(1)(c)(iv)(*a*): The licensure fee for a one-year license issued in accordance with paragraph (G)(1)(c)(iv)(*a*) of this rule shall be:
5123:2-3-06 (F): Although the fee structure indicates that there is a one-year and three-year license, there is no place in the rule that mentions issuance of a one-year license. May need to mention the possibility that a one year could be issued.	Debbie Leibig and Carol Slight, Value and Faith Alliance	

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5123:2-3-06 (G)(3): We had comments on the large jump in fees. Can you give your rationale?	Anita Allen, Vice President, Ohio Provider Resource Association	The Residential Facility Rules Workgroup discussed fees at length. The fees proposed in the April 10 draft rule reflect an increase from current rule but are considerably less than earlier proposed. DODD is still pondering fees and is considering the following fees, regardless of facility size: • $300 for a three-year license • $150 for a one-year license We are interested in your feedback on this idea. After additional discussion among DODD staff regarding the relationship between licensure fees and provider certification fees, we determined that the current practice is sound and will stand: A licensed residential facility that provides services only to its residents should not pay a provider certification fee. Entities that operate multiple lines of business (i.e., licensed residential facilities and provision of services to individuals who are not residents of the entity's licensed residential facilities) will pay fees as appropriate for the distinct lines of business. When such an entity is applying for provider certification for provision of services to non-residents, it should, for purposes of designating itself as a "small agency" or a "large agency," count each individual with a developmental disability it serves with the exception of those who are residents of the entity's licensed residential facilities.
5123:2-3-06 (G)(3): Our membership continues to be concerned about the significant increase in the fees. Currently the fee is $100 for a three-year license; new proposed rule increases this to between $300 and $1,500. This is a huge increase; is there a reason for the increase? Also there is no incentive for a one-year vs. a three-year license; could the fees show some kind of incentive for getting the three-year license?	Debbie Leibig and Carol Slight, Value and Faith Alliance	
5123:2-3-06 (G)(3): I know we had much discussion over the proposed increased fees for one-year and three-year term licenses…could you remind me of the rationale behind the significant increase? There was some discussion of a facility receiving credit if they were also paying provider cert fees, is this still the case?	Melanie Rak, Supervisor, Residential Programs, Cuyahoga County Board of Developmental Disabilities	
5123:2-3-06 (G): Total deletion of term license requirements and Department survey tool and tool deleted as an attachment to the rule (now called compliance protocol) - Under Section 5123:2-3-06, the term license and licensure survey tool have been deleted and the new compliance reviews for licensed facilities will be conducted in accordance with a compliance protocol which takes the place of the licensure survey tool. Today, the license survey tool is promulgated as an attachment to the administrative rule. Accordingly, we believe that the new compliance protocol should remain part of the administrative rule process. The term license and licensure survey tool are currently found at Section 5123:2-3-03 and Appendix A of that same rule respectively, but are noticeably absent under the proposal. The Department is proposing to post the protocol on their web site but this is not meaningful due process. The creation of the web site compliance protocol and any subsequent changes will not be subject to notice, public input, and due process as is required under the current administrative rule process governing the survey tool. We propose that the Department keep the tool/protocol as an appendix to the rule so that all stakeholders can have meaningful input and due process in the rulemaking process as is the case today with the survey tool.	Anita Allen, Vice President, Ohio Provider Resource Association	Currently a compliance review results in a residential facility accumulating points that rigidly lead to a one-year, two-year, or three-year license term. The Residential Facility Rules Workgroup considered varying term licenses and determined that generally, all facilities should receive a three-year license. The need to have a tool to calculate the licensure term evaporates. Further, the tool consists of citations to language directly from rules and probes to determine if a facility is in compliance with the rules. The tool itself has no independent legal significance.

Comment	By Whom	DODD's Response
5123:2-3-06 (G): Surveys will be called "compliance reviews" - In the proposed Section 5123:2-3-06, the Department has changed the terminology of licensure surveys to compliance reviews because the supported living standards are going to be the predominant standards. Again, we need to understand who will be conducting the compliance reviews as under the law, today, County Boards are prohibited from conducting compliance reviews of residential facilities under OAC 5123:2-2-04 (C)(2). In discussions over the past several months, the Department has stated that it believes that County Boards may someday conduct the compliance reviews of residential facilities, both Intermediate Care Facilities (ICFs) and waiver homes. This is a strong departure from current practice. OPRA has concerns about County Boards taking on this function as this is a State function and is non-delegable. Further, several County Boards are license holders of ICF residential care licenses. This creates a conflict of interest. This needs much more discussion. With regard to licensed HCBS facilities, currently, County Boards are prohibited from conducting any surveys or compliance reviews regarding licensed facilities. In fact, today it is clear that supported living standards do not apply to licensed facilities. The rule regarding supported living provider certification Section 5123:2-2-01 (A) provides that "this rule does not apply to a person or government entity licensed as a residential facility under Section 5123.19 of the Revised Code." Thus, under today's standards, licensed facilities and certified supported living providers are governed by mutually exclusive laws. This will bring them together all under supported living standards. Under the new definition section, the "Department" is defined as "the Ohio Department of Developmental Disabilities or its designee." As we mentioned, with regard to licensed facilities, only the Department may conduct surveys or compliance reviews and not any designee. The definition section opens this up and makes it unclear as to whether County Board will have a role with regard to licensed facilities. This is unacceptable with regard to any licensed facility – including group homes or ICFs. Second, with regard to ICFs, it is troubling that the supported living standard will be the predominate standard. Many of the supported living standards are inapplicable to ICFs today as is evident from our comments. We ask that the Department reconsider these inconsistencies.	Anita Allen, Vice President, Ohio Provider Resource Association	Using the term "compliance review" instead of "survey" has none of the implications you raise. And, specifically, nothing in the rule invokes the concept of Supported Living. Based on objections raised by some during Residential Facility Rules Workgroup meetings, the Department abandoned the idea of combining requirements for Supported Living and licensed settings.

Comment	By Whom	DODD's Response
5123:2-3-06 (H): Provider appeal timelines shortened - Under 5123:2-3-06, the Department has reduced the time-frames for appeals of citations from a compliance review citation from 30 to 14 days. The current law under 5123:2-3-02 (J)(6) requires that providers have 30 days to respond to the Department's citations. The only reason that the Department gave for shortening the timelines associated with provider appeals was that the Department wants similar timelines for licensure appeals as are associated with supported living certification. We are opposed to shortening the current timelines associated with providers exercising their rights. **5123:2-3-06 (H):** Provider appeal timelines shortened - Under 5123:2-3-06, the Department has shortened the time-lines for the provider to request reconsideration from 20 to 14 days. Why the change? The current requirements are found in rule 5123:2-3-02 (Q)(5)(c). We ask that all current timelines for provider appeals and plans of correction be maintained.	Anita Allen, Vice President, Ohio Provider Resource Association	The licensee must respond to each citation with either a plan of correction or an appeal. Therefore, before submitting a plan of correction the licensee must determine which, if any, citations are going to be appealed. Fourteen days is a reasonable period of time to respond to citations with either a plan of correction or an appeal. The "request for reconsideration" process described in paragraph (Q)(5) of existing rule 5123:2-3-02 (*Licensure Application, Issuance, Survey, Renewal, and Sanction Procedures*) includes submission of a plan of correction. In proposed new rule 5123:2-3-06, two steps have been combined. If a licensee wants the Department to reconsider proposed refusal to renew the license, the licensee must simply submit a plan of correction instead of requesting reconsideration and submitting a plan of correction.
5123:2-3-06 (J)(1): This differs from current rule. If voluntarily surrendered, we would like to retain the licenses for possible future use in another location. We would like the voluntary language removed.	Anita Allen, Vice President, Ohio Provider Resource Association	Voluntary surrender is at the discretion of the licensee.
5123:2-3-07 (C)(1): Regarding the grounds for immediate removal, (C)(1) provides "upon receipt of an allegation that the physical or psychological health or safety of a resident of a residential facility is at risk, the county board shall determine if the situation is one of immediate danger." Compared to current laws, the department is proposing to lower the standard from "danger" to "risk" and that would allow a county board to begin conducting their investigation regarding an allegation merely because they believe someone is at "risk." Currently, a county board can only conduct an investigation of an allegation that a resident is in danger. The new language would allow county boards to begin their investigation if the resident is at risk. At risk of what? The language is not clear and the standard is vague.	Anita Allen, Vice President, Ohio Provider Resource Association	We did not intend to change the standard. Paragraph (C)(1) has been revised as indicated to reflect wording in existing rule 5123:2-3-16 (*Emergency Removal of Individuals From a Residential Facility*): Upon receipt of an allegation that the physical or psychological health or safety of a resident of a residential facility is ~~at risk~~ in danger, the county board shall determine if the situation is one of immediate danger.
5123:2-3-07 (C)(1)-(C)(6): It appears that the department's role is minimal and there is no duty on the department to conduct its own independent investigation. Rather, it appears that the department will rely solely on the county board to conduct the investigation and to inform the department about their opinion. This is not acceptable. There have been situations over the past year where county boards have conducted investigations which were not warranted at all. Providers were then required to spend thousands of dollars to try to undo an unwarranted county investigation. If the department is going to take the extreme step to remove someone from a facility, the department must have a role in seeing what is actually going on in the facility.	Anita Allen, Vice President, Ohio Provider Resource Association	Please note that the Department has not initiated an immediate removal in more than 15 years. If we were to receive a report from a county board, we would certainly make our own determination.

Comment	By Whom	DODD's Response
5123:2-3-08 (B)(5): The definition of "development" has been revised to include "renovation" and remove "replacement." Replacement: Under the current 5123:2-3-26 (B)(7) and (F)(4), a "replacement" of assigning licensed beds to a different licensee when a license is revoked, terminated or not renewed or voluntarily surrendered is permitted when the Department determined the beds are needed to provide services to the individuals who reside in the residential facility in which the beds are located. It appears that this option has been eliminated. What will happen to these beds when a license is revoked or a provider voluntarily goes out of business? Can they no longer sell the beds? Renovation: As mentioned, this is new in the draft development rule. The definition of "renovation" in this new rule is what is currently found in 5123:2-3-02 (B)(1). So this is not new. However, renovations are currently not subject to development approval by the Department. Currently, under 5123:2-3-02 (G), a licensee is just required to notify the Department 30 days prior to its intent to begin a renovation, and the Department is to let the licensee know within 14 days if any new inspections and/or a licensure survey will be needed following the renovations. Although the development proposal process for renovations is separate for the process for modifications (see Section (H)) and mirrors the language from 5123:2-3-02 (G), renovations will presumably now be subject to the Department's discretion and approval as part of the broad development process and standards in the development rule. Further, since "renovation" is defined so broadly, providers could be burdened with submitting a development proposal for almost any renovation. This could be very cumbersome on providers and the Department in reviewing the proposals as well. **5123:2-3-08 (H):** The new rule also includes "non-extensive" renovations under 5123:2-7-25 as part of the renovations requiring development approval at Section (H). 5123:2-7-25 is for non-extensive renovations for Intermediate Care Facilities only, and this rule pertains to cost reporting, not Department approvals for the renovations. Moreover, no discussions were had with stakeholders regarding adding "renovations" to the development process and rule. We ask that the Department reconsider such a broad change. **5123:2-3-08 (H):** As we have mentioned before, the Department's "development proposal process" imposes Certificate of Need (CON)-like criteria to DD licensed beds. This draft rule even further expands the Department's authority to grant and deny development proposals by including renovations, even non-extensive renovations, in Section (H). Today, there is no CON requirement for residential beds, nor any statutory authority for the Department to impose a CON process to the development and renovation of licensed beds. The imposition of a rule that requires providers to meet a CON-like standard exceeds the Department's statutory authority. Accordingly, this would likely violate the first JCARR prong because it would exceed the scope of the Department's statutory authority regarding licensed residential beds.	Anita Allen, Vice President, Ohio Provider Resource Association	The process for approval of a renovation has not changed. The requirements in paragraph (H) of proposed new rule 5123:2-3-08 align with paragraph (G) of existing rule 5123:2-3-02 (*Licensure Application, Issuance, Survey, Renewal, and Sanction Procedures*), which applies to all residential facilities including Intermediate Care Facilities. As a matter of practice, we have actually reduced steps the provider must take by tying together nonextensive renovation described in existing rule 5123:2-7-25 (*Intermediate Care Facilities - Nonextensive Renovation*) with the process in proposed new rule 5123:2-3-08. The label on paragraph (H) of the proposed new rule has been revised from "Development proposal process for renovation" to "Renovation" to eliminate confusion. Division (H) of Section 5123.19 of the Revised Code compels the Director to adopt rules for licensing and regulating the operation of residential facilities that establish and specify procedures and criteria for issuing licenses. The Development rule is not new. Standards for development of licensed residential facilities have been in existence since 1986; the current version of the rule has been in effect since 2012. The standards are not CON-like because we are not allocating resources or permits based on availability of existing facilities or cost limitations.

Comment	By Whom	DODD's Response
5123:2-3-08 (D)(2): Language regarding a facility's ability to operate at its current "configuration" has been removed. Further, an applicant being permitted to proceed with development "at the capacity and configuration" for which it was approved was also removed. Why the Department removed such language is unclear. This should be clarified.	Anita Allen, Vice President, Ohio Provider Resource Association	Paragraph (D)(2) has been revised as indicated: An applicant who has obtained approval for a development proposal shall be permitted to proceed with development ~~as proposed and for which approval has been granted as of the effective date of this rule~~ in accordance with the terms of the approval granted by the department. Your concerns about "configuration" were addressed by earlier revisions to paragraphs (D)(5) and (D)(6) that "grandfather" facilities on adjoining property sites and facilities with more than one distinct and separate physical structure licensed on the same property site.
5123:2-3-08 (D)(3): indicates that an "intermediate care facility (ICF) shall not exceed six unless the department determines, based upon documentation provided by the operator, that the ICF requires a greater capacity to be financially viable…" Can you define/clarify what is needed to make the determination of financially viability?	Debbie Leibig and Carol Slight, Value and Faith Alliance	The Department will be developing, with input from stakeholders, guidelines for what documentation will be required.

Comment	By Whom	DODD's Response
5123:2-3-08 (E): There are numerous physical environment standards that should be moved to 5123:2-3-02 so they are all in one location. "Feasibility Requirements" have been added. These "feasibility requirements" are just all of the construction and building requirements for licensure under 5123:2-3-10 (B)(1) through (B)(7), one fire safety requirement under 5123:2-3-11 (C)(3) (requiring two means of exit), two (out of the 8) of the interior and exterior physical condition requirements under 5123:2-3-10 (E)(2), and three other building requirements under 5123:2-3-10 (H) through (J). Also added were space and usage licensure requirements and requirements for kitchen and dining and bathroom and laundry under 5123:2-3-10 (D). So, although a large part of the physical environment requirements in 5123:2-3-10 are present in the draft rule, they are not all included. We ask that the Department explain why some are included and not others. The requirement in (E)(1) (first of the "Feasibility Requirements") is new language not present in any current rule. It requires the interior and exterior of the facility to be configured in a manner that is (a) accessible to residents, (b) can accommodate the assessed needs and degree of ability of the residents, and (c) provides for service delivery that is age-appropriate. There are no definitions as to what these requirements mean. Please clarify. **5123:2-3-08 (E) & (F):** Why are the licensure requirements in sections (E) and (F) included in the development rule? They are not referenced in the standards/what the Department should consider in reviewing development proposals in Section (G). How are they going to be used? Sanctions for violations of these licensure requirements (like suspension of admissions or licensure revocation) give providers Chapter 119 appeal rights under 5123:2-3-02, but the process to waive requirements under the development rule does not afford providers a Chapter 119 hearing. This is troubling and needs further explanation. 5123:2-3-08 (J) provides that the provisions of this rule may be waived pursuant to 5123:2-3-10 (which is predominantly unchanged from the old 5123:2-3-15); this rule offers no due process rights whatsoever as the Director's decision to grant or deny the waiver is final and not appealable. Please explain the change.	Anita Allen, Vice President, Ohio Provider Resource Association	The standards in proposed new rule 5123:2-3-08 (*Development of Licensed Residential Beds*) address conditions that are not likely to change (e.g., the square footage of the facility). The standards are in the Development rule because licensees building new facilities need to be aware of the requirements. We included things we thought were particularly important. Because these standards are straightforward and simple to achieve, it seems unlikely a waiver would be requested or granted. As is currently the case, the Department's decision about waiving requirements for development of licensed residential beds is not subject to appeal. If in operation, a residential facility is cited for not complying with the standards, the licensee would have appeal rights. Requirements addressed in proposed new rule 5123:2-3-02 (*Physical Environment Standards, Fire Safety, and Emergency Response Planning*) are more likely to change after the development phase and therefore, are components of ongoing compliance reviews.
5123:2-3-08 (F)(4)(a): The bathroom and laundry requirement in (F)(4)(a) requires that the facility provide for toilet and bathing facilities at a minimum of 1:4. It cites 5123:2-3-10 (D)(4) as the basis for this requirement. However, 5123:2-3-10 (D)(4) does not require the 1:4 ratio, only that they be appropriate in number, size and design to meet the needs of the individuals and on each floor with bedrooms. Please explain why this is included.	Anita Allen, Vice President, Ohio Provider Resource Association	The parenthetical references in the draft rules you reviewed were included to help you track the source of a provision or concept. You are correct; existing rule 5123:2-3-10 (*Physical Environment Requirements*) does not specify a ratio. The Residential Facility Rules Workgroup arrived at the 1:4 ratio after discussion at multiple meetings.

Comment	By Whom	DODD's Response
5123:2-3-08 (I)(4) & (I)(5): Provides a person/government agency shall apply for a license (after obtaining development approval or placing a licensed bed on hold for future development) "in a manner prescribed by the department." Language in the current rule provides that licensure can be applied for in accordance with 5123:2-3-02 (regarding licensure application). Why was this language changed? Is the Department going to change the licensure process? This gives the Department broad discretion and is an unknown that should be clarified.	Anita Allen, Vice President, Ohio Provider Resource Association	The words in these paragraphs are based on provisions of existing rules. Paragraph (F)(1) of existing rule 5123:2-3-02 (*Licensure Application, Issuance, Survey, Renewal, and Sanction Procedures*) sets forth that: Following development approval in accordance with rule 5123:2-16-01 [now 5123:2-3-26] of the Administrative Code, each person or government agency who wishes to operate a residential facility shall submit an application for a license, on forms prescribed by the department, to the licensure office not less than thirty days prior to the date of the planned opening of the facility. Most of the existing Chapter 5123:2-3 rules went into effect nearly a decade ago. The Department is merely streamlining rules and updating them to reflect established processes, not changing the licensure process.
5123:2-2-07 (E): Who is responsible to conduct the assessment? We would like to see the team be responsible as opposed to the Service and Support Administrator (SSA). We would also like to have a standardized assessment tool. We would also like language indicating how long an SSA, team, etc. could take to approve an expenditure request to insure things are taken care of in a timely manner. The language "shall be identified in the individual plan" is counter to Imagine and other person-centered planning processes that have removed this type of language from individual service plans.	Anita Allen, Vice President, Ohio Provider Resource Association	In an Intermediate Care Facility (ICF), the Qualified Intellectual Disability Professional is responsible for coordinating assessments. In a non-ICF residential facility, the SSA is responsible for coordinating assessments. We invite OPRA and other interested groups to develop a standard tool. The requirements set forth in this rule apply only to individuals who have been assessed to need assistance with managing their personal funds. Specifically in paragraph (E), the rule requires that when the individual has been assessed to need assistance with managing personal funds, the parameters of that service be identified in the plan. This is not counter to Imagine. If the responsibility of handling an individual's personal funds needs to be assigned to another entity (e.g., the provider), this service would be important for the individual and should be addressed in the plan.
5123:2-2-07 (G): Who decides what is covered by Medicaid or other payer source? Clarification is necessary because providers are sometimes told "it's in your rate," when in fact, it is not.	Anita Allen, Vice President, Ohio Provider Resource Association	Medicaid requirements stand on their own.
5123:2-2-07 (H): This needs additional clarifying language. There are times when a provider covers costs (groceries, utilities, etc.) and is later reimbursed by the individual. Sometimes these situations are such that payment needs made immediately and cannot wait for prior authorization.	Anita Allen, Vice President, Ohio Provider Resource Association	We expect communication between the provider and other members of the team would resolve emergency situations and then the plan would be revised to reflect the resolution.
5123:2-2-07 (J): When the individual has a payee, they are not permitted to establish their own account.	Anita Allen, Vice President, Ohio Provider Resource Association	You are correct; hence use of the word "may" in this paragraph which mirrors paragraph (J) of existing rule 5123:2-3-14 (*Personal Funds of the Individual*).
5123:2-2-07 (L): This provision [a receipt when the provider gives fund to the individual or guardian] may be difficult to comply with. Sometimes guardians are non-responsive and do not comply with rules. We want to insure that providers are not held liable for guardian actions.	Anita Allen, Vice President, Ohio Provider Resource Association	This requirement is in paragraph (L) of existing rule 5123:2-3-14 (*Personal Funds of the Individual*) and offers an alternative for situations when receipts cannot be obtained.

Comment	By Whom	DODD's Response
5123:2-2-07 (N): This rule is silent on money management being billed as a Homemaker/Personal Care (HPC) service. Language needs included which specifies the differences between Representative Payee duties and HPC money management and how each can be paid for. HPC can pay for Rep Payee services, so other funding sources can be accessed for this, counter to the rule language. The Social Security Administration will not pay for services outside of their guidelines, however.	Anita Allen, Vice President, Ohio Provider Resource Association	Paragraph (N) sets forth that the provider may not request reimbursement from any other funding source for providing ***payee*** services. If the provider is performing payee services as defined by the Social Security Administration, the provider may not bill HPC. If the provider performs duties outside of payee services that meet the definition of HPC, the provider may bill HPC. We recognize the need for, and will develop, training on this topic.
5123:2-2-07 (P)(1)(b): The form 09405 can be accessed on ODM's website. You might want to mention this. In addition, Social Security funds need to be returned to the Social Security Administration.	Anita Allen, Vice President, Ohio Provider Resource Association	We corrected the revision date of form 09405 from "July 2005" to "July 2014" and added a link. Please note that form 09405 is out of date; the referenced instructions on the form apply only to Intermediate Care Facilities licensed by the Ohio Department of Health (of which there are none). Paragraph (N) of proposed new rule 5123:2-2-07 sets forth that when the provider is a payee the provider must follow all requirements set forth by the Social Security Administration.
5123:2-2-07 (P)(1)(a), (P)(1)(b), & (P)(1)(c): The rule allows a responsible entity to request the individual's personal funds upon death if they submit a written request within 90 days, otherwise the provider must send the funds along with the ODJFS form 09405 to the Medicaid Estate Recovery Program. The actual form 09405 (revised in July, 2014) says "furthermore, according to this form, the responsible entity (if applicable) has 60 days to request the funds, otherwise the remaining funds after funeral and unpaid expenses must be paid to the Medicaid Estate Recovery Program no later than 90 days after the date of death." I have attached the form for your reference.	Debbie Leibig and Carol Slight, Value and Faith Alliance	
5123:2-2-07: We have requested on numerous occasions that this rule speak to a standardized audit process/protocol so that everyone is aware of the expectations and standards of practice. We again request inclusion of these provisions and do not consider this rule completed until such language added.	Anita Allen, Vice President, Ohio Provider Resource Association	If you are addressing paragraph (Q): The department, or at the department's discretion a county board, may conduct an audit of the individual's funds. Members of the Residential Facility Rules Workgroup agreed to this wording once it was clear the paragraph was addressing auditing the individual's funds, not auditing the provider.
Rules Generally: The revisions made after our February 11th meeting are reflective of our discussions. Glad to see that these rules are ready to disseminate and move forward.	Marilyn Weber, Ohio Health Care Association	We appreciate your commitment to developing and reviewing these rules.