ANCOR
American Network of Community Options and Resources

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May 26, 1995

The Honorable Albert Gore, Jr.
Vice President of the United States
Old Executive Office Building
17th Street and Pennsylvania Avenue, N.W.
Washington, D.C. 20500

DIANA

Dear Vice President Gore:

The American Network of Community Options and Resources (ANCOR) congratulates your efforts in regards to the "reinventing government" initiative. ANCOR is also very enthusiastic about President Clinton's announcement in late February that the Administration would conduct a page-by-page review of regulations. With both of these endeavors in mind, ANCOR is forwarding the attached information to help with the regulatory review and streamlining government initiatives.

ANCOR is a nationwide association with over twenty-five years of proven leadership representing private, nonprofit, for-profit and family care agencies that together provide support and services to people with mental retardation and other disabilities. Currently, ANCOR represents more than 650 providers who provide supports to over 50,000 people with disabilities. Most member agencies support people in group homes, apartments and other supported living arrangements in the community.

ANCOR supports the Federal Government's role in assuring that people with disabilities do not experience abuse, neglect or unsafe conditions. As industry leaders in the field of disabilities and as members of the small business community, ANCOR also believes that by aggressively pursuing cost effective, efficient services with regulatory reform, financial resources can be redirected to the people who need them, reducing the harmful effects of budget constraints. ANCOR, therefore, supports substantial reform which simplifies or eliminates redundant, outdated, unfunded, and micro-managed federal regulations, standards, and mandates which contribute to the cost of services and not to the quality of life of people with disabilities.

ANCOR established a "Regulatory Work Group" in mid-March to solicit input from the entire membership. In early May, the group convened for two days in Washington, D.C. to collate the data and develop comments on specific regulations. ANCOR hopes that the attached contribution, and any others to follow, will aid you and members of the Administration in carrying out the important objectives of the second phase of "reinventing government."

If there are any questions regarding the enclosed, I would be happy to work with your designees.

Sincerely,

Joanne Fritz

Joanne Fritz
Executive Director

cc: Carol Rasco, Assistant to the President for Domestic Policy
Robert Stone, Director, National Performance Review

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY RECOMMENDATIONS

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AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY REFORM RECOMMENDATIONS

42 CFR PART 483
Intermediate Care Facilities for People with Mental Retardation (ICFs/MR):

For some years, the American Network of Community Options and Resources has been urging the Health Care Financing Administration to revise the federal rules which govern intermediate care facilities for people with mental retardation and related conditions (ICFs/MR). The most lengthy discussion was mailed in July 1994, in response to a request for comments on a revised ICF/MR survey process. In that letter, **ANCOR urged HCFA to proceed as quickly as possible with plans that would lead to a total revision of these rules. The language—and even some of the concepts (e.g., developmental programming) which formed the base on which the ICF/MR rules were developed in the early 1980s—are dated, we argued, and require total rewriting.** HCFA is to be congratulated for the steps it has taken since that time to revise the ICF/MR rules and survey process, but more should be done.

New approach to federal rules being studied

HCFA has funded a project being conducted by the Human Services Research Institute in Massachusetts which should provide the basis for a major reconfiguration of the Medicaid quality assurance process that will be in keeping with contemporary practices of human service development and support. This would also be consistent with the HCFA Strategic Plan, which is based on principles of Total Quality management and attention to the customer first, but involving all stakeholders, including providers. Frankly, change is occurring so rapidly in Washington that we fear that the ICF/MR program will be abandoned before a significant modification of the rules can take place, and much of that initiative is based on outmoded rules which have become burdensome and are not cost-effective. Abandonment of the program would be unfortunate.

The effectiveness of current service methodologies has been clearly demonstrated by the individuals with severe disabilities who, over the past several years, have moved directly from large institutions to individualized living arrangements in the community under the Medicaid waiver program for Home and Community-based Services (HCS). Outcome measures have been developed in the last few years by The Accreditation Council on Services for People with Disabilities and other entities in the states. In light of the time constraints, it might be wise for HCFA to develop a field test of existing outcome standards in ICFs/MR in one or more states.

New survey protocol being field tested

We know that HCFA is field testing a new survey protocol which we hope will significantly reduce the amount of time spent in surveying good facilities, and which would speed the survey process. When it is put in place, we hope that it will result in cost savings and more consistency in the survey process while rules are being rewritten. One ANCOR member reported that 5 surveyors spent 4 days in an ICF/MR for 4 people which had no record of *ever* having a deficiency. That is a ridiculous waste of time and resources! Until the survey protocol can be formally changed, HCFA should issue instructions to surveyors to counteract the way surveys have recently been conducted. Surveyors have told ANCOR members that their new (and

inappropriate) attention to paper and process is a result of instructions from headquarters in Baltimore. A member has also been told that surveyors have been instructed to "stop giving positive feedback during exit interviews." Customers and stakeholders are not being treated with respect.

ANCOR is not sure where these messages actually originated, but we urge that they be countermanded to improve the process and the relationships with providers. We suspect that the difficulty in transmitting messages from headquarters to surveyors is caused at least in part by the way the agency is organized, with regional offices placed between headquarters in Baltimore and the area offices. It seems to be difficult for messages to get directly from Baltimore to the state surveyors.

Interim action to improve surveys

ANCOR suggests, in addition, that HCFA speed up its effort to revise the ICF/MR rules by looking at the data collected on its surveys and dropping rules that are not resulting in citations. The absence of citations is evidence either of broad compliance in the field or the effect of other state and local surveys (e.g., state licensing and fire marshal surveys) to which ICFs/MR are subjected each year. The federal government should also consider accepting results of surveys conducted by other entities. At the present time, surveys are conducted at ICFs/MR several times a year by other groups. In some states there are more than a dozen entities which visit ICFs/MR each year. If these cover areas included in the ICF/MR surveys and in areas that the data show are in broad general compliance in a state, HCFA could deem agencies which had passed those surveys to be in compliance in the applicable areas of the ICF/MR rules.

State and surveyor issues

It is important to note that while states complain about the excessive restrictiveness of federal rules, they compound the problem by developing additional rules of their own to assure that providers will comply with the state's understanding of the federal regulations. In Maine, for example, there are xxx pages of state rules to supplement less than 10 full pages of federal ICF/MR rules. In addition, HCFA has about 140 pages of Interpretive Guidelines to supplement its own rules. Frequently, statements in the interpretive guidance or "probes" are treated like rules, all of which results in a burdensome system.

A further issue relates to the blame states sometimes lay at the feet of the federal government when surveyors indicate that requirements which the state has promulgated are instead federal requirements over which they ostensibly have no control. This occurs far too frequently to be easily dismissed.

Surveyors sometimes also cite things that are not within their purview, or which make no sense. For example, one member agency was cited for a wire hanging out of a wall outlet with wires exposed. It was a phone wire that was not being used at the time. Others have received citations for "wet paint," and another because studs in a room were not covered during a reconstruction process. Surveys which are conducted during meal time will reveal food particles in the kitchen

and dining area which will be cleaned up after the meal. Homes are cited for scrapes on walls and nicks in furniture caused by wheelchairs. These are unavoidable! In one case a home was cited for improper snow removal on the sidewalk. It was the home's only deficiency, but the survey team came back in May to see if this deficiency had been corrected. These examples go on and on! Sometimes it seems as though little common sense is used in the process.

ANCOR HAS THE FOLLOWING COMMENTS TO OFFER REGARDING SPECIFIC ICF/MR STANDARDS WHICH ARE FOUND TO BE BURDENSOME AND HAVE LITTLE RELATIONSHIP TO THE QUALITY OF SERVICES PROVIDED IN A HOME. Some of these represent the need for regulatory change, but others could be achieved through modifications in the survey process and/or surveyor training.

It must be noted that some of the regulations are used as "catch-alls" with a variety of deficiencies assigned to them. This results in different violations causing the same tag number to be out of compliance over several consecutive surveys, which in turn can bring a fine even though earlier problems have been corrected. For example, one of our members was recently fined $400 because his agency was cited under staff training three years in a row for entirely different problems.

W119 - 483.410(d)(3) - The [ICF/MR] must assure that outside services meet the needs of each [of the people they serve]. This is an unreasonable expectation in today's service delivery system when residential and day programs are operated by different agencies and the ICF/MR has no control over the daytime program. One member agency was required to develop a procedure check list for school lunch time and to send a staff person to the school (despite the fact that we understand public schools have been exempted from this requirement) and other daytime programs to monitor their teaching/programs.

An alternative method should be devised to hold daytime and other outside programs directly responsible for complying with federal rules. If not administered by the ICF/MR, and if no alternatives are available, the facility has no control over problems identified with the quality of outside services, particularly when these are medical services. It is difficult to find medical specialists who will accept a person whose services are paid for by Medicaid and it is unrealistic to expect the ICF/MR to exert control over medical providers with whom they contract for services.

Citations under this tag number result in paperwork which seldom leads to a change in the quality of services. ICF/MR providers should not be held responsible for citations in program areas over which they have no control. The exception for educational programs operated by public schools should be extended to other daytime programs, and these programs should be surveyed separately. It is not productive to threaten a contractor with termination of the provider agreement if there are no alternatives available, and the ICF/MR provider can do little else.

W128 - 483.420(a)(6) - Ensure that [the people who live in an ICF/MR] are free from unnecessary drugs and physical restraints. Many citations under this regulation have nothing to do with ensuring that the purpose of the rule is achieved. Examples of "unnecessary drugs" have included Advil, Oscal and over-the-counter vitamins—and these are not aberrations. This

application of the rule has nothing to do with ensuring that people are free from unnecessary drugs or restraints.

W130 - 483.420(a)(7) - [The ICF/MR must] provide each [of the people living in the home] with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs. The survey process itself frequently violates this regulation when surveyors insist upon observing toileting and other personal hygiene activities, often inappropriately. Such observations should be required only when there is some evidence that an individual is being physically injured by a staff person or by equipment used to help in toileting or bathing.

A member was cited when one of the people who lived in the ICF/MR was observed walking from his bedroom to the bathroom with his robe open. There was no staff person present to prompt that person to close his robe, so the agency was cited.

Some members have been ordered to install privacy curtains in bedrooms for more than one person, even for children. This makes bedrooms far more institutional in appearance. In one of those wonderful Catch 22 situations, one of ANCOR's members was cited because privacy curtains did not meet this ICF/MR regulation. Later a fire marshal cited the facility because the life safety requirement calls for mesh curtains.

W136 - 483.420(a)(11) - Ensure [that the people who live in the ICF/MR have] the opportunity to participate in social, religious, and community group activities. This rule is not adequately funded in some states. For example, one ANCOR member estimates that adequate implementation of this standard would cost his agency an additional $8.63 per day for each individual served, for a total of $274,468 per year. That agency looked at staffing, administration, training and transportation costs; and at the staffing level necessary for all of the people they support.

W157 - 483.420(d)(4) - which requires that **appropriate corrective action be taken when allegations of abuse are verified** is difficult to enforce when a parent is responsible for using punishment that exceeds that which a facility is permitted to use.

W159 - 483.430(a) - Each [person's] active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. The effect of citations under this tag number result in forcing the QMRPs to spend more time addressing paperwork to be certain that records document "coordination and monitoring." This has a paradoxical effect in that the QMRPs are spending *less* time actually involved with the people who receive services facilitating the integration, coordination and monitoring of supports. To focus on outcomes, interactions should be observed to determine whether people are receiving integrated, coordinated supports.

To provide some examples of citations which have occurred under this rule which resulted in increasing the amount of time spent in record keeping: (1) "John will lift his cup and drink from it" is an inadequate statement because it contains two behavioral statements. Why should the focus be on the paper rather than observing John to see if he is using a cup correctly? (2) A

provider was told that tooth brushing should be broken down into 35 separate steps. It is interesting that this represents more than one for each tooth. The paperwork, including data collection, that results is costly and unnecessary. The field has moved well beyond this type of programming.

W164 - 483.430(b)(1) - Each [person served] must receive the professional program services needed to implement the active treatment program defined by each [person's] individual program plan. If staff can perform the necessary treatments/services, it should not be necessary for a professional to be involved in the hands-on delivery of those services. This regulation should not be cited unless the program is not being implemented appropriately. As it is, citations under this standard are often nitpicking and costly to correct. This is an example of a situation where "guidance to surveyors" is sometimes treated like a rule. However, on the other hand, the guidance that surveyors are to "determine if the facility's delivery of professional services is adequate by they extent to which individuals' needs are aggressively and competently addressed," (emphasis ours) is not well followed. Here we have a case where the Interpretive Guideline is ignored in some instances and over-enforced as a rule in others. One ANCOR member was found to be out of compliance under the definition of the program plan section of this tag number when a program addressing verbal and physical aggression did not include a written definition of these two terms.

W167 - 483.430(b)(2) - The facility must have available enough qualified professional staff. . . is used to enforce paper requirements, while outcomes for the people receiving services are ignored.

W168 - 483.430(b)(3) - Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process. The needs and choices of individuals, rather than the process, should determine which staff should attend IDT meetings. This issue is addressed in some consent decrees which indicate that it is sometimes appropriate to meet with one person, which would violate this rule.

W169 - 483.430(b)(4) - Professional program staff must participate in on-going staff development and training . . . People other than the QMRP have the ability to train staff. The types and number of staff should be determined by the needs of the people served, but this rule is used in some surveys to require an ICF/MR to have contracts with professionals of each of the listed types.

W181 - 483.430(b)(5)(xi) - indicates that: **"If the [person's] individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5)(I) through (x) of this section are not required,"** but is usually ignored. If outcomes were the focus of surveys, there would be fewer citations of (I) through (x). However, these have become a mandate for agreements with an array of professionals, many of whom never see any of the people living in the ICF/MR. Surveyors often are required to prove that professional licenses of those with whom the ICF/MR has contracts have not expired.

W186 -483.430(d)(1) - The facility must provide sufficient direct care staff . . . Has been cited when: one of the people living in a home ate with her face too close to her plate, an individual stood up while spooning food onto her plate instead of remaining seated at the dinner table, and an individual with a program to use a napkin did not receive the full benefit of that program since staff failed to "model" how to use a napkin. In yet another instance, an agency was cited because not all of the people living in a home participated in setting the diner table. It is unusual for everyone to participate in setting the table in an ICF/MR or in a typical family home. Generally one person is given this task, and the task may rotate from person to person.

W190 - 483.430(e)(2) Staff Training - is one of the "catch-all standards" mentioned above. In one case a series of citations began with this one: the ICF/MR was first cited with a deficiency under this tag number because staff were pouring milk into glasses because it was believed that the gallon milk jugs were too heavy and did not have handles that were appropriate for the people living in that home to use. To correct this deficiency, the ICF/MR purchased small pitchers with wide handles so the people living in the home could pour their own milk. During the resurvey, the agency was cited under a sanitation tag for pouring the milk out of its original container into the pitchers! The resulting correction was to purchase milk in smaller containers— which is less cost-effective.

In another case, an agency was cited because one of the people living in the ICF/MR used a fork rather than a spoon to eat meat. This individual had a history of using no utensils and training was in place to address this. (This is a case where the paperwork was not reviewed by the surveyors when it should have been.) To address this citation, the agency hired another staff person to continually observe this individual at mealtimes—a costly response to the citation! A year later, the home was cited under the same tag number because the same individual ate bacon with a fork. According to the surveyor, the individual should have been directed to eat the bacon with his fingers since it was "crisp" bacon! The program called for the person to use appropriate utensils, and to later re-introduce finger foods. Again the paperwork was ignored when it should have been referenced to verify the plan before a citation was given.

ANCOR members routinely report that surveyors have a minimal understanding of people who experience challenging behaviors and how active treatment programs for these people are designed. Homes are frequently cited under this tag for incidents where the people who live in a home behave differently, even if no harmful outcomes occur. The survey protocol itself, with 3 or 4 surveyors in a home for 4 to 10 people can affect behavior, but this is seldom acknowledged by surveyors.

Another small ICFs/MR was cited under this tag number because three of the people who live in a home are on special diets and they were served pre-dished foods and pre-poured liquids rather than serving all food at the table family style.

Sometimes cultural and geographic norms are ignored by surveyors. For example, a home in Arkansas received a citation because a staff person called one of the people who lives in the home "Sweetie." This employee addresses the administrator of the home the same way. While this may

not be normative in some areas, it is pretty typical in the South and has nothing to do with whether a person is disabled or not.

Direct staff become discouraged when such incidents are cited. Some of the frustration which follows surveys undoubtedly increases the high turnover rate experienced in many ICFs/MR.

W196 - Active Treatment standard - This is another of those "catch-all" standards. Dr. Wayne Smith, the HCFA author of these rules, has defined active treatment like "good parenting." It is often taken far beyond that concept, however. Some surveyors imply that interventions should occur at frequent intervals, whether inappropriate behavior is occurring or not. For example: one home was cited because one of the people who lives in the home sat watching television for 20 minutes without attention from staff. In this case, it is the outcome which should have been judged (e.g., was the individual enjoying the program and watching without engaging in any inappropriate behavior?). People with developmental disabilities need time to relax and enjoy leisure activities without the need for intervention, just as the rest of us do. It is when they sit staring into space because they do not know how to use free time that a citation should occur. Sometimes, however, people will sit doing nothing for short periods. Some surveyors say that these should be no longer than 5-minute periods. That seems an unrealistic short period of time.

Some providers believe that the over implementation of this standard actually leads to in increase in negative behaviors due to the requirement for "continuous" active treatment. This is one of the most subjectively defined, misinterpreted and costly rules to implement.

W198,W199 & W200 - 483.440(b) - Admissions, transfers and discharge - leads to a review of whether the people served need active treatment. One member agency was cited for permitting the admission of an 18-year old who had lived with his family and attended public school before moving to the ICF/MR. The implication is that if you attend public school, you don't need ICF/MR support later in life. Federal education law encourages mainstreaming all students, no matter how severely disabled. People can go to public school, living at home, and still require active treatment in adulthood.

W201- 483.440(b)(4)(I) - Have documentation in the [person's] record that [he or she] was transferred or discharged for good cause. While this rule in itself is appropriate, it is applied when an individual moves to another ICF/MR operated by the same agency.

W205 - 483.440(b)(4)(ii) - the requirement for a post-discharge plan of care is unrealistic when it is accompanied by an expectation that there will be follow up to assure that it is implemented. ICFs/MR have little opportunity to maintain contact with people who are discharged, nor should they be responsible for assuring that a post-discharge plan is implemented when they are not paid for doing so.

W210 - 483.440(c)(3) which requires **"accurate assessments or reassessments as needed"** was originally surveyed only for need, but as time passes, there is more and more pressure—accompanied by more citations—to do complete evaluations in all professional areas identified in W216 through W225. Most of the problems with these tag numbers are caused by surveyor

misinterpretation of the rule and requiring excessive assessment.

W214 - 483-440(c)(3)(iii) - Identify the [person's] specific developmental and behavioral management needs - The detail expected results in the QMRP spending time planning the precise wording of the strengths and needs lists which could better be spent in planning for the individual. Examples of citations include: "Needs are expressed in global, imprecise terms and phrases which do not clearly communicate what the individual cannot do;" "client has needs which include 'increasing auditory skills,' 'improving toileting skills,' 'improve grooming skills.'" The IDT members are aware the specifics of these needs and develop goals and programs accordingly. More specific definitions and listing of what the individual cannot do is not necessary. Doing this tends to focus attention on tasks in which people have the fewest skills, rather that maximizing progress in areas of ability and interest.

W229 - 483.440(c)(4)(I), which requires that active treatment: **"[b]e stated separately, in terms of a single behavioral outcome,"** is being cited inappropriately in many current surveys, and with no relationship to outcomes. For example, one member agency was informed that the objective "pick up the cup and drink" was a double objective and should be stated as two separate objectives. The examples of citations provided for Tag number W159 were also cited under this rule. Surveyors focus on task analyses instead of teaching ways to support a person to engage in choice and activities that are meaningful to him/her which will enhance self-dependence.

W230 - 483.440(c)(4)(ii) requires the assignment of **projected completion dates,** which often has no relationship to outcomes, and nothing to do with health and safety of individuals. QMRPs and typists spend time each month writing, proofing and refiling amendments to the IP document just to update the expected completion dates. One agency has estimated that this could add as many as 60 hours per caseload per year.

W234 - 483.440(C)(5)(I) - Each written training program designed to implement the objectives in the individual program plan must specify **the methods to be used** - requires such specificity that staff attend more to the paperwork than to those who receive supports. Examples of citations include: (1) "The client is to turn his/her head with physical prompts when the staff calls his/her name. Methodology does not define physical prompts. It only states prompts and physical assistance." (2) "Client has a program . . . to wash his chest area with physical prompts when the wash cloth is placed inside of his left hand. Methodology does not define physical prompt. It only states to provide prompts to the left hand as needed." Citations such as these lead to the QMRP writing goals in greater detail than most staff probably bother to read, and to the QMRPs spending a lot of time agonizing over written detail when their time would be better spent training and observing the goal implementation and the individual's progress.

W237 - 483.440(c)(5)(iv), which requires **data collection,** is an outmoded special education concept that is often irrelevant and time consuming, with no productive outcomes for the people receiving services. This rule has become an end in and of itself. It contradicts person-centeredness and can involve an inordinate amount of a QMRP's time, reducing direct contact with the people who receive supports and/or it is used as an excuse to avoid doing things with people to focus on paper. It is possible to document how a person is progressing in non-data laden ways. Task

analysis can be undertaken without measuring outcomes. Observation of an individual performing a task would provide a more accurate assessment of progress.

W242 - 483.440(c)(6)(iii) - Include, for those clients who lack them, training in personal skills essential for privacy and independence . . . is often over-interpreted by surveyors. There is also disagreement over how many skills can or should be addressed at one point in an individual's life. One surveyor insists that toileting can be broken down into 35 separate steps. He also refused to consider the incorporation of programs throughout the day during appropriate activities as adequate. He has stated that goals should be stated formally with data collection and monitoring by a professional.

W252 - 483.440(e)(1) - Data . . . must be documented in measurable terms is an outmoded special education concept, which results in penalizing staff for person-centered assistance. For example, if a person is clean and well-kept and wants to learn to brush his teeth, it should not be necessary to reduce this procedure to its individual steps and then record completion of those steps. When this is done, more time is spent in documentation than in training and observing behaviors. If one staff person works with three people over an eight-hour shift, a total of one hour can be spent by staff to record the outcome of the specific objectives, by the supervisor to check to book to see if the goals were documented properly, and by the QMRP to observe behavior to see if the task was performed exactly as the program was written. The usefulness of the information gathered is questionable. With a caseload of 8 people, an experienced QMRP spends about one third of his or her time in writing, reviewing and amending the plans which are not an accurate or likely indicator of active treatment services.

One member states: "We have storage boxes full of old yellow records that give up such valuable gems of information as, 'on May 17, 1988, [a person served] needed hand-over-hand assistance to brush his teeth.'"

W311- 483.450(e)(2) - Drugs used for control of inappropriate behavior must be approved by the interdisciplinary team. Conflicts arise when the professional opinion of the physician who prescribes a drug is questioned by the IDT. This can be a real issue in rural areas where

there are few physicians, particularly those willing to accept people whose services are paid by Medicaid.

W312 - 483.450(e)(2) - Drugs used for control of inappropriate behavior must be used only as an integral part of the [individual's] program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This is an example of a situation where the "probes" are applied as though they were regulations, and contain more specificity than does the interpretive guidance.

W313 - 483.4450(e)(3) - which requires that drugs used for control of inappropriate behavior . . . not be used until it can be justified that the harmful effects of the behavior clearly outweigh[s] the potentially harmful effects of the drugs is over stated. This rule should be outcome based. If the drug is prescribed by the physician and approved by the IDT, if it is

working, the person is not lethargic and behaviors are improving, it should not be cited.

W316 - 483.450(e)(4)(ii) - which requires that drugs used for control of inappropriate behavior must be **[g]radually withdrawn at least annually,** raises problems when a drug used to control seizures is one also reduced behaviors. Providers have been told they had to have a behavioral program, appealed that citation and lost the appeal, and were inappropriately ordered to withdraw the drug. Drugs used for seizure control should be **reevaluated** annually, not withdrawn.

W336 - 483.460(c)(3) - requires that people who are certified as not needing a medical care plan have their **heath status reviewed** by a nurse in a direct physical examination **on a quarterly or more frequent basis.** This is a costly requirement and an example of one for which HCFA data should be examined. It is important to know if this tag number is cited because the quarterly exams have not been conducted, or if health difficulties have been identified because they have not been conducted. The annual physical examination conducted by the physician should be adequate, with additional exams by an RN or LPN based on individual need at the recommendation of the physician. In today's world, health care is being reorganized with less emphasis on RNs. In fact, physician's assistants can, in some states, conduct the routine examinations once done only by MDs. QMRPs monitor physical health and staff are trained in signs and symptoms of disease. The overall quality of the ICF/MR should also be taken into consideration before such examinations are routinely required. If violations of this rule are not resulting in health issues for those served, this rule should be dropped. Outcomes should prevail.

This is a costly rule to implement, with staff costs in addition to the professional fees.

W348-356 483.460(e) - Dental services - are often over-regulated. After the admitting exam, this should not be enforced for people who do not have teeth. The mouth can be examined by the physician during the annual physical examination, or by the RN, with referral to a dentist if a problem is identified. It must also be pointed out that most states don't pay for dental services, despite the standard. The cost of implementation can be $30 to $60 per person a year.

W362 - 483.460(j)(1) - requires a drug regimen review by **[a] pharmacist . . . at least quarterly.** The annual physician review should be adequate. Today's computerized systems automatically indicate if the medication regimen is a concern. The pharmacy, physician and nurse should develop procedures ordered by the physician and reviewed by the IDT.

W363 - 483.460(j)(2) - The pharmacist must report any irregularities in clients' drug regimens to the prescribing physical and the interdisciplinary team. This is another paper requirement which may be unnecessary in terms of notifying the IDT, which is time consuming. One of our members was cited for having four different kinds of milk (regular, skim, 1% and 2%) in the refrigerator of an ICF/MR. It was felt that this required a physician's order.

W383 - 483.460(1)(2) - The issue of medication administration by unlicensed people needs to be resolved by states. This is frequently raised by providers but it is not a federal issue.

W383 - 483.460(1)(2) - The issue of medication administration by unlicensed people needs to be resolved by states. This is frequently raised by providers but it is not a federal issue.

W405 - 483.460(n)(4) - requires that **[i]f the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved by the Medicare program.** It is inappropriate to require the ICF/MR to make such assurances. Instead, the referring lab should be required to show proof that it is dealing with another certified lab. The ICF/MR should not be held responsible, but the separate survey of the laboratory should used to identify violations of HCFA laboratory requirements.

W432 - 483.470(f)(1) requires **[n]onabrasive carpeting, if the area used by [people who live in the home] is carpeted and serves [people] who lie on the floor to ambulate with parts of their bodies, other than feet, touching the floor.** This regulation should be stated in terms of outcomes, (e.g., people will be free from avoidable abrasions) and it then would be up to the agency and staff to keep people free from abrasions. Is there such a thing as "non-abrasive carpeting?"

W454 - 483.470 - the infection control standard - requires that **[t]he facility must provide a sanitary environment to avoid sources and transmission of infections.** Unreasonable interpretations occur but provide good examples of how inappropriately this rule is applied. For example, one surveyor turned a toaster upside down and shook crumbs out on the counter, using that as an example of a potential source of infection. In others, citations have occurred . . .

One member agency was required to have an "Infection Control Chairperson" monitor meals weekly to observe and document incidence of face touching and hand cleansing.

If people are healthy and the ICF/MR meets normal standards of cleanliness, there should be no citation.

W461- 483.480(a)(4) - A qualified dietician must be employed either full-time, part-time, or on a consultant basis at the facility's discretion. The need for a dietician is less necessary than it once was since software programs have been designed to develop menus for both regular and special diets prescribed by physicians. These are, in fact, used by most dieticians to do menu planning. One ANCOR member was cited because individual documentation of nutritional intake was not in the dietician's reports. Agencies are paying about $1,000 per year; sometimes much more, to contract with a dietician.

W462 - 483.480(a)(1) - If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services. Plans should be reviewed annually and as they change. QMRP should be capable of reviewing the plan. Reviewing data not people.

W469 - 483.480(b)(1)(I) - prohibits the passage of **more than 14 hours between a substantial even meal and breakfast of the following day.** This regulation is inappropriate when enforced strictly. It restricts people who like to sleep late on the weekend from having a late breakfast, or

skipping breakfast if they rise just before lunch. **W470** and **W471** also do not permit enough flexibility.

W473 - 483.480(b)()(ii) - requires that food be served **[a]t appropriate temperature.** The regulation is appropriate but the probe is frequently treated like a rule and agencies are cited when food is served at anything that varies by as little as two degrees from 140 degrees. (One member was cited for serving a baked potato at a temperature of 137 degrees.) This is particularly ironic when one considers that water temperature is restricted to 110 degrees. People are therefore expected to eat food that is hotter than the water with which they wash their faces. The probe should be deleted.

W478 - 483.480(c)(1)(ii) requires the ICF/MR to **[p]rovide a variety of foods at each meal -** This rule is often interpreted unreasonably. For example, in a home for eight people, with six on special diets, the surveyor wanted choices presented for each person. In another, individualized salt and pepper shakers were required. There is a question as to what extent variety is required.

The rule does not assure quality and it is unnecessarily burdensome and costly to fully implement. Surveyors should instead determine if people are healthy. It is appropriate to observe a meal to see if people seem to be enjoying it.

Application of the NFPA Life Safety Code Depends upon fire marshal's interpretation. Agencies are now having to do things to older buildings that were not previously required and are confused regarding which are state issues and which relate to the ICF/MR rules.

42 CFR 456.1-456.614 - Inspection of Care & Utilization Reviews - These surveys are extraordinarily time consuming and costly. They are paper intensive, with every individual's record reviewed in great detail—at least in some states. Teams are required no matter how small the home and may spend days, weeks or months, depending on the size of the ICF/MR. Citations have been made for things such as the absence of a complete staff title; or the date on some document, the absence of which has no effect on outcomes for the people served.

ANCOR suggests that these be rolled into the regular ICF/MR survey, and that a random sample of the records be substituted for a review of each person's file. At a minimum, these should be focused on outcomes. Data should be kept regarding the number of inappropriate admissions that are found, with surveys targeted to the places where violations have occurred.

Additional general comments:

While most providers would agree that the 1988 standards improved the overall quality of services to persons with disabilities at the time they were implemented, they are quick to point out that much of the early flexibility and focus on outcomes that initially accompanied the new rules has been lost over time, and that compliance has come with a hefty price tag. Theories of service delivery have changed while the rules have not. "The last five years have been a time of deep and serious frustration over understanding the intent of the regulations and how to most effectively

implement them, the subjective nature of the surveys, the inconsistency between surveyors, the real and practical relevance of some of the regulations themselves and the skyrocketing costs which always follow each and every on-site visit from survey teams," one ANCOR member states.

The manner in which violations are sometimes cited can result in as many as 30 pages of deficiencies even when there are a few minor violations of the rules and there are no Conditions of Participation (CoPs) out of compliance. This results in a lengthy, time consuming (therefore costly) response as the ICF/MR has to address each statement individually, despite the fact that many relate to just one incident or relatively minor violation.

In addition, rather than labeling people with disabilities, as the rules are rewritten, we ask that HCFA drop the use of words like "client," or "consumer" throughout the standard and instead refer to "the people who live in an ICF/MR." This could be done immediately in new guidelines and surveyor reports.

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY REFORM RECOMMENDATIONS

Occupational Safety and Health Administration

Introduction

ANCOR members are deeply concerned about protecting the health and safety of its employees. Providing supports and services to people with disabilities in their own homes and apartments, in group homes, and intermediate care facilities for people with mental retardation (ICES/MR) is labor intensive. It would be counterproductive to be cavalier about employee health and safety issues or abandon the responsibility of protecting these employers' most valuable resources —human resources.

ANCOR members are increasingly finding that their agencies are subject (frequently only after an OSHA inspection, citation and fine), to a host of general health and safety standards for which the employer is unaware. Rather than a violation of flagrant disregard for health and safety issues, ANCOR members are faced with voluminous health and safety standards developed with no eye to the nature of business carried out by these human service agencies.

OSHA has become increasingly active in workplaces other than traditional manufacturing, construction, and maritime industries. This foray into new workplaces has not been with concomitant understanding of these new work environments, with the result that OSHA applies many of its standards across industries. **OSHA is not required to develop these standards based upon a cost-benefit analysis that determines the degree of risk involved and the cost of alleviating that risk in different industries. Neither has OSHA developed these standards consistent with industry-specific workplaces nor included industry-specific leaders from the various workplaces in the formulation of new standards**. So, for example, standards that apply to hospitals will be uniformly (and, laboring under misinformation or little information) applied equally to such different workplaces as those where employees provide supports and services in private homes where people with disabilities live.

New White House Approach

ANCOR is, therefore, encouraged by the recent White House announcement of a "whole new mind-set for OSHA." Without knowing any more details than those chronicled in the *Washington Post* on May 16, 1995, ANCOR is most receptive to the two White House goals explicit in the new OSHA "mind-set:" "increase the protection of worker health and safety, while decreasing red tape and paperwork."

The White House announcement of a new approach to workplace safety inspections that "focuses on the worst offenders while relying primarily on voluntary compliance with federal health and safety rules for much of the rest of the nation's employers" would be a much improved approach.

Not only have the regulations increased "red-tape," but the OSHA inspections have taken on a "ticket writing" approach with heavy fines to "fix"questionable "risks." OSHA needs to go beyond this to reduce burdensome requirements and red-tape where the risk does not warrant time-consuming, costly, and burdensome standards which are frequently interpreted in an impossibly strict manner.

Life Carries Some Degree of Risk

ANCOR members often find themselves in the untenable position of protecting employees from little or no real health or safety risk at the expense of their primary mission. ANCOR members have a responsibility to the people to whom they provide supports and services to live self-dependent, productive lives in the community. With a serious eye to the health and safety of employees, this primary charge regarding people with disabilities must not be undermined. Not only have employers questioned the aims of many of the OSHA standards when applied to the field of disabilities, but employees have questioned many of the underlying assumptions when regulations and inconsistent interpretative applications fly in the face of historic struggles by people with disabilities to achieve "normalized" living in the community.

Increasingly, the supports and services provided by ANCOR members are provided in homes that resemble the homes occupied by employees at OSHA, by members of Congress, and by all other Americans. Yet, many of OSHA's requirements are applied in a manner that is intrusive, restricts the choice of people with disabilities, and de-humanizes the necessarily sensitive relationship established between the person with a disability and the individual(s) that provide supports and services. In other words, the same standards and regulations are not applied to the homes of most Americans.

In addition, the voluminous standards and regulations subvert staff time and fiscal resources away from the delivery of quality supports and services to people with disabilities. In many cases, these standards force ANCOR members to guard against phantom health and safety risks and divert resources away from the primary customer—people with disabilities—without the means available to other employers to pass along the increased costs to their "customers." (The cost of doing business for most ANCOR members is directly tied to established federal and state allocations for supports and services.)

ANCOR members abide by a principle of "normalization" in supporting opportunities for people with disabilities to live and work and play within America's neighborhoods and communities. This principle includes the "dignity of risk." This means that living in the community and life in a free society carries some risk. While protecting America's workforce is a laudable goal, it is impossible to protect people from every conceivable risk that might raise some level of health or safety concern. Employees should have some responsibility for controlling the risks in their lives, based on informed choices.

Some degree of risk is inherent with any undertaking. None of us are free from risk—even walking to work could result in a serious accident or death. Increasingly, workplace violence has introduced a new risk to workers in such seemingly "non-risky" workplaces as McDonald's and the U.S. Post Office. And, as the nation has all too unfortunately experienced recently, even working in a federal office building can carry grave risk.

ANCOR recommends that OSHA approach work sites like those in which ANCOR member employees work with a common sense approach to the "risk" of occupational health and safety issues based upon the specific industry. This would include a knowledge about the industry's real employee duties and not an assumption based upon other industries, for example, hospitals and medical units.

Recommended Guiding Principles:

To this end, ANCOR offers several guiding principles to re-focus the efforts of OSHA:

•***OSHA should be a resource for business—not a government strong arm.*** Much more could be done to protect the real health and safety of America's employees if OSHA performed as the repository for information and functioned as the resource for "helping" employers achieve safe working environments, rather than working to find "fault" and preceding with a "gotcha" attitude, without regard to the intent and extent of employer efforts to provide a work environment that meets sensible health and safety protections.

•***OSHA should develop "outcome based" standards, providing employers with information needed to meet the outcome, but giving employers the flexibility to meet that outcome with whatever measures they deem necessary.*** If OSHA develops a standard that it states is "outcome based" and not prescriptive (for example, as with the bloodborne standard), then OSHA should provide employers with the information needed to meet the outcome envisioned by the agency. If OSHA can not provide clarity to employers regarding a specific risk in a standard, then the employer should be free to develop cost-effective abatement measures and not be penalized because a compliance officer's interpretation holds there to be a "better"—and often, unnecessarily more costly and less efficient—approach to take.

•***With a re-focused mission, OSHA could devote its resources to providing written materials and direct training to industry leaders and employers on industry specific health and safety issues.***

•***OSHA should focus on those industries with the worst health and safety records***; i.e., examine workers' compensation claims as a means to identify employers where employees are at genuine risk.

•***OSHA should develop the expertise, after consulting with recognized industry leaders and employees in each field, about what constitute major health and safety risks for that industry.***

In developing these standards, these industry leaders should "weigh" into the formula of what constitutes reasonable costs to ameliorate the identified risks.

•***OSHA inspections of employer sites within each specific industry, should then focus on those limited health and safety concerns identified for that industry that pose genuine risks.***

•***OSHA inspections should focus on voluntary compliance of employers to "fix" infractions when they are discovered.*** That is, agreement to participate in a plan to reduce the hazards, utilizing OSHA's expertise to address the health or safety *dangers*. **Citations and fines should only be used as a last resort when employers fail to develop a plan that meets with established "industry-wide" practices.**

•***The overall range of OSHA's fines should be reduced.*** Higher fines should only be levied in the absence of a good faith effort and flagrant disregard for genuine health and safety violations.

•***OSHA should eliminate penalties (fines) for "deficiencies" where employers have shown good faith efforts to comply with specific health and safety standards.*** For example, when employers have a hazard communications plan in place, have a bloodborne pathogens exposure plan, and have a general safety plan in place, OSHA inspections should focus on "ways to improve" the plan **when a genuine risk is discovered**—rather than looking for any and all possible "violations" and issuing a citation and fine for smaller, incremental components of a standard.

In addition to the above general comments, ANCOR is providing specific comments on two OSHA standards—***Hazard Communication*** and ***Bloodborne Pathogens***—and general comments on pending regulations—***Indoor Air Quality*** and ***Ergonomics.***

49 CFR Part 1910.1200
Hazard Communication Standard

In 1992, OSHA documented that there are an estimated *575,000* existing chemical products, and hundreds of new ones being introduced annually, that pose a serious problem for exposed workers. To combat the "seriousness" of safety and health problems as a result of exposure to chemicals, OSHA adopted a rule called "Hazard Communication." The "basic goal of the standard is to be sure employers and employees know about work hazards and how to protect themselves" in order "to reduce the incidence of chemical source illness and injury."

Under this standard, all chemical manufactures and importers must convey the hazard information they learn from their evaluations by means of labels on containers and material safety data sheets (MSDS). *In addition, all covered employers must have a hazard communication program to get this information to their employees through labels on containers, MSDSs, and training. The coverage of this standard extends to all industries.* OSHA makes no distinction as to size or "low hazard" industries.

The requirement to obtain and file MSDS forms and forward information and training to employees includes ***consumer products***—common household products that are used by all American households—under certain circumstances. OSHA determined that workers exposed to "hazardous chemicals" in consumer products are at a significant risk of experiencing adverse health effects and holds the employer responsible for an employee using the products in a manner not anticipated by the chemical manufacturer or using them in such a way that the exposures are more substantial (e.g., quantity used, frequency used, and usage over an extended period of time) than those consumers would normally experience.

Issue Consumer Household Product [(b)(6)(ix)]: OSHA exempts consumer products or hazardous substances as follows:

> Any consumer product or hazardous substances, as those terms are defined by the Consumer Product Safety Act (15 U.S.C. 2051 et seq.) and Federal Hazardous Substances Act (15 U.S.C. 1261 et seq.) respectively, *where the employer can show that it is used in the workplace for the purposed intended by the chemical manufacturer or importer of the product, and the use results in a duration and frequency of exposure which is not greater than the range of exposures that could reasonably be experienced by consumers when used for the purpose intend;* [Emphasis added.]

OSHA's MSDS requirement as defined above poses a significant problem for ANCOR member agencies. ANCOR work sites are not factories, foundries, nor manufacturing plants; rather individualized homes and apartments, group homes and other congregate living environments subject to numerous other federal regulations (see section on ICFs/MR) that provide living arrangements for people with disabilities in a "normalized" environment.

The household products are those common consumer products purchased off of grocery and

hardware shelves which are required by other regulations to print information about content and risks on the containers. They are used following the same instructions as those presented to other consumers and used in homes across the nation. The only difference is that the product *may* be used more often in a day with more than one application of a product because employees provide supports and services to more than one individual with a disability and in multiple workplaces.

Deodorants, Hair Shampoo, and Dove Soap?

Thus ANCOR members must keep MSDSs on such consumer household products as shaving cream, deodorants, salon hair shampoo, dishwashing liquids, laundry soaps and fabric softener, Windex, thinner for liquid paper correction fluid, and common household cleaners. Because many of these products come in varied forms—liquid or powder—multiple MSDS sheets must be maintained on the same product. Attached are lists submitted by three ANCOR member to serve as examples of the kinds of products for which MSDS sheets are kept on file. One list contains over 160 household products, each of which can be purchased at K-Mart or WalMart retailers or any grocery store. **[See OSHA Appendices A, B, and C.)**

These lists are comprised of household products that could be found in any home in America, including the White House, those of members of Congress, and employees of OSHA. Yet Americans who use these products in their own homes are not required to file MSDS forms or receive extensive training on their use. However, the homes of people with disabilities are not so equally treated. Because *paid* assistants use these products in conjunction with meeting personal assistance needs, performing routine household chores such as preparing meals and cleaning kitchens and bathrooms, or teaching people with disabilities who live in their homes to manage their own daily personal hygiene and households chores, extensive recordkeeping and training is required of ANCOR employers.

These same products are used daily in homes across the nation, but, according to OSHA, represent a hazard when the workplace is a home for people with disabilities. For example, because ANCOR member employees use a personal hygiene product with more than one person with a disability, or assist more than one person with a disability to use such a product each day (constituting greater frequency) or clean kitchen or dining rooms following each meal preparation or clean bathrooms daily to meet other quality control standards (constituting frequency and duration), the OSHA MSDS forms and training must ensue.

Given that these same household products are used by mainstream Americans in their own homes, contain required labels for proper use and instructions regarding risk when used, and considering that other consumers are not required to maintain MSDS forms or complete training when using these products, the OSHA standard places a heavy burden on the nation's employers of supports and services to people with disabilities not otherwise required by other consumers of these same products.

Cost

It is difficult to provide a typical cost base for complying with this standard. However, consider the follow examples from ANCOR members of costs associated with meeting OSHA's Hazard Communication standard:

1. Cost of training video = $1,000.
2. Employee training (320 employees at 1 hour of training away from direct staff duties computed at minimum wage per hour) = $1,500 annually.
3. Cost of purchasing agent time devoted to requesting, receiving, and routing MSDS sheets to multiple home sites (at 10% of $20,130 annual salary) = $2,013. Another ANCOR member reports that the agency has hired a health safety specialist who spends 25%-30% of work time on the MSDS requirement.
4. One member reported that her agency spent over $12,000 obtaining MSDSs on all products used in the group homes administered by her agency, photocopying those MSDSs, placing them in large 3-ring binders and then putting a binder in each group home.

•Another agency estimated the initial set up cost of between $12,000-$15,000 in labor costs. This expense does not include the cost of duplicating additional forms and transmitting them to individual residential settings, nor the annual costs of training staff on "chemical hazards" in the workplace.

There are additional burdens added to meeting this standard when a physician orders a specific product for a person with a disability, for example, daily use of dove soap for severe skin problems. This kind of physician's order happens frequently with soaps, powders, and lotions. The agency may have to wait 3-4 weeks to start using the new product until the MSDS sheet arrives and is then placed in the individual's home. **In order to comply with the OSHA standard, the employer must assume responsibility for not complying with the physician's order in a timely manner.**

How critical is the information contained on an MSDS that does not appear on the label of a product? When people get consumer cleaners, cosmetics, etc. in their eyes, do they read the MSDSs or the label on the container in their hand? Are MSDSs really being used in a practical way?

Outside Contracts [(e)(2)]: If an employer contracts with an outside business, the employer must obtain MSDS forms from the outside contractor. So, for example, if an agency contacts a plumber late at night to fix a plumbing problem, the agency must first ask for the contractor's MSDS forms. This would hold true for other household services such as painting or pest control. However, there is no similar requirement when these services are brought into the homes of other Americans.

ANCOR Recommendations Regarding Hazard Communication Standard

1. OSHA should differentiate between serious chemicals hazards and products that do not pose a serious hazard (do not pose a significant illness or injury) when used by the general public. Criteria

should also include use of products purchased in typical grocery and other retail stores for the purpose of household use and for which there is no training required if used by public consumers at large.

2. Eliminate the MSDS requirements and training for household products used by public consumers.
3. Eliminate the MSDS requirement and training for employees who provide supports to people in their own homes.
4. Eliminate the requirement that an employer obtain MSDS forms for outside contractors.
5. Develop an outcome-based criteria that requires general training on hazardous chemicals and employee instructions to seek medical care when exposed to a hazard.

49 CFR Part 1910.1300
Bloodborne Pathogens Standard

OSHA's bloodborne pathogens standard was issued three years ago to protect all workers from occupational exposure to bloodborne pathogens, including Hepatitis B Virus (HBV), the Human Immunodeficiency Virus (HIV), and other bloodborne pathogens which can cause serious and deadly disease. The issuance of this standard and the scope of coverage— including residential programs where people with disabilities live—not only surprised our membership, but signaled the encroaching role of OSHA into the field of disabilities. This standard has also brought on the greatest controversy and concern to ANCOR members over unnecessary costs. The lack of clarity over the standard's abatement requirements and varied citations indicating inconsistent application in the field eventually led ANCOR to seek Congressional intervention to obtain a meeting within OSHA officials.

ANCOR members want to protect their employees from occupational exposure to serious illness and deadly disease. There is no quarrel with practicing reasonable precautions (for example, effective training and the use of universal precautions). It is wise for employers and employees alike to be as careful and cautious as possible. ANCOR's issue with this standard relates to the degree of risk involved, the unreasonable scope and coverage of the standard as applied by OSHA.

Degree of Risk of Transmission Questioned

ANCOR has always questioned the likelihood of risk of transmission explicit and implicit in OSHA's standard and the onerous and costly precautions given the nature of the duties and tasks carried out by providers of supports and services to people with disabilities. To our knowledge, there has been not one documented case of transmission of Hepatitis or HIV/AIDS between staff or from a person receiving services to an employee.

It has been reported to ANCOR that 400 people die annually from Hepatitis B. This rate pales in comparison to those individuals who die from AIDS, cancer, diabetes, etc. To prevent the transmission of Hepatitis B with that level of death rate, our industry spends millions of dollars annually. ANCOR seriously questions OSHA's burdensome and costly requirements (vaccinations, thirty year record-keeping, waste disposal, and excessive personal protective equipment), and the agency's overly strict interpretations of these requirements in the face of the risk presented in providing supports and services to people with disabilities where they live.

The costs involved are not only borne by employers (reflected in direct fiscal outlays and employee resources), but also by employees in the time devoted to meeting the requirements, and—most importantly—by people with disabilities. The intrusive and excessive personal protective equipment and precautions related to the genuine risk de-humanize the relationship between the person providing supports and the person with a disability. They also adversely affect the choice to lead "normalized" lives in the community. While sound and reasonable health practices must be provided to protect workers, as well as people to whom supports are provided, this standard and OSHA's

application goes beyond the need of the risk presented.

There is as yet no vaccination for the HIV/AIDS virus and, at the current time the result of contracting this disease is death. Prevention of this deadly disease is one in which ANCOR supports our nation's efforts. Although the risk of transmitting HIV/AIDS leads to a more serious ultimate end than the transmission of Hepatitis B, the transmission of this disease is different than that of Hepatitis B. There have been no reported transmissions of the disease except through sexual contact, sharing of hypodermic needles by people using drugs, blood infusions during surgical/medical care, and the one as yet unconfirmed transmission occurring in a dentist's office. Employer responsibility for preventing the transmission of this disease should follow from the known medical demonstrations of its transmission pattern.

Coverage and Scope Too Broad

The current bloodborne pathogens standard requires that all workers with reasonable anticipation of occupational exposure to certain body fluids (blood, semen and vaginal fluids as well as vomitus, feces and urine and saliva that is mixed with blood) must exercise "universal precautions" (an approach which presumes that there may be bloodborne pathogens in any body fluids). It also requires that such workers be provided appropriate personal protective equipment (e.g., gloves and goggles), and receive the three-shot series of Hepatitis B vaccinations. Employers must offer the vaccination to employees regardless of following universal precautions, utilizing appropriate personal protective equipment (PPE), or any other abatement measures.

OSHA's current interpretation of coverage to workers with "reasonable anticipation of occupational exposure" includes duties beyond medical, surgical and health care activities that occur with traditional hospital, physician, dental, and emergency response "health care" treatment. OSHA's coverage extends to workers in group homes and other congregate living arrangements and private homes who provide personal assistance, housekeeping duties and enhance habilitation and vocational skills for and with people with disabilities. Examples of some of the activities for which OSHA has issued citations and fines or indicated coverage include:
•toothbrushing (because blood may occur with daily teeth cleaning);
•bed linens (handling, bagging and labeling as hazardous waste materials because there "may be" contaminated with semen or vaginal fluids);
•bathing or feeding (where a person has a history of biting or scratching);
•toileting

Due to this coverage, people with disabilities living in group homes and private homes are now subjected to living, working, and playing in anything but a "normalized" community environment. They are quite literally treated with "kid gloves." As the attached photograph demonstrates, people with disabilities may find their personal care attendant or direct care worker dressed for "a moon walk." **[Appendix D from Minnesota newspaper.]** This provides a living environment which is anything but individualized, personal, and homelike. Instead, it returns people with disabilities to an era in which their condition was treated as a medical one and they live in a "hospital-like"

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY REFORM RECOMMENDATIONS

29 CFR §778.114
U.S. Department of Labor Rules Governing Overtime for Non-Exempt Employees

This rule requires excessive bookkeeping to compute overtime for hourly employees who do not work the same number of hours each workweek.

Current federal rules at 29 CFR §778.114 prohibit employers from paying workers a fixed salary which includes some maximum number of hours of overtime — including the overtime premium. Instead, the wages must be computed weekly. When employees work a different number of overtime hours from one week to the next, this involves a great deal of bookkeeping. ANCOR proposes an alternative method of paying non-exempt employees. The method ANCOR suggests falls within the scope of the statute, but is prevented by federal regulation. It:

1. guarantees a salary employees can count on — which makes each employee's personal budgeting more secure — and actually pays people a little extra in the weeks when they work fewer hours;

2. maintains minimum wage and overtime protections for employees;

3. enables employers to more accurately budget expenses of operating a small human service business; and

4. reduces bookkeeping costs, thereby freeing up income which can be used to increases services to people supported by the agency, or to raise wages.

ANCOR represents more than 660 private agencies nationwide that together support more than 50,000 people with disabilities. About 85 percent of our members are nonprofit agencies. Traditionally, most of our members operate community residences and support people in their own homes. Most of the individuals supported by our members have mental retardation or another developmental disability, a traumatic head injury or, in some cases, mental illness. ANCOR members are small businesses with total annual income which ranges from — in most cases — less than $500,000 to a few million dollars per year. Some larger agencies have higher operating budgets, depending on the number of people with disabilities they support and the types of services they provide. Most of the money member agencies receive is comprised of county, state and/or federal dollars. It is usually State government which controls the amount paid for each type of support; and pressure from government to keep costs down is high, particularly in today's economy.

It would simplify things tremendously if lower-paid workers could be paid on a salary basis

for a fluctuating number of hours worked from week to week — even when the time exceeds 40 hours per workweek — provided that the amount paid every week represents at least the minimum wage, plus

overtime for any hours over 40 worked in that workweek, for the maximum number of hours the employee is every expected to work. Under such a system, the employees would:

- continue to maintain records of hours actually worked,
- have to understand the actual hourly rate of pay on which the salary is based, and
- have to be paid overtime at that rate of pay in any workweek in which he or she worked more than the maximum number of hours represented by the regular salary.

For example: If an employee was paid on a $5 per hour basis and routinely worked from 50 to 60 hours per week, s/he could be paid a salary of $350 per week, regardless of the number of hours worked up to 60 hours a week. (This represents $5 per hour for 40 hours and $7.50 per hour for 20 hours.) Employees still would be required to keep a record of the actual hours worked each week and, under such an agreement, anytime the individual worked more than 60 hours, s/he would receive an additional $7.50 for each extra hour worked. This provides a higher rate of pay than that achieved in calculations permitted by §778.114, which results in lowering the hourly rate of pay as more hours are worked in a workweek.

Labor Department Concerns Addressed

Labor officials believe that court decisions imply that overtime must be computed each week based on the actual number of hours worked. They cite the Missel case in making their argument. However, in that case, the court ruled that the overtime provision of the Fair labor Standards Act had been violated because there was no discussion in the contract between the employer and the worker which addressed the rate the employee would be paid in a workweek when he worked *more* than the maximum number of hours on which his salary was based. If this matter *is* addressed in an agreement or a contract between an employer and a worker (i.e., if the agreement specifies the hourly rate of pay on which overtime will be based in workweeks in which the number of hours worked exceeds the maximum number on which the salary is based), then the Department's concerns should be eliminated.

This proposal represents the best of all worlds: it guarantees employees that they will receive a fair wage, including overtime protections of the FLSA; simplifies bookkeeping (thus reducing the employer's costs, freeing more money for services or for increasing employee wages); and enables employers to better project their costs of business.

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY REFORM RECOMMENDATIONS

29 CFR §785.23
Letter of Interpretation of June 30, 1988

Department of Labor interpretation regarding sleep time creates hardship for employees.

It is not unusual for employees who work in community residences supporting people with mental retardation and other developmental disabilities to be able to sleep at night when the people they support are asleep. In some cases, it is not necessary to pay those people for sleep time, provided that they can actually sleep during a regularly scheduled sleep period. Under federal interpretations of court decisions, the only times that people do not have to be paid for sleep time is when they either (1) work for 24 hours or more and have a regularly scheduled sleep period of up to eight hours within that 24-hour period, or (2) when they reside on the employer's premises. Circumstances governing those situations are described at 29 CFR Sections 785.22 and 785.23, respectively.

Section 785.23 applies to an employee who "resides on his employer's premises on a permanent basis or for extended periods of time," and permits any "reasonable agreement" between the employer and employee regarding exactly which hours are work time, which are sleep time and which are off-duty time. Prior to 1981, the U.S. Department of Labor had not defined what it means to be residing on the employer's premises for an extended period of time. Agencies which were providing support for people with mental retardation and other developmental disabilities in group residences were applying the provisions of §785.23 to situations where an employee worked at a group home for five days a week, sleeping there four or five nights. No formal policy defined those situations existed, however.

1981 interpretation of residing on the premises for an extended period of time

In February of 1981, the U.S. Department of Labor issued a letter of interpretation to the American Network of Community Options and Resources - ANCOR (then the National Association of Private Residential Facilities for the Mentally Retarded - NAPRFMR) and the National Association of State Directors of Developmental Disabilities Services - NASDDDS (then the National Association of State Mental Retardation Program Directors - NASMRPD) defining when an employee would be considered to be "residing on the employer's premises for an extended period of time" under Interpretive Bulletin 785.23.

That letter says in part: "In general, we take the position that employees who reside on their employer's premises five days a week are considered to reside there 'for extended periods of time'. . .even though they may have another residence which they may regard as their principal residence." In addition, the letter states that the employer must provide a home-like

environment and private quarters for this policy to be in effect. The letter also indicates that off-duty time may be allowed for a few hours each day. Typical staffing patterns that resulted from that agreement include the one illustrated in attachment A.

Employer questions raise concerns about possible loophole in the interpretation

Over the next several years, Wage/Hour officials responded to questions from employers who wished to employ people under this enforcement policy and were seeking clarification of the policy. Some of the questions led Labor officials to believe that a loophole in the 1981 letter could lead to exploitation of employees. In a "worst case scenario" they envisioned an employer who would require an employee to be on duty from 10:00 p.m. to 8:00 a.m. (10 consecutive hours) five days a week, but paying those people for only two hours in each 24-hour period, since up to eight hours of bona fide sleep time need not be compensated. (See attachment B.)

1988 enforcement policy designed to close loophole

To close this loophole and to clarify other questions which had arisen about the 1981 policy, a new enforcement policy was released on June 30, 1988. It required that employees who work under the policy be "full-time employees." Unfortunately, another restrictive provision was added at the same time. This requires not only that the employees be full-time employees, but that "the employee is on duty at the group home and is compensated for at least eight hours in each of five consecutive 24-hour periods." Examples of staffing patterns which comply with this requirement were described in the letter. They are represented in attachments C and D.

Eight hour per 24-hour period requirement creates unnecessary overtime, causing a hardship for employees

ANCOR has no quarrel with the full-time employment requirement. In fact, most employees who reside on the premises for an extended period of time work more than 40 hours per week. That is, in fact, the problem with the new requirement. Since most employees must work *more* than eight hours in order to be at the home when the people who live there are back from their daytime education, training or employment programs, employees are forced by the policy to work a considerable amount of overtime each workweek. Requirements of the home result in staffing patterns like that found in attachment E.

Employees would prefer to work fewer hours each week, and employers in our field would like to permit them to do so because it means that the employees have greater job satisfaction, are more productive workers and stay in their jobs longer. To do this however, the June 1988 enforcement policy would have to be revised, retaining the full-time requirement, but dropping the requirement that employees be on duty and compensated for at least eight hours in each of five consecutive 24-hour periods, as cited in paragraph (1) on page 3.

ANCOR requests therefore that the 1988 policy be amended by dropping paragraph (1) on page 3 of the policy, thereby deleting the eight hour per 24-hour period requirement.

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY RECOMMENDATIONS

29 CFR Part 825
Department of Labor, Wage and Hour Division
Family and Medical Leave Act

ANCOR is raising an issue for clarification under the Family and Medical Leave Act (FMLA). The issue for clarification concerns the threshold for reaching the definition of "covered employer" and the definition of "employee" as the later definition relates to "clients" who are receiving training in rehabilitation programs or work centers.

A "covered employer" under the FMLA is one *who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar.* Both full-time and part-time employees who are on the employer's payroll are to be included in the aggregate number of employees to meet the 50-employee threshold.

It is the understanding of ANCOR members that the DOL includes "clients" of rehabilitation training services within the aggregate number of "employees" deemed to reach the 50-employee threshold for purposes of the FMLA. However, this interpretation appears inconsistent with other federal rulings governing an "employer-employee relationship."

Providers of supports and services to people with disabilities may also provide diagnostic and evaluation services, counseling and training services to people with disabilities as part of a rehabilitation program designed to prepare them for placement in private industry. The purpose is to accustom the individual to working conditions. As "clients" of the rehabilitation program, the individuals in training receive certain allowances during this training period, but are not eligible for the benefits which are available to recognized employees of the community rehabilitation center.

IRS Revenue Ruling 65-165

Under IRS Revenue Ruling 65-165 (2931.3121(d)-1 Who are employees?), the IRS was asked to determine whether people who were blind and who were receiving rehabilitation services in a "sheltered workshop" were employees of the 501(c)(3) organization. The revenue ruling defined three classes of individuals and separately discussed the employment status of each class. The IRS clearly made a distinction between those individuals who were in a training period and "individuals who had completed the training and who either continue to work in the workshop temporarily while awaiting placement in private industry or permanently if they are unable to compete in regular industry." **The revenue ruling held that the former individuals were not employees,** while those individuals in the latter instance were employees of the organization.

Using the IRS revenue ruling, there may be both "clients" and "employees" in the same

rehabilitation facility or training center at the same instance. Furthermore, the DOL "certificate for sub-minimum wage" in sheltered workshops would appear to also modify the "employment relationship.

The FMLA regulations do not address this apparent inconsistency in federal interpretations of "employee" that exists between the Department of Labor and the Internal Revenue Service. **ANCOR recommends that the Department revisit the definition of employee and under the circumstances allowed under the IRS Revenue Ruling 65-165, exclude individuals who are "clients" in a rehabilitation facility or training center from the aggregate number of people that determines the 50-employee threshold for purposes of FMLA. These individuals do not meet the employee-employer test and should not be counted toward the "employee" threshold to determine "covered employers."**

environment.

Hepatitis B Vaccinations (29 CFR 1910.1030 (f)(2)(I) and (g)(2)(vii))

Access and Cost

Due to the coverage of these activities, employers must provide **within 10 days** of work assignment and at no expense to workers, the Hepatitis B vaccination series. For workers who provide "first aid" (including applying a band-aid or supplying a Kleenex for a bloody nose) only as an ancillary duty and who do provide "first aid" relative to an incident, they must receive the first of the 3-shot vaccination series **within 24 hours** of providing first aid, regardless of whether or not there was any exposure to bloodborne pathogens.

The availability of vaccinations is particularly difficult in rural areas where clinics may only be open to provide vaccinations every thirty days. Therefore, agencies must have access to an emergency supply of the vaccine and appropriate medical personnel within 24 hours (even during weekends) for the purpose of possible post-exposure protection if simple first aid is provided. Some agencies have had to rely on the local emergency rooms of hospitals to provide the post exposure vaccination in order to comply with the 24 hour deadline, thereby taxing the existing health care system.

The cost of this vaccination varies and, at times, is not readily available in the community. The cost of the Hepatitis B vaccine varies ranges from $125-$350 for the complete three-shot series—depending upon the geographic area and contractual arrangements with local private medical personal. ANCOR has repeatedly advocated with the Congress that the hepatitis vaccination be made available at no cost or at federally contracted rates as part of our nation's immunization program (for example, through childhood and other immunization programs and the public health program to public non-profit entities) to agencies that provide supports and services to people with disabilities.

However, ANCOR providers must continue to meet this requirement without the benefit of any such immunization program and receive no additional reimbursement for the cost of the vaccinations, but must include the cost of meeting this vaccination requirement and the other bloodborne standard requirements with the established federal and state allocation. In order to avoid OSHA citations and costly penalties, many agencies have taken the steps to offer the vaccination to all employees who have *any responsibility or contact* with a person with a disability.

Examples of the added costs of this standard include:
•One non-profit agency which provides day, residential, and community services to 200 people with disabilities reported an initial cost of $4,000 for the vaccination. Considering that the same agency reports a 50% turnover rate for its staff, the cost of the vaccinations continue each year relative to the loss of staff.
•Another agency providing services to 250 people with disabilities reported an initial cost of $10,000 for the Hepatitis B requirement. Depending on how broadly the requirement is extended to other

services, it reports that the cost could go up to $70,000 annually (or $326 per person being served.)
•One agency that employs 325 full- and part-time staff to provide supports to nearly 300 people with mental retardation and mental illness in group homes, supervised apartments, and private homes and apartments, reported that in the first year following the effective date of this standard, the cost to vaccinate those staff who were offered the vaccination (approximately 60% elected the option) totaled $25,000. If the employer vaccinated all staff the cost would be $62,400.
•One agency received an OSHA citation for failure to offer the pre-exposure vaccination to staff even though the employer had contacted the public bureau of health immunization and was told that it was ineligible for the vaccine and after referral to the vaccine distributor who never returned phone messages.
•Another agency that employs 360 staff reports an annual cost of implementing the bloodborne standard at $50,000. The employer averages 410 injections per year at a cost of $49.10 per injection for an annual cost of $20,150. To date, the agency estimates that providing the Hepatitis B vaccine (2,052 injections since the effective date of the standard) has cost $100,753. This cost does not include that of nursing time involved in administering the injections, ordering vaccine and recordkeeping. The annual nursing costs (estimated at 10 minutes per injection) add an additional $735 to the cost of the vaccine.

Personal Protective Equipment (PPE) (29 CFR 1910.1030 (d)(3))

OSHA's bloodborne standard also requires that employers provide employees with appropriate PPE (gloves, goggles, gowns, etc.). As the photograph demonstrates **[Appendix D from Minnesota newspaper]**, the extent of the PPE varies and so does the cost of meeting this requirement. Providers report that people with disabilities are "frightened" by someone approaching them with goggles and a mask to help them with brushing their teeth.

One agency received an OSHA citation for not using rubber gloves while bathing a person with a disability, when the worker was using latex, disposable gloves. The agency was told that if you are assisting a person with bathing you must wear special bathing gloves ("nitro" gloves) that extend up the arm. The cost of the gloves are between $9-$15 and are the same gloves as those used for chemical exposure. These gloves are not soft and are slippery when wet, thereby inhibiting comfort and safety.

Cost of PPE

Examples of the cost of PPE include:
•One agency estimated the one time cost of CPR masks at $1,920 and blood-spill kits at $800. It estimates annual costs of $9,000 for rubber gloves.
•One agency estimated the annual cost of rubber gloves to be $1,913.
•Another agency estimate the annual cost of rubber gloves to be $2,603.

The above cost data does not include costs involved with infection control training. One agency estimates an annual cost of $1,617 for the trainer and $6,648 for the staff time to attend training.

ANCOR Recommendations for
Bloodborne Pathogens Standard

1. **OSHA should revisit the standard with a serious review of the benefit and cost of risk involved.** OSHA should revisit the standard on an industry by industry basis and develop industry-specific requirements related to the vaccination, personal equipment, and waste disposal requirements. OSHA should consult industry-specific leaders and workers as to the risk involved and the best and most reasonable precautions.

3. **Elimination of the 30-year recordkeeping requirement.** Even the Internal Revenue Service does not anticipate a 30-year recordkeeping practice. The rationale and cost of storing training and medical records pursuant to this standard is unreasonable. Employees must also assume some responsibility in maintaining their own medical and training records.

3. **Recognize good faith efforts and reduce citations for minor infractions.** Where employers have an exposure control plan in place and have made a good faith effort to comply overall with the standard, the focus of OSHA inspections should be focused on correcting "deficiencies" where genuine risks are involved and "improving" plan components, rather than issuing citations and fines for each and every incremental aspect of a standard. The emphasis should be on helping those employers who make an honest effort to meet the spirit of the standard and citing willful violators who ignore genuine health risks as opposed to "catching" and "penalizing" good citizens.

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY REFORM RECOMMENDATIONS

Occupational Safety and Health Administration

29 CFR Part 1904
OSHA Injury and Illness Forms

There are nearly 400 recordkeeping and reporting requirements included in various OSHA standards. The most common recordkeeping and reporting requirement is the recording of employee injuries and illnesses as they occur (OSHA 200 Form and OSHA 101 Form). The requirements apply to all employers of 11 or more employees, except for some employers engaged in certain retail trades and service industries.

Employee injuries and illnesses must be recorded on OSHA-supplied forms (or their equivalent) on a calendar year basis. Entries must be made on the forms at the time employee injuries and illnesses occur. The forms must be kept for five years and be available for inspection.

Employers must keep a log and summary of all recordable occupational injuries and illnesses sustained by their employees (OSHA 200 Form). The OSHA 200 Form must be maintained and posted regardless of whether any injuries or illnesses have been sustained by employees. In addition, OSHA requires that employers keep supplementary records containing additional details on each recordable injury and illness (OSHA 101 Form) (CFR 1904.4). These records are to provide a higher level of detail than the recordkeeping requirement for the OSHA 200 Form.

ANCOR members have been told that their OSHA 200 Form did not provide enough detail, even though this form is not the same as an "incident report." The following are examples for which ANCOR members have been cited:

•One provider was cited (CFR 1904.2(a) because the OSHA Form 200 was not completed in the detail provided in the form and the instructions contained therein. The provider's OSHA 200 Form contained the following specific description:"three inch scratch on left side of lower patella."
•ANCOR providers have been cited for failure to maintain the OSHA 200 form at each and every worksite (e.g., each group home).
•OSHA cited another provider because there were no totals on the OSHA 200 summary page (CFR 1904.2(b)).
•Another citation was levied because case numbers were not assigned to all cases in the OSHA 200 log.
•One agency was cited for failure to have the OSHA 200 log certified as true and complete on the summary page.

29 CFR Part 1910.20
OSHA Records Access Standard

OSHA requires that employers keep a copy of the OSHA Records Access Standard (29 CFR Part 1910.20) readily available for employees at each workplace. This requirement means that providers with multiple worksites must duplicate and maintain a copies of the Standard and appendices at each group home or other supported living site.

ANCOR members have been cited for failure to keep a copy of 29 CFR 1910.20 and its appendices at each workplace (CFR 1910.20 (g) (2). Employers who maintain a central office where employers typically extend employment and arrange for training should not have to duplicate this Standard and its appendices and maintain at each workplace (e.g., each group home.)

ANCOR Recommendations for Injury Recordkeeping

These are examples of the level of specificity and regulatory burden to which employers are subjected during an OSHA inspection. They are also examples of a "government strong arm" mind-set at OSHA which only burdens employers without adding to the health and safety of employees.

In order to reduce paperwork, duplication, regulatory burden and cost to employers, ANCOR makes the following recommendations.

•OSHA requires that the OSHA 200 form be certified annually as true and complete (1904.5 (c)). The certification carries with it an additional fee. In order to reduce regulatory paperwork, OSHA should accept the forms that have to be filled out for workers' compensation. **ANCOR recommends that workers' compensation forms be permitted in lieu of the annually certified OSHA 200 form.**

•Since many agencies provide supports and services to people with disabilities in multiple worksites, including group homes, individual homes and apartments, and other supported living arrangements, **ANCOR recommends that OSHA permit employers to maintain monthly summaries of illnesses and injuries and other injury reports at a central office.**

•ANCOR recommends that employers with multiple workplaces (such as group homes and supported living arrangements) that have a central office be in compliance with 29 CFR Part 1910.20 if a copy of the Standard and appendices are maintained at the central office and are available upon request to employees.

•ANCOR recommends that the failure to post the OSHA log when there are no injuries and illnesses no longer be cited as a violation.

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY RECOMMENDATIONS

Occupational Safety and Health Administration

Pending Standards

Increasingly, people with disabilities are living in the community in their own homes or apartments, supervised apartments, group homes and other supported living arrangements. These are real "homes" to people with disabilities—environments which are not considered workplaces by the people who live in them. While providers of these supports and services have a keen interest in maintaining healthy and well trained employees to provide these supports wherever people live, work, and play, it must also be remembered that providers have a primary responsible to people with disabilities to enhance the quality of their lives.

ANCOR would like to take this opportunity to recommend that OSHA exercise both care and clarity in formulating standards in the following areas:

- **Tuberculosis**
- **Indoor Air Quality**
- **Ergonomics**

OSHA is in very stages of developing proposed or promulgating final standards regarding the above areas. Although all three areas may involve some degree of risk of injury or illness to employees in various workplaces, OSHA should develop standards which are industry-specific, taking into account the genuine risks involved in specific workplaces as well as the cost to employers for reducing risk.

Following the promulgation of new standards, OSHA resources should be devoted primarily to helping employees meet health and safety outcomes. An OSHA that is available to help employers provide a reasonably healthy and safe environment in which employees can carry out their responsibilities to enhance the lives of people with disabilities would be a better use of limited federal resources—as well as that of federal and state resources allocated to providers—than penalizing the efforts of good faith citizens. A common sense approach to health and safety, rather than a government strong arm enforcing volumes of regulatory red-tape is needed.

Revised 1/95

HAZARDOUS SUBSTANCE LIST

PRODUCT

A-33 Dry

AFBC

Alcare foamed alcohol

Aqua Soft

Bleach

Bissell 4-in-one carpet formula

Brake fluid (heavy duty DOT)

Cascade

Cepacol

Charcoal lighter fluid (Kroger & Kingsford)

Chem-tox do it yourself pest control

Colgate instant shave cream

Colorworks

Comet cleanser
Liquid Comet

Conquer disinfectant deodorant

Dawn

Dial Antibacterial Soap

Decorator Paints

Duco spray adhesive

Easy-off oven cleaner (heavy duty)

Elmer's carpenter wood glue

Fantastik

HAZARDOUS SUBSTANCE LIST - Continued
PAGE 2

Fire Extinguisher (Dry Chemical - General)

Floor cleaner (Armstrong)

Floor polish (Armstrong)

Formula 409

Fresh & Clean Disinfectant

Fuse (flare) Highway

Glade Carpet & Room deordorizer

Hollister Medical adhesive Spray

Hydrogen peroxide Hollister Skin Cleanser

Jet Dry

Joint Compound

Kleenmaster Brillianize

Lacquer thinner (Klean Strip)

Laser Printer Toner (Dry Toner)

Latex flat (Moorcraft)

Latex semi-gloss enamel (Moorcraft)

Laundri Destainer

Lemon 3-D

Lemon polish (Clark)

Limeaway

Liquid nails (Macco)

Liquid paper correction fluid

Lysol foam Spray

Mikroklene

Murphy's Oil soap

HAZARDOUS SUBSTANCE LIST - Continued
PAGE 3

Motor Oil (Valvoline 10W40)

Odor destroyer

Old English scratch cover (for dark wood)

Paint thinner (Klean-Strip)

Plasti Dip

PMR Primer

Polyurethane

Puncture Seal

Raid Ant & Roach Killer

Raid Max Roach & Ant

Resolve Carpet Cleaner

Roto-Rooter Drain Cleaner

Rubber Cement (Ross)

Rust Tough

Sani-Soft Hand Cleaner

Scotchguard carpet protector

Scotchguard fabric protector

Shout (aerosol)

Shout (liquid)

Silicone rubber sealant

Skin Barrier Lotion

Snap starting fluid

Spic & Span

Spot bet

HAZARDOUS SUBSTANCE LIST - Continued
PAGE 4

Stanley Steemer Carpet & Upholstery Spot Remover

STP vinyl protectant

Steele Brite

Tile Pro High Gloss Dressing

Top Quartile

Touch of Scent

TPD Thinner

Tri Star L2000

Tub and Tile Caulk

Urinal Sentry Cleaner block

Vegalene

Wax remover (Armstrong - New Beginning)

WD-40 (aerosol)

WD-40 (bulk liquid)

Windex

Woodfinish (Miniwax)

HYGIENE MSDS LIST

ACT Fluoride for Kids
ACT Dental Rinse
Aqua Velva After Shave
Aquafresh Toothpaste

Aramis

Attend Wipes

Avon
- Double Action Deodorizer Foot Powder
- Protective Lip Balm
- Care Deeply Lip Balm
- Skin So Soft Bath Oil
- Fancy Feet Deodorizer
- Provocative Cologne
- Cool Confidence Roll On
- Odyssey Talc
- Vita Moist Cream

Baby Shampoo

Ban Roll On

Bard Moisture Barrier Ointment

Bold Hold Salon Styling Spritz

Bonne Belle Lipstick/Lip Gloss

Calgon ECF Hair and Body Shampoo

Calgon Septi-Soft Body Wash and Shampoo

Care Creme

Care Roll On

Chap Stick

Chateau Baby Oil

Children's Bubble Bath

Clear Choice Mouthwash

Colgate Shave Cream

Colgate Toothpaste

Consort Aerosol Hair Spray - Extra Hold

Coppertone Sun Block

Crest-Tartar Control
Original Flavor
Fresh Mint Gel
Smooth Mint Gel

Crest - Regular
Mint
Cool Mint Gel
Icy Fresh Gel
Crest for Kids

Dep Spray Gel

Dep Styling Gels

Dial soap

Dove Beauty Bar

Dow Brands Hair Spray

Este Lauder Frangrances

FDS with Powder/Regular

Flex Styling Mousse

Generic Brand Nexxus Therappe Shampoo

Gentle Lotion Soap

Gentle Plus Deodorant
Use - hygiene

Gentle Rain Shampoo
Use - Hair Washing

Gillette Foamy Shave Cream

Hair Spray
Use - hair hold

Head & Shoulders Concentrate Shampoo

Hygenic Cleansing Towelette

Jergons Refreshing Body Shampoo

Jergons Refreshing Body Shampoo Deodorant

Ivory Soap

Lady Mitchum Deodorant

Maybelline Medium Foundation

No-Ad Sun Block
Use - sun screen

OFF! Skintastic

Old Spice After Shave
Old Spice Stick Deodorant and Shave Cream

Pert Plus

Provon Enriched Shampoo for Body and Hair

Sante Fe Cologne
Selsun Blue Dandruff Shampoo
Sensodyne Toothpaste

Skin Barrier Lotion

Skin Lotion
Use - Moisturize Skin

Shower to Shower Body Powder, Roll-On Antiperspirant,
Stick Antiperspirant
Softsoap Liquid
Stetson Sierra

Suave Baby Shampoo

Suave Hair Spray

Suave Shampoo - Normal to Oily and Normal to Dry

Summer's Eve Cleansing Cloths

TopiCare Products (lotions and hair care) Teen Spirit Spritz
Teen Spirit Shampoos
Teen Spirit Hair Conditioners

Udder Balm

Vagisil Feminine Powder

White Rain Baby Shampoo

Zest

One MSDS for:

Vaseline Intensive Care

Cutex	Aqua Net	Brut
Ponds	Rave	Mentadent
Q-tips	Faberge	Signal
Close Up	Aim	

FIRST AID SUPPLIES NSDS LIST

Alcohol Prep Pads
Use - first aid

Aloe Vera Gel
Use - first aid

Cold Comfort Instant Cold Pack
Use - first aid

Lemon Glycerine Swabs
Use - first aid

Smelling Salts
Use - first aid

Surgilube
Use - first aid

Triple Antibiotic Ointment

OFFICE MSDS LIST

Chemical:	Equipment:
Black Toner	N/A
Black Developer	N/A
Correction Fluid	N/A
Correction Fluid Thinner	N/A
Dip It 2	N/A
Erasable Marker	N/A
Glue Stick	N/A
Marker Board Cleaner	N/A
Opti Fluid	N/A

MAINTENANCE MSDS LIST

Chemical:	Equipment:
Paint (cameo) Use - Wall and Trim Paint	Ventilation Goggles
Paint (Matchmaker) Use - Wall Base Paint	Ventilation Goggles
Silicone Sealer Use - on tile	Ventilation Goggles
STP Son of a Gun Cleaner One Step Tire Protectant Vinyl Protectant Car Cleaner Car Wash Concentrate	Ventilation Gloves Goggles
Windshield Washer Solvent Use - Care Windshield Washer	Organic Vapor Mask Goggles
WD-40 Use - Lubricant	Ventilation Goggles

ARTS AND CRAFTS MSDS LIST

Aleene's Tacky Glue

Elmer's Glue All

Slomon's Sobo Glue

Tulip Products:

- Glitter Paint
- Polymark Iridescent
- Soft Glitter Paint
- Soft Metallic Paint

HOUSEKEEPING MSDS LIST

CHEMICAL	EQUIPMENT
ACE - Ammonia Chloramine Eliminator	N/A
Airwick Stick-Ups	Ventilation
Ammonia Use - wax remover	Rubber gloves Goggles Mask (green container)
Auto Glass Cleaner	
Banish II Liquid Deodorant Bissell Carpet Shampoo Bleach (Comsource)	Chemical Resistant Gloves Safety Goggles
Bleach (Shopper's Value)	
Bleach (liquid and dry) Use - Laundry Sanitizer, Floor Sanitizer, CPR Mask Sanitizer	Liquid - Rubber gloves - Goggles
Blue Concentrate Use - All Purpose Cleaner Blue Magic Waterbed Conditioner Blue Ribbon Bleach	Glasses or goggles Mask Rubber Gloves Splash-proof chemical-resistant goggles
Bounce Fabric Softener	N/A
Brillo Lemon Soap Pads	
Cascade Use - Dishwasher	N/A
Charcoal Lighter Fluid	Ventilation
Use - Cooking	Keep away from excessive heat
Clark Conquer Hospital Disinfectant Use - to disinfect surfaces	Ventilation, goggles
Creme Cleanser (Sysco)	Ventilation, goggles
Dawn Liquid Dishwashing Detergent	
Dove Use - Dishes before dishwasher	Safety glasses with side shields Impermeable gloves
Downy Sheets Fabric Softener	N/A
Dragon Fly & Crawling Insect Spray	
Dryer Fabric Softener Use - In Dryer	Goggles

CHEMICAL	EQUIPMENT
Flash Dri Use - Dishwasher	N/A
4-in-One Use - Carpet Cleaner	Goggles
Glade Plug In's	
Glass Mates Cleaning Wipes	
Laundry Prep Plus Use - Prewash for Laundry	Goggles Gloves
Lemon Polish Use - Dust Furniture	Ventilation
Liquid Comet Use - Stain Remover	N/A
Love My Carpet Use - Carpet Deodorant	N/A
Love My Carpet Rug Cleaner	N/A
Lysol Disinfectant Spray Use - Disinfect Surfaces and Air	N/A
Lysol Foam Spray	
Mikro Klein Use - Rinse Dishes by Hand	Goggles Gloves Water below 120
Murphy Oil Soap/Spray Use - On Floor, Walls, Wood	
Neutrodor Use - Room Deodorizer	N/A
Nuggett Liquid Bleach	
Odo-Ban Deodorizer/Disinfectant	
Oven Cleaner Use - Clean oven interior only	Gloves Goggles
Pine 3-D Use - All Purpose Cleaner	Ventilation Goggles Gloves
Purex Toss N Soft Fabric Sheets	
Scotch Guard Upholstery Protector	Ventilation
Scotch Guard Fabric Protector	
Scrub Free Use - Tubs, countertops spot removal	Ventilation Gloves Goggles
Shoppers Value Charcoal Lighter Fluid	

CHEMICAL	EQUIPMENT
Shout Aerosol	N/A
Shout Liquid	N/A
Shout Stick - Laundry Prespotter	N/A
Spot Bet Use - Spot Clean Carpet	Ventilation Gloves Goggles
Spray 'N Wash Aerosol/Liquid Use - Laundry Stain Remover	Gloves (aerosol)
Steri-Fab	
Tetrex Use - Wash Dishes by Hand	
Tide Use - Laundry	
Toilet Bowl Cleaner (Kola and Kling) Use - Disinfect Toilet	Ventilation Gloves Goggles
Wax Use - Wax Tile Floor	Ventilation
Windex Use - Clean Windows	N/A
Woolite Cold Water Wash	
Zud Use - Rust Remover	

LISTINGS OF MATERIAL SAFETY DATA SHEETS (MSDS's)

UPDATED: April 12, 1995

The following is a list of Material Safety Data Sheets, (MSDS's) currently on file at Central Office:

MSDS #	PRODUCT	COMPANY
BLEACHES		
✓BL-01	Shop & Save Bleach	Laundry Aids, Inc.
✓BL-02	Shop & Save Lemon Fragrance Bleach	Elite Chemicals
✓BL-03	Clorox Bleach	Wonder Chemical Corp.
✓BL-04	Elite Bleach	Elite Chemicals
✓BL-05	Purex Liquid Bleach	The Dial Corporation
OVEN CLEANERS		
✓OC-01	Mr. Muscle Oven Cleaner	The Drackett Products Co.
✓OC-02	K-Mart Our Best Oven Cleaner	Chemsico
✓OC-03	Dow Oven Cleaner	DowBrands
✓OC-04	Easy-Off Non-Caustic Oven Cleaner - Lemon	Boyle-Midway Division of American Home Products Corp.
✓OC-05	Easy-Off Oven Cleaner Original, Heavy Duty	Reckitt & Coleman, Inc.
✓OC-06	Easy-Off Fume Free Max Oven Cleaner	Reckitt & Coleman, Inc.
GLASS/WINDOW CLEANERS		
✓GW-01	Shop & Save Glass Cleaner	Kleen Brite Laboratories, Inc.
✓GW-02	CINCH Glass & Multi-Surface Cleaner	Procter & Gamble
✓GW-03	Spartan Glass Cleaner (New & improved)	Spartan Chemical Co., Inc
✓GW-04	Spartan Glass Cleaner	Spartan Chemical Co., Inc

MSDS #	PRODUCT	COMPANY
GLASS/WINDOW CLEANERS (continued)		
✓GW-05	Clear-Vue Glass Cleaner	Clear-Vue Products, Inc.
✓GW-06	Windex Glass Cleaner with Amonia	S.C. Johnson Wax
✓GW-07	K-Mart Window Cleaner	Barcolene Co.
✓GW-08	Bon-Ami Glass Cleaner	Bon-Ami Co.
✓GW-09	Glass Plus	Dow Brands
✓GW-10	409 Glass & Surface Cleaner	Clorox, Inc.
✓GW-11	Windex Glass Cleaner (Blue)	S.C. Johnson Wax
✓GW-12	Spring Fresh Glass Cleaner	Sunshine Quality Products
BATHROOM CLEANERS		
BC-01	Soft Scrub with Bleach	The Clorox Company
✓BC-02	Scrub Free Bathroom Cleaner	Benckiser Consumer Products, Inc.
✓BC-03	Comet Bathroom Cleanser	Proctor & Gamble
✓BC-04	Shop & Save No-Scrub Bathroom Cleaner	The Stanson Corporation
✓BC-05	Dow Disinfectant Bathroom Cleaner II with Scrubbing Bubbles	Dow Brands
✓BC-06	Vanish Mildew Plus Stain Remover	Drackett Products Co.
✓BC-07	Bathroom Duck	S.C. Johnson & Son, Inc.
✓BC-08	Lysol Brand Disinfectant Basin, Tub & Tile Cleaner (Trigger)	L & F Products
✓BC-09	Lysol (R) Brand Disinfectant Liquid Toilet Bowl Cleaner (All Scents)	L & F Products
✓BC-10	Scrub Free One Bathroom Cleaners	Benckiser Consumer Products, Inc.

MSDS #	PRODUCT	COMPANY
GENERAL HOUSEHOLD CLEANERS		
✓GC-01	Comet Cleanser (Regular & Lemon Fresh Fragrances)	Proctor & Gamble
✓GC-02	Ajax Cleanser	Colgate-Palmolive Co.
✓GC-03	Spic & Span Liquid Non-Phosphate	Protor & Gamble
✓GC-04	BON AM Kitchen & Bath Cleaner	Faultless Starch/Bon Ami Company
✓GC-05	Xtra Pine Cleaner	White Cap, Inc.
✓GC-06	Spartan Sterigent Cleaner	Spartan Chemical Co., Inc
✓GC-07	Steriphene II Brand Disinfectant Deodorant	Spartan Chemical Co., Inc
✓GC-08	CDC-10	Spartan Chemical Co., Inc
✓GC-09	Barcolene with Amonia	The Barcolene Company
✓GC-10	Shop & Save Brand Household Amonia	Laundry Aids, Inc.
✓GC-11	Simple Green Industrial Cleaner & Degreaser	Sunshine Makers, Inc.
✓GC-12	Pine-Sol Cleaner	Clorox Co.
✓GC-13	Comet Liquid Chlorinated Cleanser	Proctor & Gamble
✓GC-14	Fantastik All Purpose Cleaner	Dow Brands
✓GC-15	Swiss Pine	USA Detergents, Inc.
✓GC-15	Household Ammonia (Clear, Clear Blue, Lemon, Sudsy)	Dial Corp.
✓GC-16	Murphy Oil Soap, Liquid	Clogate-Palmolive Co.
GC-17	Sun Magic All Purpose Cleaner	Gemstone Enterprises, Inc
✓GC-18	Shop & Save Heavy Duty All Purpose Cleaner	Grow Consumer Products
✓GC-19	Parsons Amonia	The Dial Corp.

MSDS #	PRODUCT	COMPANY
GENERAL HOUSEHOLD CLEANERS (continued)		
✓GC-20	Kleen Guard Furniture Polish	Alberto-Culver Co.
✓GC-21	Scotch Pine All Purpose Cleaner	Canton Industries, Inc.
✓GC-22	Formula 409 All Purpose Cleaner	The Clorox Company
✓GC-23	NOW All Purpose Cleaner/Degreaser	Mirachem Corporation
✓GC-24	Tackle Cleaner Disinfectant	Clorox Co.
✓GC-25	Shaw's Amonia	Shaw's, Inc.
✓GC-26	Sea Mist Amonia	Laundry Aids, Inc.
✓GC-27	Ultra Mr. Clean with Bleach	Proctor & Gamble
✓GC-28	Shop & Save Heavy Duty Cleaner with Amonia	Grow Consumer Products
SPRAY DISINFECTANTS/AIR FRESHENERS		
✓SD-01	Shop & Save Spray Disinfectants	Grow Consumer Products
✓SD-02	Arm & Hammer Deodorizing Air Freshener (All Scents)	Church & Dwight, Co., Inc
✓SD-03	Lysol Brand Disinfectant Spray Original, Fresh, Light, Country Scents	L & F Products
DRAIN CLEANERS		
✓DC-01	Liquid Drano Drain Opener	The Drackett Products, Co
✓DC-02	Liquid Plumber	Clorox Co.
✓DC-03	Lewis Red Devil Lye Drain Opener	Reckitt & Coleman, Inc.

MSDS #	PRODUCT	COMPANY
GASOLINE/ANTIFREEZE		
✓GA-01	Irving Gasoline, (Regular, Unleaded, Plus Unleaded, Supreme Unleaded)	Irving Oil Corporation
✓GA-02	Irving Everflow	Irving Oil Corporation
✓GA-03	Heet Gasline Antifreeze	DeMart & Dougherty, Inc.
CARPET CLEANERS		
✓CC-01	Resolve (TM) Carpet Cleaner with Teflon	L & F Products
✓CC-02	Rug Doctor Steam Detergent	Rug Doctor, Inc.
✓CC-03	Rug Doctor/Vibra Vac Spot Remover/Spot & Blot	Rug Doctor, Inc.
✓CC-04	Rug Doctor/Vibra Vac/Acs Anti-Foam	Rug Doctor, Inc.
✓CC-05	Rug Doctor Flea Killer	Rug Doctor, Inc.
✓CC-06	Rug Doctor Original Steam Carpet Cleaner	Rug Doctor, Inc.
✓CC-07	Woolite Deep Cleaning Rug Cleaner	Reckitt & Coleman, Inc.
✓CC-08	Tru-Test Concentrated Rug Shampoo RS-18	Tru-Test Manufacturing Division of Cotter & Co.
✓CC-09	RinseVac Prespotter	Blue Luster Home Care Products, Inc.
PAINT/VARNISH REMOVERS		
✓PR-01	5F5 Paint & Varnish Remover	Sterling-Clark-Lurton Corp.
✓PR-02	Oops Latex Paint Remover	DIY Products
PAINT THINNERS		
✓PT-01	THIN-X	Sterling-Clark-Lurton Corp.
✓PT-02	DAP Weldwood Cleaner/Thinner	DAP, Inc.

MSDS #	PRODUCT	COMPANY
PAINTS/VARNISHES/COATINGS		
PV-01	Rust-Oleum Wood Saver Topcoats (Aerosol)	Rust-Oleum Corporation
PV-02	Tru-Test Supreme EX-Kare Flat Enamel	General Paint & Chemical Co.
PV-03	Tru-Test Supreme Latex Enamel Undercoat	General Paint & Chemical Co.
PV-04	Bin Primer/Sealer	William Zinsser & Co. Inc
INSECT KILLERS/REPELLENTS		
IK-01	Green Thumb Roach, Ant & Spider Killer	Wilbur-Ellis Company
IK-02	Cutter Unscented Insect Repellent Spray	Miles, Inc.
IK-03	RAID Flying Insect Killer Formula 12	S.C. Johnson Wax
IK-04	DEEP Woods Off, Insect Repellent II	S.C. Johnson Wax
IK-05	OFF Insect Repellent	S.C. Johnson Wax
IK-06	Repel Insect Repellent Scented Family Formula 27	Wisconsin Pharmacal Co.
IK-07	Repel Insect Repellent Sportsmen Formula 29	Wisconsin Pharmacal Co.
IK-08	RAID House & Garden Bug Killer	S.C. Johnson Wax
IK-09	RAID Flying Insect Killer Formula 5	S.C. Johnson Wax
PLANT/GARDEN CHEMICALS		
PG-01	Ortho Leaf Polish (Pump Spray)	Chevron
PG-02	Ortho Leaf Polish (Aerosol)	Chevron

MSDS #	PRODUCT	COMPANY
CHARCOAL LIGHTER STARTERS		
✓CS-01	Royal Oak Lighter Fluid/ Charcoal Starter	Royal Oak Enterprises, Inc.
✓CS-02	Shop & Save Charcoal Lighter Fluid	Linwood Industries Limite
✓CS-03	Kingsford Odorless Charcoal Lighter	The Clorox Co.
✓CS-04	Amberglo Charcoal Lighter	Sebring Forest Industries
✓CS-05	BI-RITE Charcoal Starter	Glendale Foods, Inc.
FLOOR WAXES/REMOVERS		
✓FW-01	Becon Self Polishing Floor Wax	Lehn & Fink Products Co.
✓FW-02	Parson's Wax & Acrylic Remover	The Dial Corp.
✓FW-03	Brite Floor Wax	S.C. Johnson Wax
✓FW-04	Electrolux Wood Floor Wax	Electrolux
UPHOLSTERY CLEANERS		
✓UC-01	TLC Vinyl Claener	Great Lakes Biochemical Co., Inc.
✓UC-02	Aerosol Upholstery Shampoo	Bissell, Inc.
✓UC-03	Resolve (TM) Fabric & Upholstrey Cleaner	L & F Products
MEDICAL/FIRST AID		
✓MD-01	Shop & Save/Welby Hydrogen Peroxide	Hamond Drug, Inc.
✓MD-02	Shop & Save/Welby 70% Isopropyl Alcohol in Water	Divina/Diamond Drug

MSDS #	PRODUCT	COMPANY
POOL CHEMICALS		
✓PL-01	Tarry 3" Chlorine Tablets	Qualco, Inc.
✓PL-02	Chlorine Stabilizer	Coastal Industries
✓PL-03	Whale Brand Ph Plus	DLM Laboratories, Inc.
✓PL-04	Whale Brand Shock It Chlorine	DLM Laboratories, Inc.
✓PL-05	Whale Brand Algae Prevent 40	DLM Laboratories, Inc.
DISHWASHING DETERGENTS		
✓DD-01	Sunlight Light Duty Liquid Dishwashing Detergent	Lever Brothers, Co.
✓DD-02	Octagon/Crystal White Dishwashing Liquid	Colgate-Palmolive Co.
✓DD-03	Dawn Liquid Dishwashing Liquid	Proctor & Gamble
✓DD-04	Lemon Cascade Liquigel Dishwashing Detergent	Proctor & Gamble
HAND SOAPS/CLEANERS		
✓HS-01	Clean & Smooth Liquid Lotion Hand Cleaner	Benckiser Consumer Produsts, Inc.
✓HS-02	Liquid Antimicrobial Soap	The Dial Corporation
LAUNDRY CLEANERS		
✓LC-01	SHOUT Aerosol	S.C. Johnson Wax
✓LC-02	SHOUT Liquid	S.C. Johnson Wax
✓LC-03	SHOUT Stick Laundry Presotter	S.C. Johnson Wax
✓LC-04	SHOUT Gel Laundry Prespotter	S.C. Johnson Wax
✓LC-05	X-TRA Liquid Laundry Detergent	U.S.A. Detergents, Inc.

MSDS #	PRODUCT	COMPANY
MISCELLANEOUS		
✓MS-01	Eaton's Stick-Em Glue Traps	J.T. Eaton & Company, Inc
✓MS-02	WD-40 Aerosol	WD-40 Co.
✓MS-03	SOS Steel Wool Pads	Miles, Inc.
✓MS-04	Liquid Paper Correction Fluid	Gillette Company
✓MS-05	Cameo Aluminum & Stainless Steel Cleanser	The Dial Corp.
✓MS-06	Niagara Professional Finish Original Spray Starch	Best Foods, CPC International, Inc.
✓MS-07	Old English Scratch Cover for Dark Wood	Reckitt & Coleman, Inc.
✓MS-08	Sure Melt (rock Salt)	WH Shurtleff Company
✓MS-09	Liquid Nails Contact Cement (Latex Contact Adhesive)	Macco Adhesives

VILLAGE
Master Chemical List
Revised 1/94

No.	Product Name
001	Diversey Zerospot Dishwasher Rinsing Agent
002	Elite II Dishwasher Detergent
003	SpectraCare Microbial Hand Soap
004	Sani-Fresh Body Shampoo
005	Command Center LOOK Glass Cleaner #2
006	Command Center General Purpose Cleaner #3
007	Command Center Blue Skies II Disinfectant #8
008	Fountainhead Carpet Extraction Cleaner
009	High Noon Floor Finish
010	Purity ENBAC AP Enzyme Cleaner
011	Purity Kreme Kleen Abrasive Cleaner
012	Purity D200 Disinfectant Aerosol
013	Purity 4-Way Toilet Bowl Cleaner
014	Purity Rinse Free Stripper
015	MAD Mild Acid Detergent
016	RA-25 Insect Spray, Aerosol
017	Purity One Step Detergent
018	Salute Dishwasher Detergent
019	Benchmark Floor Finish
020	Ironstone Acrylic Floor Sealer
021	Over Drive Spray Buff Floor Finish
022	Bare Knuckles Floor Stripper
023	Jackhammer Baseboard Stripper
024	Acetone
025	Lubecon Series I Lubricant
026	Purity AFBC Bathroom Cleaner
027	Spot Bet/Spot Relief Spot Remover
028	Oven & Grill Cleaner
029	Purity Pot & Pan Hand Dishwashing Detergent
030	Spinout Spin Bonnet Cleaner
031	Sundance Q Disinfectant
032	Look Glass Cleaner, Ready To Use
033	First Defense Soil Retardant
034	Phenex 256 Phenolic Disinfectant
035	Vertex Bleach
036	#F120 Indoor/Outdoor Insecticide
037	Low Energy Drying Agent - Rinse Additive
038	RAID MAX Roach & Ant Killer
039	ABC Dry Chemical Fire Extinguisher
040	Regular Dry Chemical Fire Extingusher
041	Command Center Hot Springs General Purpose Cleaner Concentrate 20
042	Command Center Triple Team Citric Washroom Cleaner
043	Novaweld P
044	Purity Pine Forest 5 Disinfectant Cleaner
045	CFR Defoam
046	BARE KNUCKLES
047	CLOCKWORK
048	SPEED TRACK
049	
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No.	Product Name
056	
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MAINTENANCE DEPT. CHEMICALS - MSDS kept in Maint. Building

No.	Product Name
065	Nyco Concent. Calci-Solv
066	Oatey Reg Clear PVC Solv/Cement
067	Oatey Clear Primer
068	Oatey #5 Soldering Paste
069	Krylon Crystal Clear Spray Coat
070	Round-Up Herbicide
071	Pro-Turf Trimec Broadleaf 881
072	Unleaded Gasoline
073	Heet Gasline Antifreeze
074	NAPA Silicone Brake Fluid
075	Carb & Choke Cleaner
076	Brake Cleaner
077	Sulphuric Acid Drain Opener
078	Dust Mop Treatment
079	Reducer
080	Acrylic Enamel Reducer
081	Acrylic Enamel Retarder
082	All Purpose Thinner
083	Fish Eye Preventer
084	Flatting Paste
085	Wax & Grease Remover
086	Flexative
087	Hardener
088	Wash Primer
089	Wash Primer Catalyst
090	Accelerator Additive
091	Kondar Primer Surfacer
092	Nitrocellulose
093	Zinc Chromate Primer
094	Grey Flash Primer
095	Clear Sealer
096	Red Cap Spot Putty
097	Acrylic Urethane Clear
098	Deltron Catalyst
099	Del-Seal
100	Paint Remover
101	All Purpose Lacquer Thinner
102	Kleen-Up Solvent
103	Power Steering Fluid 61A,B
104	White Lube
105	NAPA Windshield Washer Solvent
106	Cemented Carbide Products
107	Brazing Flux #1 Silver Solder
108	Acid Flux Cored Solder
109	SP-30 Soldering Paste Flux

Maintenance Chemicals Continued

No.	Product Name
110	Clean-R-Carb
111	Engine Degreaser
112	Battery Cleaner
113	Permatex Hi Temp RTV Silicon
114	Acetylene
115	All Climate Motor Oil 10w-40
116	All Climate Motor Oil 10w-30
117	Motor Oil SAE 40w, non-det
118	Motor Oil SAE 30w, non-det
119	Auto-Trans Fluid, Type FA
120	Auto-Trans Fluid, Dextron II
121	Valvoline Wheel Bearing Grease
122	Marvel Auto Trans Sealer & Con.
123	Devcon Sunroof & W'shield seal
124	Mobil Diesel Fuel
125	Rustoleum Paint Thinner
126	PVC Cement-Clear
127	Delstar Acrylic Enamel DAR-8000
128	" " " DAR-9000
129	" " " DAR-71654
130	" " " DAR-80046
131	" " " DAR-2058
132	Oxygen (02)
133	Grinding Wheels
134	Coolant/Anti-Freeze
135	#1 Diesel - Mobil
136	Gasoline -Aviation
137	
138	Airco Easy Arc 7018AC Weld Rod
139	NAPA Silicone Brake Fluid
140	duPont Lacquer Thinner
141	Loctite Radiator Repair
142	Permatex Gasket Remover
143	Duro Contact Cement
144	Loctite 271 Threadlocker
145	Silicone
146	White Grease
147	Carb & Choke Cleaner
148	Brake Cleaner

SWIMMING POOL CHEMICALS - MSDS are kept in pool office

No.	Product Name
149	Spa-Brom & Related Chems.
150	HCL Solution
151	Sodium Hypochlorite
152	Calcium Hypochlorite
153	Oxysheen
154	Sodium Bicarbonate
155	Sodium Thiosulphate Crystals
156	DPD Powder
157	FAS DPD Titrating Reagent
158	Potassium Iodide Crystals
159	DPD #3 Tablets-Total Chlorine
160	Multitest Reagent #2 Phenol Red
161	Guardex Reagent #4

Pool Chemicals Continued

No.	Product Name
162	Multitest 1200 Reagent #4
163	Tile & Vinyl Cleaner
164	Filter Cleaner
165	Stain/Scale Control
166	Dermapro Spa Bath
167	Multitest 1200 Reagent #3
168	Alkaline Demand Reagent
169	Multitest Reagent #5
170	DPD #1 Tablets
171	Algae Killer
172	Alkalinity Control
173	Guardex Solution #1
174	Guardex Solution #6
175	Guardex Solution #7
176	Guardex Solution #8
177	Guardex Solution #10
178	Reagent #2 Bromine Titrant
179	Guardex Solution #9
180	#7 Alkalinity Indicator
181	#9 Calcium Buffer Reagent
182	#10 Calcium Indicator
183	Guardex Algaecide 60
184	Guardex Algae Control Concent.
185	Aquatech Aquacide
186	Guardex Conditioner
187	Guardex Pool Water Clarifier
188	Guardex pH Stabilizer
189	Guardex Hardness Increaser
190	Guardex Chlorinating Concent.
191	Alkaline Surface Cleaner
192	Alkaline Demand Reagent 3/B
193	Strip Kwik Filter Cleaner
194	DPD #4 Tablets
195	Holister Deodorizer/Germicide
196	Pool Magnet/Metal Inhibitor

SWIMMING POOL CHEMICALS - MSDS are kept in pool office

No.	Product Name
149	Spa-Brom & Related Chems.
150	Muriatic Acid
151	Sodium Hypochlorite
152	Burn Out/Break Out/Pro Shock/Break Point/CLC
153	Oxysheen
154	Sodium Bicarbonate
155	Sodium Thiosulphate Crystals
156	DPD Powder
157	FAS DPD Titrating Reagent
158	Potassium Iodide Crystals
159	DPD #3 Tablets-Total Chlorine
160	Multitest Reagent #2 Phenol Red
161	Guardex Reagent #4
162	Multitest 1200 Reagent #4
163	Guardex Super Chlorinator 35 & other trade names
164	Aquabrome Tablets/Guardex Brominating Tablets
165	pHD, Guardex Dry Acid, Aquatech pH Minus Control IV
166	OPEN FOR FUTURE USE
167	Multitest 1200 Reagent #3
168	Alkaline Demand Reagent
169	Multitest Reagent #5
170	DPD #1 Tablets
171	Guardex Reagent #3 - Acid Demand
172	Hydrotech Reagent #3 - Stabilized pH Indicator
173	Reagent #1-Bromine Indicator Powder, DPD #1 Tablets, Hydrotech Accutest DPD #4
174	DPD #3 Tablets/Hydrotech Accutest DPD #3
175	Guardex Solution #5/Hydrotech Accutest Reagent #6
176	Guardex Solution #2 - Phenol Red
177	Foam Away/AquaTech Defoamer
178	Guardex Tile & Vinyl Cleaner
179	Spa-Guard Brominating Pool Tablets
180	#7 Alkalinity Indicator
181	Mercury Thermometer
182	Muriatic Acid 20 Deg.
183	Vertex CSS-12
184	Alkaline Surface Cleaner
185	Alkaline Demand Reagent 3/B
186	Strip Kwik Filter Cleaner
187	DPD #4 Tablets
188	Holister Deodorizer/Germicide
189	Pool Magnet/Metal Inhibitor

HANDICAP VILLAGE
Chemical List
Revised 6/92 -

V#	Trade Name	Mfg code
001	Vani-Sol	2
002	Vesta-Syde	4
003	Umbrella Floor Sealer	2
004	Umbrella Syntha Seal	2
005	Umbrella Wax/Polish Stripper	2
006	Improved True Blue	1
007	Scene Glass/Multi Cleaner	5
008	Sanasorb	2
009	SC-200	6
010	Outright	1
011	Mr Pip Solvent	7
012	Phosphoric Bowl Cleaner	8
013	Easycare Lemon Polish	5
014	Mist 'n Clean	9
015	1st Degree Degreaser	1
016	Lemon Oil Polish	10
017	Galley Oven Cleaner	5
018	Furniture Cream	8
019	d-Con Mist Insecticide	5
020	d-Con Ant & Roach Liquid	5
021	Professional Scene II	5
022	Roccal II Disinfectant	5
023	d-Con Flying Insect Killer	5
024	Ajax Cleaner	11
025	N.L Creme Cleanser	5
026	Neutrodor Lemon Deodorizer	5
027	Metalist SBR-2000	5
028	Pure and Soft Fabric Softener	12
029	Liquid Paper Correction Fluid	13
030	Wizard Charcoal Lighter	14
031	Fresh Start Laundry Deterg.	11
032	Humidifier Helper	15
033	Whink Humidifier Helper	15
034	Humidifier Descaler	15
035	Humidifier H2O Treatment	16
036	Terro Ant Killer	17
037	Antrol Ant Traps	14
038	N L High Foam Cleaner	5
039	3M Carpet Spray Cleaner	18
040	Masterpiece Floor Finish	5
041	Pro. "Love My Carpet"	5
042	NL All Purpose Cleaner	5
043	Plumbers Friend Drain Cleaner	19
044	Vanisol Disinfectant	5
045	Z-56 Ultra-fast Stripper	5
046	Metalist Floor Finish	5
047	Institutional Lysol Cleanser	5
048	Duration Floor Sealer	5
049	Lime-Shine Acid Deterg.	5
050	SCP HD Bowl Cleaner	19
051	Lime Away	20
052	Super Trump - Dishwasher Det.	20
053	Clorox - Reg. Bleach	21
054	Soft Scrub	21
055	Mr. Muscle Oven Cleaner	22

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056	TLC Pool and Tile Cleaner	23
057	Hil-Tex II - Floor Sealer	24
058	Expediter Floor Finish	24
059	Hil-Tex Floor Finish	24
060	Easy Glow DFM	2
061	Easy Touch Restorer	2
062	Easy 20 Floor Polish	2
063	Medi-Scrub	2
064	Glass Cleaner Concent. VPT	8
065	Nyco Concent. Calci-Solv	25
066	Oatey Reg Clear PVC Solv/Cement	26
067	Oatey Clear Primer	26
068	Oatey #5 Soldering Paste	27
069	Krylon Crystal Clear Spray Coat	28
070	Round-Up Herbicide	29
071	Pro-Turf Trimec Broadleaf 881	30
072	Unleaded Gasoline	31
073	Heet Gasline Antifreeze	32
074	NAPA Silicone Brake Fluid	33
075	Carb & Choke Cleaner	34
076	Brake Cleaner	35
077	Sulphuric Acid Drain Opener	10
078	Dust Mop Treatment	10
079	Reducer	36
080	Acrylic Enamel Reducer	36
081	Acrylic Enamel Retarder	36
082	All Purpose Thinner	36
083	Fish Eye Preventer	36
084	Flatting Paste	36
085	Wax & Grease Remover	36
086	Flexative	36
087	Hardener	36
088	Wash Primer	36
089	Wash Primer Catalyst	36
090	Accelerator Additive	36
091	Kondar Primer Surfacer	36
092	Nitrocellulose	36
093	Zinc Chromate Primer	36
094	Grey Flash Primer	36
095	Clear Sealer	36
096	Red Cap Spot Putty	36
097	Acrylic Urethane Clear	36
098	Deltron Catalyst	36
099	Del-Seal	36
100	Paint Remover	36
101	All Purpose Lacquer Thinner	36
102	Kleen-Up Solvent	24
103	Power Steering Fluid 61A.B	37
104	White Lube	37
105	NAPA Windshield Washer Solvent	38
106	Cemented Carbide Products	39
107	Brazing Flux #1 Silver Solder	40
108	Acid Flux Cored Solder	41
109	SP-30 Soldering Paste Flux	41
110	Clean-R-Carb	42
111	Engine Degreaser	42
112	Battery Cleaner	42
113	Permatex Hi Temp RTV Silicon	43
114	Acetylene	3
115	All Climate Motor Oil 10W-40	44
116	All Climate Motor Oil 10W-30	44

117	Motor Oil SAE 40w. non-det	44
118	Motor Oil SAE 30w. non-det.	44
119	Auto-Trans Fluid, Type FA	44
120	Auto-Trans Fluid, Dextron II	44
121	Valvoline Wheel Bearing Grease	44
122	Marvel Auto Trans Sealer & Con.	45
123	Devcon Sunroof & W'shield seal	46
124	Mobil Diesel Fuel	47
125	Rustoleum Paint Thinner	48
126	PVC Cement-Clear	49
127	Delstar Acrylic Enamel DAR-8000	36
128	" " " DAR-9000	36
129	" " " DAR-71654	36
130	" " " DAR-80046	36
131	" " " DAR-2058	36
132	Oxygen (02)	50
133	Grinding Wheels	51
134	Coolant/Anti-Freeze	52
135	#1 Diesel - Mobil	47
136	Gasoline -Aviation	53
137	Open	00
138	Airco Easy Arc 7018AC Weld Rod	54
139	NAPA Silicone Brake Fluid	33
140	duPont Lacquer Thinner	55
141	Loctite Radiator Repair	43
142	Permatex Gasket Remover	43
143	Duro Contact Cement	43
144	Loctite 271 Threadlocker	43
145	Silicone	35
146	White Grease	35
147	Carb & Choke Cleaner	34
148	Brake Cleaner	35
149	Spa-Brom & Related Chems.	56
150	HCL Solution	57
151	Sodium Hypochlorite	58
152	Calcium Hypochlorite	59
153	Oxysheen	59
154	Sodium Bicarbonate	60
155	Sodium Thiosulphate Crystals	61
156	DPD Powder	62
157	FAS DPD Titrating Reagent	62
158	Potassium Iodide Crystals	62
159	DPD #3 Tablets-Total Chlorine	59
160	Multitest Reagent #2 Phenol Red	59
161	Guardex Reagent #4	56
162	Multitest 1200 Reagent #4	59
163	Tile & Vinyl Cleaner	56
164	Filter Cleaner	56
165	Stain/Scale Control	56
166	Dermapro Spa Bath	63
167	Multitest 1200 Reagent #3	59
168	Alkaline Demand Reagent	59
169	Multitest Reagent #5	59
170	DPD #1 Tablets	59
171	Algae Killer	56
172	Alkalinity Control	56
173	Guardex Solution #1	56
174	Guardex Solution #6	56
175	Guardex Solution #7	56
176	Guardex Solution #8	56
177	Guardex Solution #10	56

178	Reagent #2 Bromine Titrant	56
179	Guardex Solution #9	56
180	#7 Alkalinity Indicator	56
181	#9 Calcium Buffer Reagent	56
182	#10 Calcium Indicator	56
183	Guardex Algaecide 60	56
184	Guardex Algae Control Concent.	56
185	Aquatech Aquacide	56
186	Guardex Conditioner	56
187	Guardex Pool Water Clarifier	56
188	Guardex pH Stabilizer	56
189	Guardex Hardness Increaser	56
190	Guardex Chlorinating Concent.	56
191	Alkaline Surface Cleaner	59
192	Alkaline Demand Reagent 3/B	59
193	Strip Kwik Filter Cleaner	59
194	DPD #4 Tablets	59
195	Holister Deodorizer/Germicide	64
196	Pool Magnet/Metal Inhibitor	59
197	Parsons' Sudsy Ammonia	
198	SPC Enzyme Eliminator	
199	Dermapro Spa Bath	
200	Pro Love My Carpet Powder	
201	Masterpiece Stripper	
202	Sprayway Tru-Nox	
203	Sure-Trac Quarry Tile Cleaner	
204	Diversey Zerospot	
205	Elite II - dishwasher detergent	
206	SpectraCare Handwash Micorbial	
207	Sani-Fresh Body Shampoo	
208	Command Center GLASS CLEANER Concentrate 2	
209	Command Center GENERAL PURPOSE CLEANER Concentrate 3	
210	BLUE SKIES Disinfectant Cleaner	
211	FOUNTAINHEAD Extraction Cleaner	
212	HIGH NOON Urethane Floor Finish	
213	Purity ENBAC AP	
214	Purity Kreme Kleen	
215	Purity D200	
216	Purity 4-Way Bowl Cleaner	
217	Purity Rinse Free Stripper	
218	MAD Mile Acid Detergent	
219	#RA25 Residual Insecticide Spray	
220	Purity One Step	

Bill Arrow

Brushing up

Lisa Cornwell, an apartment coordinator at the Harry Meyering Center, displays the equipment staff members now have to wear while helping mentally retarded residents with their daily needs.

Astronaut care?

Director: New rules put dents in dignity

By JOE TOUGAS
Free Press Staff Writer

MANKATO — How would you feel if the person helping you take care of yourself at home one day showed up wearing a plastic mask, rubber gloves and an apron?

"That I'm less than whole, that I'm not a healthy person," figures Carol Lee, director of the Harry Meyering Center (HMC).

As a supervised home for the mentally retarded, HMC and other similar facilities this week began following new federal regulations that require treating all residents as if they were carrying blood disease.

And in homes such as HMC, where the staff philosophy is to foster an atmosphere of normalcy, the new measures amount to needless overkill, Lee said. And, she continued, part of the cost of following the new standard is residents' dignity.

The new standards, established by the Occupational Safety and Health Administration (OSHA), require protective equipment on all employees who can "reasonably anticipate" coming into contact with

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CARE: A good law that goes way too far

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blood on the job. The measure is designed to limit exposure to blood diseases such as hepatitis B or the HIV virus.

Daryl Anderson, chief of the Minnesota Department of Health's Occupational Division, said that although the new standard is focused upon the medical profession, it's still a blanket requirement for all facilities where exposure to blood can be expected.

At homes such as HMC, which houses 44 residents, routine staff duties such as helping residents eat, brush teeth, change clothes, change laundry and take medication now have to be done with protective clothing — varying degrees of masks, gloves and aprons.

Lee said that while some residents take the new measures in stride, others who have an acute fear of medical personnel and equipment are further traumatized by the medical garb, "which looks as though you just came from Mars."

Judy Dunlop, nursing supervisor at HMC, says group homes offer different circumstances from a hospital or health care center.

"This is where they live, this is their home. We're to approach them in a way a friend might approach you."

Beyond the potential cost to residents' comfort, the new regulations also are expensive. The new equipment, plus an already rescinded provision that hepatitis vaccinations be made available for any staff members desiring them, has cost HMC more than $6,000, Lee said.

In addition, an example that staff members try to set for clients to recycle and avoid use of plastic products doesn't jibe with the amount of disposable protective gear required by OSHA's standard.

Dunlop said the standard is a reaction to the AIDS epidemic, and the result is that facilities such as HMC are implementing AIDS-prevention standards that simply aren't appropriate to the facility. The odds are minimal — if existent at all — of HMC clients contracting HIV, she said.

"The majority of our population is severely and profoundly mentally retarded, so they have to be supervised all the time. They're certainly not sexually active with people outside the facility."

Hepatitis B has been around much longer than HIV, Dunlop noted, yet never before have such widespread precautions been activated in the name of hepatitis.

"It's all changed because of HIV, not hepatitis B."

And protective measures have always been taken with those clients diagnosed with blood diseases. In her 17 years at HMC, she has never caught anything from a client, including those who had hepatitis B.

"And now they're saying we have to treat everyone as though they're a carrier. I think it's overkill, to say the least."

From the health department's point of view, the standard is a blanket approach to safety.

"I know that's somewhat confusing because the hepatitis B rate is relatively low, especially in greater Minnesota," Anderson said. "But the federal folks have decided that all people have to be treated as though they're HIV-positive or hepatitis B positive, because you just don't know."

The rule says it's up to all workplaces to determine whether there's reasonable likelihood staff members will come into contact with blood. Once that determination is made and reported to the state, the standards kick in.

Linda Kilvington, director of Christian Concern (CC), which like HMC operates both group homes and supervised independant homes for the physically and mentally retarded in Mankato, said CC staffers use the protective equipment in incidents where there's an identifiable risk, such as the presence of blood, semen or saliva tinted with blood.

They know which clients will tend to bleed when helped, for instance, with tooth-brushing, and staff members equip themselves accordingly.

"It's discretionary as to who would need that," she said.

Lee said she's uncomfortable going along on a discretionary basis. Although she disagrees with the scope of the standard, she said she's obliged to follow the mandate until it's revised. Efforts are under way at the state and federal levels to get HMC-type facilities out from under the mandate.

"I want to see something in writing that says to me you have the freedom to use your discretion."

But no such leeway is given in the standard, she said.

When the new regulations were unveiled in December, Gerard F. Scannell, assistant secretary of Labor, said: "Employees must treat blood and certain body fluids as if infectious. Meeting these requirements is not optional. It's essential to prevent illness, chronic infection and even death."

"I definitely think it's overreaching," Dunlop said, "that they're asking you to treat everyone as though they're infected. It's impractical, it's costly, it's not good for the environment, and it's not a well-thought-out standard."

AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES

REGULATORY RECOMMENDATIONS

Housing and Urban Development

24 CFR Part 890
Section 811 Supportive Housing for People with Disabilities

There are several HUD programs that provide assistance to people with disabilities. HUD's *Section 811 Supportive Housing for Persons with Disabilities Program* provides financing (in the form of capital advances and project-based assistance) to non-profit sponsors for approximately 2,500 units annually to acquire, rehabilitate or develop affordable housing for people with disabilities (group homes, independent living facilities, and units in multifamily, condominium, and cooperative developments).

Section 811—formerly part of the Section 202 Elderly and Handicapped Housing Program—is one of HUD's most successful programs, scandal-free, and with a history of good management. However, some of HUD's regulations and interpretative guidance relative to Section 811 program are unnecessarily burdensome and restrictive. To its credit, HUD has made some measurable progress in efforts to "streamline" the program in the past few years. However, the program is no longer a loan program but a grant award and HUD has as yet to make the necessary changes. The Section 811 regulations still add to time delays in developing critically needed housing and add unnecessarily to the cost of units.

Since the Administration has proposed consolidating the Section 811 program into a single "performance-based" affordable housing fund, transferring the fund to state and local governments to continue this housing as an eligible activity, ANCOR will reserve making many specific recommendations for the program at this time. Instead, ANCOR will continue to work directly with HUD and with the Congress on the future of this program and other HUD assistance for people with disabilities to meet the critical need for affordable and accessible housing.

However, ANCOR does have the following specific regulatory concern relative to HUD and OMB Circular A-133.

24 CFR Part 45
And HUD Prohibition Against Use of Single Audit

OMB Circular A-133 "Audits of Institutions of Higher Education and Other Nonprofit Institutions," provides policy guidance to Federal agencies for establishing uniform requirements for audits of awards provided to institutions of higher education and other nonprofit organizations. The provisions of Circular A-133 apply to:

a. Federal departments and agencies responsible for administering programs that involve grants, cost-type contracts and other agreements with institutions of higher education and other nonprofit recipients.

b. Institutions of higher education and other nonprofit institutions whether they are recipients receiving awards directly from Federal agencies or are subrecipients receiving awards indirectly through other recipients.

ANCOR member provider agencies are sponsors under Section 811 housing program and its predecessor Section 202 housing program. Nonprofit organizations are the only eligible applicants under this program. However, for HUD programs whose regulations are set forth in 24 CFR parts 200 series and 800 series, a nonprofit institution is the nonprofit corporation which owns the individual property receiving the HUD assistance. Therefore, these projects are required to complete project-specific audits because they are deemed to be "separate entities."

In accordance with the OMB Compliance Supplement, incident to the insured mortgage, where HUD provides federal fund, the audit reports pertaining to nonprofit organizations subject to these regulations are to be submitted within 60 days after the end of the fiscal year audited. The audits currently conducted under applicable HUD audit guides for these programs serve as the organization-wide audits. This means that ANCOR members must bear the cost of a single audit for some federal funds and in addition bear the cost of a separate audit for HUD funds.

HUD's Section 811 program is no longer a loan program nor when the program was previously a part of the Section 202 program was it part of an insured mortgage program. It is both costly and duplicative for nonprofit organizations who receive HUD funding to provide housing for people with disabilities as well as other federal financial participation as direct recipients or as subrecipients to complete both a HUD project-specific audit and an agency-wide single-audit.

ANCOR Recommendation Regarding OMB Circular A-133 and HUD

ANCOR members have an interest in ensuring that federal funds to provide housing for people with disabilities and supports and services to people with disabilities are subject to appropriate accounting procedures. ANCOR members have a responsibility to use federal funds in a cost-effective and efficient manner. Therefore, ANCOR members have an interest in reducing federal regulatory burdens that add unnecessarily to the cost of the supports and services financed with federal funds. Nonprofit organizations who sponsor HUD "supportive housing for people with disabilities" should not have to undergo the added expense of an additional HUD project-specific audit when other federal funding to the same entity is eligible for the organization-wide audits required by OMB Circular A-133.

ANCOR recommends that the current prohibition against an organization-wide audit for HUD Section 202 and 811 programs under OMB Circular A-133 be abolished. With an eye to streamlining government and reducing unnecessary regulatory burden, ANCOR recommends

that nonprofit organizations who receive HUD funding to provide housing for people with disabilities and who receive other federal financial participation be able to complete a single organization-wide audit for all federal participation under a revised OMB Circular A-133 policy guidance.