



MONTANA
ADMINISTRATIVE
REGISTER



DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

NOTICE OF ADOPTION

MAR NOTICE NO. 2026-323.3

Summary

Amendment of ARM 37.106.2801, 37.106.2802, 37.106.2805, 37.106.2809, 37.106.2810, 37.106.2814, 37.106.2816, 37.106.2824, 37.106.2829, 37.106.2836, 37.106.2839, 37.106.2866, 37.106.2899, 37.106.2899A, 37.106.2899B, 37.106.2899C, 37.106.2899D, 37.106.2899E, and 37.106.2899H and adoption of NEW RULE 1 pertaining to assisted living facility licensing

Previous Notice(s) and Hearing Information

On February 20, 2026, the Department of Public Health and Human Services published MAR No. 2026-323.1 pertaining to the public hearing on the proposed amendment and adoption of the above-stated rules in the 2026 Montana Administrative Register, Issue Number 4. On April 24, 2026, the department published MAR Notice No. 2026-323.2, a supplemental notice concerning the proposed amendment and adoption of the above-stated rules in the 2026 Montana Administrative Register, Issue Number 8.

A public hearing was held on May 18, 2026.

Final Rulemaking Action – Effective September 26, 2026

ADOPT AS PROPOSED

The agency has adopted the following rule as proposed:

NEW RULE 1 (37.106.2899I) CATEGORY D1: LEVEL OF CARE AND SERVICES TO RESIDENTS

AMEND AS PROPOSED

The agency has amended the following rules as proposed:

37.106.2801 SCOPE

37.106.2802 PURPOSE

37.106.2809 LICENSE APPLICATION PROCESS

37.106.2810 LICENSE RESTRICTIONS

37.106.2814 ADMINISTRATOR

37.106.2816 ASSISTED LIVING FACILITY STAFFING

37.106.2824 INVOLUNTARY DISCHARGE CRITERIA

37.106.2829 RESIDENT FILE

37.106.2836 FURNISHINGS

37.106.2839 ENVIRONMENTAL CONTROL

37.106.2866 CONSTRUCTION, BUILDING, AND FIRE CODES

37.106.2899 CATEGORY D: CONSTRUCTION

37.106.2899A CATEGORY D: ADMINISTRATOR QUALIFICATIONS

37.106.2899B CATEGORY D: DISCLOSURE TO CATEGORY D RESIDENTS

37.106.2899C CATEGORY D: STAFF

37.106.2899D CATEGORY D: RESIDENT ASSESSMENTS

37.106.2899E CATEGORY D: HEALTH CARE PLAN

37.106.2899H CATEGORY D: SECLUSION ROOM REQUIREMENTS

AMEND WITH CHANGES

The agency has amended the following rule with the following changes from the original proposal, stricken matter interlined, new matter underlined:

37.106.2805 DEFINITIONS

The following definitions apply in this subchapter:

- (1) "Activities of daily living (ADLs)" means tasks usually performed in the course of a normal day in a resident's life that include eating, walking, mobility, dressing, grooming, bathing, toileting, and transferring.
- (2) "Administrator" means the person designated on the facility application or by written notice to the department as the person responsible for the daily operation of the facility and for the daily resident care provided in the facility.
- (3) "Advance directive" means a written instruction, such as a living will, a do-not-resuscitate (DNR) order, or durable power of attorney (POA) for health care, recognized under state law relating to the provision of health care when the individual is incapacitated.
- (4) "Ambulatory" means a person is capable of self-mobility, either with or without mechanical assistance. If mechanical assistance is necessary, the person is considered ambulatory only if they can, without help from another person, transfer, safely operate, and utilize the mechanical assistance, exit and enter the facility, and access all common living areas of the facility.
- (5) "Assisted living facility" is defined at 50-5-101, MCA.
- (6) "Change of ownership" means the transfer of ownership of a facility to any person or entity other than the person or entity to whom the facility's license was issued, including the transfer of ownership to an entity which is wholly owned by the person or entity to whom the facility's license was issued.
- (7) "Department" means the Department of Public Health and Human Services (DPHHS).
- (8) "Direct care staff" means a person or persons who directly assist residents with personal care services and medication. It does not include housekeeping, maintenance, dietary, laundry, administrative, or clerical staff at times when they are not providing any of the above-mentioned assistance. Volunteers can be used for direct care, but may not be considered part of the required staff.
- (9) "Health care plan" means a written resident specific plan identifying what ongoing assistance with ADLs and health care services is provided on a daily or regular basis by a licensed health care professional to a category B, C, or D resident under the orders of the resident's practitioner. Health care plans are developed as a result of a resident assessment performed by a licensed health care professional who may consult with a multi-disciplinary team.
- (10) "Health care service" means any service provided to a resident of an assisted living facility that is ordered by a practitioner and required to be provided or delegated by

a licensed, registered, or certified health care professional. Any other service, whether or not ordered by a physician or practitioner, that is not required to be provided by a licensed, registered, or certified health care professional is not to be considered a health care service.

- (11) "Involuntary transfer or discharge" means the involuntary discharge of a resident from the licensed facility or the involuntary transfer of a resident to a bed outside of the licensed facility. The term does not include the transfer of a resident from one bed to another within the same licensed facility, or the temporary transfer or relocation of the resident outside the licensed facility for medical treatment.
- (12) "License" means the document issued by the department that authorizes a person or entity to provide assisted living services.
- (13) "Licensed health care professional" means a licensed physician, physician assistant-certified, advanced practice registered nurse, or registered nurse who is practicing within the scope of the license issued by the Department of Labor and Industry.
- (14) "Mechanical assistance" means the use of any assistive device that aids in the mobility and transfer of the resident. Assistive devices include braces, walkers, canes, crutches, wheelchairs, and similar devices.
- (15) "Medication administration" means an act in which a prescribed drug or biological is given to a resident by an individual who is authorized in accordance with state laws and regulations governing such acts.
- (16) "Mental disorder" means a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior.
 - (a) For the purpose of this subchapter, the term includes dementia, Alzheimer's disease, and traumatic brain injury.
- (17) "Mental health professional" means:
 - (a) a certified professional person;
 - (b) a physician licensed under Title 37, chapter 3, MCA;
 - (c) a professional counselor licensed under Title 37, chapter 23, MCA;
 - (d) a psychologist licensed under Title 37, chapter 17, MCA;
 - (e) a social worker licensed under Title 37, chapter 22, MCA;
 - (f) a marriage and family therapist under Title 37, chapter 37, MCA;
 - (g) an advanced practice registered nurse, as provided for in ~~37-8-202~~ 37-8-102, MCA, with a clinical specialty in psychiatric mental health and mental disorders nursing; or

- (h) a physician assistant licensed under Title 37, chapter 20, MCA, with a clinical specialty in psychiatric mental health.
- (18) "Nursing care" means the practice of nursing as governed by 37-8-102(7), MCA and by administrative rules adopted by the Board of Nursing, found at ARM Title 24, chapter 159.
- (19) "Personal care" means the provision of services and care for residents who need some assistance in performing ADLs.
- (20) "Practitioner" means an individual licensed by the Department of Labor and Industry who has assessment, admission, and prescription authority.
- (21) "PRN medication" means an administration scheme, in which a medication is not routine, is taken as needed, and requires the licensed health care professional or individual resident's own cognitive assessment and judgement for need and effectiveness.
- (22) "Resident" means anyone at least 18 years of age accepted for care in an assisted living facility.
- (23) "Resident agreement" means a signed, dated, written document that lists all charges, services, refunds, and move out criteria and complies with ARM 37.106.2823.
- (24) "Resident certification" means written certification by a licensed health care professional that the facility can adequately meet the particular needs of a resident. The licensed health care professional making the resident certification must have:
 - (a) visited the resident on site; and
 - (b) determined that the resident's health care status does not require services at another level of care.
- (25) "Resident's legal representative" or "resident's representative" means the resident's guardian, or if no guardian has been appointed, then the resident's family member or other appropriate person acting on the resident's behalf.
- (26) "Self-administration assistance" means providing necessary assistance to any resident in taking their medication, including:
 - (a) removing medication containers from secured storage;
 - (b) providing verbal suggestions, prompting, reminding, gesturing, or providing a written guide for self-administrating medications;
 - (c) handing a prefilled, labeled medication holder, labeled unit dose container, syringe or other labeled container from the pharmacy or a medication organizer as described in ARM 37.106.2847 to the resident;
 - (d) opening the lid of the above container for the resident;

- (e) guiding the hand of the resident to self-administer the medication;
 - (f) holding and assisting the resident in drinking fluid to assist in the swallowing of oral medications; and
 - (g) assisting with removal of a medication from a container for residents with a physical disability which prevents independence in the act.
- (27) "Service coordination" means that the facility either directly provides or assists the resident to procure services including, but not limited to:
- (a) beauty or barber shop;
 - (b) financial assistance or management;
 - (c) housekeeping;
 - (d) laundry;
 - (e) recreation activities;
 - (f) shopping;
 - (g) spiritual services; and
 - (h) transportation.
- (28) "Service plan" means a written plan for services developed by the facility with the resident or resident's legal representative which reflects the resident's capabilities, choices and, if applicable, measurable goals and risk issues. The plan is developed on admission and is reviewed and updated annually and if there is a significant change in the resident's condition. The development of the service plan does not require a licensed health care professional.
- (29) "Severe cognitive impairment" means the loss of intellectual functions, such as thinking, remembering, and reasoning, of sufficient severity to interfere with a person's daily functioning. Such a person is incapable of recognizing danger, self-evacuating, summoning assistance, expressing need, and/or making basic care decisions.
- (30) "Significant change" means a resident status or condition change that results in a change in service and care needs. This includes:
- (a) admission to, or discharge from hospice services;
 - (b) a change in categorization; or
 - (c) an accident or health event that changes the functional or cognitive abilities of the resident.
- (31) "Therapeutic diet" means a diet ordered by a physician or practitioner as part of treatment for a disease or clinical condition or to eliminate or decrease specific

nutrients in the diet, (e.g., sodium) or to increase specific nutrients in the diet (e.g., potassium) or to provide food the resident is able to eat (e.g., mechanically altered diet).

- (32) "Third party services" means care and services provided to a resident by individuals or entities who have no fiduciary interest in the facility.
- (33) "Treatment" means a therapy, modality, product, device, or other intervention used to maintain well-being or to diagnose, assess, alleviate, or prevent a disability, injury, illness, disease, or other similar condition.

Authorizing statute(s): 50-5-103, 50-5-226, 50-5-227, MCA

Implementing statute(s): 50-5-225, 50-5-226, 50-5-227, MCA

Statement of Reasons

Statement of Reasons

The agency has considered the comments and testimony received. A summary of the comments received, and the agency's responses are as follows:

Comment #1: A comment was received indicating that creation of the Category D1 designation under NEW RULE 1 is contrary to controlling Montana statutes (50-5-226 and 53-21-199, MCA) and the legislative intent behind these statutes. The commenter indicates these statutes define a single Category D population and allow individuals within this population to reside in any Category D facility willing to accept them. The commenter believes the statutes distinguish facilities based only on their choice to be "seclusion and restraint-free" or "seclusion and restraint-capable" and that each type of facility may serve any Category D resident. The commenter indicates that NEW RULE 1 upends this legislative intent by creating a separate "Category D1" facility and population, restricting placement for individuals with practitioner orders for restraint/seclusion or those who are involuntarily admitted.

Response #1: The Office of Inspector General (OIG) thanks the commenter for this comment and the concerns expressed, but disagrees that the establishment of the category D1 designation conflicts with statute or the legislative intent behind the statutes. NEW RULE 1 was developed by the OIG in consultation with the department's Senior and Long Term Care division and serves two primary purposes. First, a Category D facility that intends to admit individuals who have orders for restraint and seclusion will have additional requirements that must be met, including physical plant requirements, to ensure the health and safety of these individuals and these requirements should not apply for all Category D facilities, since not all facilities necessarily plan to admit such individuals. The establishment of a Category D1 designation allows facilities to determine which level of category D residents they intend to serve and

ensures that facilities are subject only to those regulations necessary to ensure the health and safety of the particular residents they intend to serve.

Second, the establishment of a Category D1 designation to serve individuals who are involuntarily admitted or who have a practitioner order for restraint or seclusion is necessary for the department to implement a service reimbursement model under 50-5-226(5)(h), MCA. Specifically, the statute directs the department to “develop and maintain a reimbursement model that secures adequate capacity in category D assisted living facilities to allow for sufficient bed space to divert as many people as possible from commitment to the Montana state hospital.” To ensure maximum available funding for Category D services, the department is seeking to use a combination of Medicaid Home and Community Based Services (HCBS) funds and state general funds as part of the reimbursement model. The federal HCBS settings rule (42 CFR 441.301) impacts the ability for Medicaid HCBS funds to be used in a Category D facility that accepts individuals for involuntary placement or that utilizes restraint or seclusion. By creating a separate category D1 designation for these facilities, the department believes it will be able to use general funds for these services and HCBS funds for category D facilities in a manner compliant with the requirements of the federal settings rule.

Comment #2: Two written comments were received regarding amendments to ARM 37.106.2805 that clarify and define activities of daily living (ADLs) being limited and suggest that it be a broader definition to ensure more options for care.

Response #2: The OIG thanks the commenters for this suggestion; however, ADLs are defined in ARM 37.106.2805(1) and remain unchanged from the original definition. No changes to the rule are needed.

Comment #3: A written comment was received regarding concerns about restricting couples from living together, restricting ongoing service for evolving needs, and the fear of allowing residents who meet the care-needs requirements but do not fit the community demographic, which could create social instability.

Response #3: The OIG thanks the commenter for these concerns. The OIG has had discussions with providers regarding couples and the concern of potentially splitting them up due to one needing ALF services and the other not. The OIG cannot make changes to statutory requirements through rulemaking.

In response to the comment about the fear of allowing residents who meet care needs but do not fit the community demographic, the licensure bureau cannot establish licensing rules that are specific to “community demographics” as this can be widely different from one ALF to another, and is a matter of interpretation, which cannot be easily assessed for compliance. Determining whether a resident is a good fit in an ALF is the responsibility of the facility, and can be analyzed through the required pre-move-in Resident Needs Assessment (RNA).

Comment #4: A written comment was received regarding clarity for people choosing to enter assisted living before needing assistance with ADLs, but as a means of maintaining community.

Response #4: The OIG thanks the commenter for their question. There is no obligation for a facility to admit everyone who wants to be admitted. It is a facility's responsibility to screen and assess individuals applying or requesting to be admitted to a facility, and ensure that those they intend to admit are appropriate for the level of care for which the ALF is licensed to provide. This requirement remains unchanged and is expected to continue under the new Category A and Category D parameters.

Comment #5: Three written comments were received regarding clarification on ADLs covering physical needs, but not other needs, such as medication management.

Response #5: The OIG thanks the commenters for this question. Medication management has never been considered an ADL in licensing. ARM 37.106.2805(1) defines ADLs, and this section of the rule has been in place, unchanged, since 2004. Medication management is an approved "criterion" for certain Medicaid waiver entities, which is separate from licensing. The rule mirrors the current definition of ADLs found in 50-5-101(2), MCA. The OIG does not have authority to alter this statutory definition.

Comment #6: Two written comments were received regarding concern about the separation of a couple in which only one meets the ADL requirements to be considered a resident in an assisted living facility.

Response #6: The OIG thanks the commenters for addressing these concerns. Please see response #3.

Comment #7: Eleven written comments were received requesting broadening the requirements for ADL support to include those who still live independently, those with a spouse still living independently, and residents needing assistance with medications.

Response #7: The OIG thanks the commenters for the suggestions noted above. Please see responses #2 and #5.

In response to comments regarding supporting individuals who still live independently, the OIG supports them through the licensing and regulatory oversight of retirement homes. Retirement homes (RTH) are defined as "a building or buildings in which separate living accommodations are rented or leased to individuals who use those accommodations as their primary residence." (50-5-101(49), MCA).

RTH and ALF licensing within the same building has always been allowed, provided the populations are distinctly separated, and beds are licensed as either ALF or RTH. With the new law change, the OIG has extended the flexibility on this former requirement, allowing populations to be mixed within a building. When conducting licensing reviews, the OIG would

instead look at the individual's designation occupying a bed, rather than identifying the bed itself as RTH or ALF. This would allow residents who do not meet ALF Category A requirements and are "independent" to still be admitted under a facility's RTH license and designated as an RTH resident, rather than an ALF resident. There are no stipulations against RTH residents intermingling with ALF residents for activities or meals, and there are no regulations within RTH licensing requirements that prohibit RTH staff from providing medication management. This would also facilitate providers not having to move a resident who went from the RTH level of care to the true ALF level of care. The resident would be allowed to remain in the same room/space and be identified by their level of care specifically.

Comment #8: A written comment was received requesting the addition that ADLs include basic, functional ADLs and instrumental ADLs.

Response #8: The OIG thanks the commenter for this request. Please see response #5.

Comment #9: Two written comments were received requesting that ARM 37.106.2805 be rewritten to broaden the scope of ADLs and to avoid excluding couples where only one qualifies for that level of care.

Response #9: The OIG thanks the commenters for this suggestion. Please see responses #2 and #4.

Comment #10: A written comment was received requesting that the language be updated to include the need for "at least one ADL or IADL."

Response #10: The OIG thanks the commenter for this suggestion. Please see response #4.

Comment #11: A written comment was received regarding NEW RULE 1 concerning category D1 classifications and requesting clarity on those being involuntarily admitted to a facility for care and the expectations for care.

Response #11: The OIG thanks the commenter for this request for clarification. The involuntary admittance is to facilitate the diversion from involuntary commitment to the Montana State Hospital, as described in 53-21-199, MCA. This Category D resident can voluntarily choose to go to a Category D ALF and be under a standard Category D ALF license, given that they meet the criteria. However, when the diversion is court-ordered, the resident will be required to be admitted under a Category D1 designation, and all criteria for D must be met, along with the provisions required under NEW RULE 1.

Comment #12: Twelve written comments were received regarding concern over ADLs restricting those whose main need is medication management, and where one spouse meets criteria for that level of care but the other does not.

Response #12: The OIG thanks the commenters for these concerns. Please see responses #2 and #4.

Comment #13: A written comment was received requesting that additional language be added to clarify licensure requirements between private-pay facilities and government-funded facilities. Additionally, the commenter requested broader admissions guidelines to allow spouses to stay together.

Response #13: The OIG thanks the commenter for this suggestion. Please see response #3.

Comment #14: Two written comments were received expressing concern that the rule amendments do not address those needing assistance managing medications, those who choose assisted living for community and security, and those with a spouse who does not meet admission requirements.

Response #14: The OIG thanks the commenters for these concerns. Please see responses #3 and #4.

Comment #15: A written comment was received regarding concerns related to ADLs being restrictive and non-inclusive of needs such as medication management, the financial strain on seniors seeking alternative short-term options before meeting the necessary requirements, and suggesting that the small business impact is inaccurate, with a much higher number of businesses impacted (especially rural businesses).

Response #15: The OIG thanks the commenters for these comments. Please see responses #4 and #6.

The OIG granted a waiver allowing all currently admitted residents to be grandfathered in and remain at the ALF despite the new category A requirements in law. Notice of this waiver was sent to all providers on April 14, 2026. Under this waiver, the OIG is not requiring facilities to discharge any currently admitted residents.

Expanding on the bureau's flexibility with RTH allowances as described in response #7, the licensing fees for an RTH are the same as ALF fees, meaning most RTHs in rural areas would pay \$20 for a license (given their RTH license was designated for 20 individuals or less). Due to the minimal requirements for RTHs – which are almost exclusively physical plant requirements – if a facility keeps up with its maintenance, most RTHs get three-year licenses. An approximately \$20 licensing fee every three years does not constitute a significant impact on small businesses.

Comment #16: Four written comments were received requesting that 50-5-226(2), MCA be waived until the next legislative session to reconsider concerns such as the separation of couples based on differing care needs, and the definitions of ADLs to include assistance with medication management. Two comments contained two petitions containing 116 signatures from concerned family and friends, and 10 signatures from concerned citizens.

Response #16: The OIG thanks the commenters for this suggestion. Please see responses #3 and #5.

Comment #17: Three written comments were received requesting updating of the ADLs requirement to be more inclusive. One of the commenters included signatures from residents and family members in support of the request.

Response #17: The OIG thanks the commenters for this suggestion. Please see response #5.

Comment #18: A written comment was received expressing concern with the restriction of married couples being unable to cohabitate due to differing levels of needs, the restrictive nature of the new definition for required ADLs that do not necessarily include IADLs, the need for community that these facilities offer, and a concern that long-term stability in these facilities will be compromised due to the movement of residents and staff too frequently.

Response #18: The OIG thanks the commenters for voicing these concerns. Please see responses #2 and #5.

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Approval

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