LTCCC LONG TERM CARE COMMUNITY COALITION
Working to improve long term care through research, education & advocacy

CARE AND OVERSIGHT OF ASSISTED LIVING IN NEW YORK STATE

Written by

Cynthia Rudder, Ph.D., Director of Special Projects

Richard J. Mollot, J.D., Executive Director

Lucia A. Caltagirone, J.D., MPH, Public Policy Intern

Supported by a grant from the Robert Sterling Clark Foundation

May, 2011

EXECUTIVE SUMMARY

INTRODUCTION

There are currently a diverse array of "assisted living" arrangements offered in New York State. Those licensed by the state include: adult homes, enriched housing, assisted living residences (ALRs) (which must first be licensed as adult homes or enriched housing), and the Medicaid assisted living program[1] (ALP) that may be located in any of the other three. In addition, ALRs may apply for special certification to provide care to special populations such as residents with dementia and residents who are becoming sicker and more dependent (e.g., "aging-in").

Though assisted living provides home and services to vulnerable populations, and is the fastest growing form of senior housing, its development in New York State over the years has been chaotic. While we have had mandated licensure for adult homes and enriched housing for many years, we did not have a legal requirement for licensure of assisted living residences until 2004 and no regulations implementing that law until 2008. In September 2009, as the result of two provider industry lawsuits, the Albany County Supreme Court ruled invalid key components of the 2008 assisted living residence regulations. Importantly, from the consumer perspective, the court nullified: the requirement for at least one professional caregiver on staff for facilities certified to provide special care for those with dementia or enhanced needs (those aging-in); a number of structural and environmental standards in the regulations; and rules relating to resident notice of fee increase.

The adult home industry in New York State has had a long history of poor care. In 1977, then Deputy Attorney General Charles Hynes issued a report detailing the poor conditions, financial corruption and mistreatment of residents rampant in the adult home system. In 2001, LTCCC completed a three year study of the assisted living industry in New York State. Among its findings: forty percent of the unlicensed facilities reported using nurse aides, not professional nurses, to administer medication to those individuals not self directing; few of the facilities had procedures that assured fully informed consent related to refusal of treatment; and there were many problems finding and keeping well trained staff. In April 2002, *The New York Times* investigated the adult home industry in New York and published a three part series on the existence of extremely poor conditions. Discussing the homes catering to the mentally ill, the article stated: many had, "…devolved into places of misery and neglect…" In August of that year, the New York State Commission on Quality Care for the Mentally Disabled released a study which concluded that they had "…found a fundamentally flawed service system…."

[1] A Medicaid covered entity established and operated for the purpose of providing long term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator who need skilled nursing care and can be safely cared for in an adult home or enriched housing.

In October of that year, a workgroup set up by the New York State Department of Health (DOH) to study the issue released its report. The report stated that certain segments of the industry had a long history of problems stretching back as far the late 1970s. It raised issues with medication management, service coordination, resident assessment and payment. In 2006, the Commission on Quality Care released a new study on impacted adult homes (i.e., homes with 25 percent or more mentally ill). The findings indicated continuing issues with: medication, adequate resident assessment, layering of services and coordination of services. In 2007, the Commission released a study on ALPs in the impacted adult homes. The Commission found that some providers were spending much less on care than they received from the state, Medicaid payment levels were inflated by unsupported need assessments and providers had substantial disparities between level of need and plans of care and actual services provided. In 2007, a consumer group, the Schuyler Center for Analysis and Advocacy, released an action plan for the state. According to their report underlying the plan, adult homes are unsuitable residences for people with psychiatric disabilities because they fail to promote skill development, independence and/or recovery. In addition to recommendations to move these residents out of adult homes, the report also discussed the need to improve the state's adult home inspection process.

STUDY FINDINGS

LTCCC undertook the present study with the goal of identifying the current state of the quality of care and life in the state's assisted living facilities as well as the ability of the Department of Health (DOH) to monitor the system. The following data were analyzed: summaries of quarterly inspection reports posted on DOH's website; a random sample of nine percent of all the inspection findings of adult homes, enriched housing, ALPs and assisted living residences from 2002 to mid September 2010; ombudsmen complaint data from 2007 through 2009; on-line survey results from both ombudsmen and consumer respondents; follow up interviews with a select group of ombudsmen and consumer representatives; and all DOH enforcement actions from 2002 through 2010.

Department of Health Inspection

- ***Endangerment of residents drops but most facilities still violating the rules.*** According to DOH quarterly reports on inspections, over the years 2002 to 2011, between 63 percent and 86 percent of all the facilities inspected were cited for non-compliance, which represented harm or risk of harm to residents and to resident quality of life, with the rules governing care. In the last two years, while the percentages of facilities being cited dropped, a majority of facilities are still being cited. Percentages of facilities cited for endangering their residents ranged from zero to almost nine percent for the years 2002 to 2011. In the last two years, the percentages dropped to a range of under one percent to almost three percent.
- ***The areas cited most frequently remained the same for nine years across the state.*** The three most cited areas by DOH were Resident Services, Medication and Environment. While the

numbers of citations dropped in the 2007-2010, these areas remained high and continued to be the areas most cited.

- ***The same violations and findings in medication and environment are repeated year after year.*** Of all the violations for medication in recent years, 24 percent were repeated non-compliance that was systemic **or** so significant that it created conditions which directly caused or exposed residents to harm. Over 19 percent of the environment citations were also repeats in recent years.
- ***Use of resident interviews for documentation of violations is infrequent.*** Statewide, for the 2002-2010, the most often used source for the citation by inspectors was examining facility records. Interviewing residents was listed infrequently as a source of documentation for citations. This raises the question of whether inspectors are interviewing enough residents to adequately identify existing problems.
- ***Homes with a mentally ill population more likely to have many problems.*** DOH surveyors are now finding twice as many violations in the impacted homes as the non-impacted homes.
- ***Assisted living residences licensed under the new law have the same types of problems as traditional facilities.*** Inspectors cited the same three areas the most in the licensed ALRs as they did in the adult homes and enriched housing and in the same numbers (as in those which are not impacted): resident services, medication and environment. In addition, admission standards were a very close fourth area cite in ALRs.

Department of Health Enforcement

- **Few violations cited led to enforcement actions unless they were "endangerment" violations.** Over the years 2002 through 2010, the Department found violations, (i.e., harm or risk of harm) on over 5000 surveys. Only a little over 400 of these led to enforcement actions. One of the reasons for this may be that current state law does not permit a sanction for such violations if a facility corrects within 30 days.
- **73 percent of the endangerment citations led to sanctions.** Of the 86 facilities that endangered their residents at least once during the years 2006 to 2010, to date DOH has fined or sanctioned 63 facilities.
- **17 percent of the endangerment cases are "pending," several for from three to five years.** Some of the cases from years ago have yet to be finalized. Of the 116 endangerment citations, 16 are pending. **Eight of the pending cases are from three to five years ago**. Although they should have been, a number of these cases (10) were not referred to the legal staff for action by the regional offices.
- **New York's public health law impedes enforcement action.** Many facilities violating the rules and regulations cannot be fined because the law does not permit DOH to sanction them if they correct within 30 days (except for an endangerment violation).
- **Insufficient DOH agency staffing appears to hinder effective and timely enforcement.** Though appropriate preparation for hearings is time consuming, DOH has few attorneys handling these cases. Thus, years can go by before some cases are finalized**.**

The Long Term Care Ombudsman Program

- **In addition to problems in resident services (also found by DOH), ombudsmen received many complaints related to resident rights and food.**

- **Half of the ombudsmen respondents find the DOH to be only somewhat effective in monitoring.**
- **Ombudsmen want DOH to increase the effectiveness of the survey and enforcement processes.** A number of ombudsmen suggested increasing fines, scheduling more unannounced inspections, interviewing more residents and implementing a six-month self-assessment for facilities.
- **Ombudsmen want stronger rules and regulations in resident services, personnel and resident rights.** Ombudsmen noted that they would like to see increased staffing, improved staff training, and more resident engagement in decision-making.

Consumer Advocates

- **Consumer advocates have found problems related to: retaliation; inappropriate discharge and eviction; poor food quality, choice and quantity; lack of access to personal funds and property; co-mingling of funds; lost or stolen items; dignity, respect and staff attitudes; poor supervision by administrators ; and lack of activities in impacted homes.**
- **Consumer advocates feel that DOH needs to change or improve by interviewing or speaking to residents more and by looking at outcome as well as process.**
- **Civil penalties were seen as too small to make any difference and the rule that if a facility corrects within 30 days it cannot be fined was seen as "...an even bigger slap in the face."**

DISCUSSION

Despite a long history of problems, and major initiatives over the years to address those problems, the assisted living industry in New York State still has serious issues related to resident care and quality of life. From our perspective, it is – or should be – unacceptable that the very same areas identified as problematic over the last few decades are still causing harm to residents in assisted living today. It is particularly outrageous that two of the three major identified issues are repeated year after year by some of the same facilities. Medication citations are still rampant and, alarmingly, almost a quarter of them are repeats from earlier inspections. In addition, 19 percent of the environmental violations are repeats. These include safety issues as well as issues related to quality of life. This is deplorable. To make matters worse, the number of problems may in fact be under identified by DOH: some ombudsmen and resident advocates believe that DOH is not identifying major problems that they see relating to resident rights, discharge and transfer, personal funds and property.

Our data indicate that even after the investigations of the early 2000s, the impacted homes, homes with 25 percent or more residents with mental disabilities, still have more problems when compared to non-impacted homes. The impacted homes have twice the number of violations as the non-impacted homes. This too, especially given the longstanding public acknowledgement of these issues, is simply unacceptable.

Ombudsmen and resident advocates suggest that one of the reasons inspectors are not citing problems that they believe are occurring is that inspectors are not speaking to residents and/or do not

treat residents as credible sources of information about the facilities in which they live. Our analysis of the documentation of violations also indicates that inspectors may not be speaking to enough residents to identify the problems that ombudsmen and resident advocates see. Although the data do not permit us to analyze how many residents inspectors are interviewing, the infrequent times an inspector lists a resident interview as a source of a citation seems to indicate that they are either not interviewing enough residents and/or are not finding them credible.

Alarmingly, enforcement data indicate that too few homes are being held accountable for their violations in a timely fashion. Findings, or non-compliance that does not meet the threshold of a violation due to its scope and severity, are never referred for enforcement action. In addition, many homes escape an enforcement action, even for serious problems, because state law does not permit DOH to levy a fine if the home corrects or has implemented an acceptable correction and monitoring plan within 30 days of notice (except for an endangerment violation). Thus, even if a home is found to have repeatedly violated minimum standards, harmed their residents or put their residents at risk of harm, so long as it is not an endangerment violation or it is correcting within 30 days each time it is cited it cannot be fined.

There are other reasons that few homes being held accountable. The state law requirement that DOH can levy only a "per day" fine, has led to referral for enforcement action of only those non-endangerment violations which have continued to occur at a second inspection. DOH needs evidence that the violation is continuing past one day and that the violation has not been corrected within 30 days. Another possible reason for a lack of strong and timely enforcement may be a lack of sufficient resources at DOH. Preparing for hearings is extremely labor-intensive, especially since facilities can argue a number of technical issues at a hearing rather than whether or not they violated the rules. For example, they can argue that the problem was corrected within the 30 days of the notice they received or that there were problems with the way in which they were given notice of their violation(s) that should prevent them from being sanctioned. DOH attorneys must prepare for such arguments in addition to proving that the facility did it fact violate the rules and harm or put residents at risk of harm. Since there are very few attorneys working on these issues, some enforcement actions languish. During the last few years, we were told that DOH counsel has worked to shorten the time it takes to prepare for hearings by improving communication with program staff by appointing a staff member as a liaison between the legal staff and the program staff as well as by giving legal staff access to the program enforcement data base. This gives them the history of facility enforcement and helps them when they interview the DOH surveyors who cited the violations. In addition, DOH changed the regulation that permitted the administrative law judge's decision to be final. In the past, DOH attorneys did not have the ability to appeal an administrative law judge's decision. Now the judge can only recommend to the DOH Commissioner and DOH counsel has the right to argue its case to the Commissioner. These are good steps towards improving the efficacy of enforcement of the basic rules and standards.

Based on our findings (discussed in greater detail in the body of the report), following are recommendations for state policy makers on ways in which the quality and safety of assisted living in New York State can be improved.

RECOMMENDATONS

Legislature

To improve assisted living quality:

1. **Amend Section 461-a of the Public Health Law (Responsibility for Inspection and Supervision) to require an annual inspection of each facility.** Currently a facility receiving the "highest rating" may be inspected every 18 months rather than once a year. However, there is no definition of "highest rating." Furthermore, even facilities with few or no problems on one survey may deteriorate in a year and half. Given the vulnerability of the assisted living population and our increasing reliance on assisted living as a substitute for nursing home care, DOH should be furnished with sufficient inspectors and other resources to inspect annually.
2. **Amend Section 46-b of the Public Health Law (Assisted Living) to require better training of direct care staff in facilities, particularly for individuals dealing with medication by mandating a specific curriculum.** Currently, the law only permits guidelines for a training program for direct care staff.
3. **Introduce and pass legislation to require licensure for administrators.** Running an adult home or assisted living residence, especially an impacted home or one that has special/enhanced needs certification, requires specific training and competencies.
4. **Introduce and pass legislation to require facilities to provide residents with additional hours of care per week for medication assistance in addition to the 3.75 now required.** Currently facilities are required to give all residents, whether on multiple medications or not, 3.75 hours of care per week. It is clear that more time is needed for help with medications, especially now that more and more residents are on medications.

To encourage effective and speedy enforcement:

1. **Amend Section 460-d of the Public Health Law (Enforcement Powers) in two ways similar to nursing home law:**
   a. **Permit the levying of fines "per violation" in addition to the "per day" now permitted.** Currently fines can be levied only for each day a violation exists and has not been corrected. Facilities should be sanctioned for each violation they incur, not just the ones that are continuing. Even a one-time violation may cause harm to a resident.
   b. **Remove the ability of a facility to escape a penalty for harming a resident or putting a resident at risk of harm by correcting within 30 days.** Currently a facility that has either corrected within 30 days of receipt of the citation or has put in place a correction plan may not be fined unless the citation is considered to have endangered a resident. This permits facilities to be out of compliance, correct and then be out of compliance again and again without being held accountable. This may account for the persistence of repeat violations.

2. **Amend Section 460-d of the Public Health Law (Enforcement Powers) to increase current limits on fines.** $1000 or less per day (or even per violation if number 2 above was adopted) may be too low a fine to be meaningful for some violations (especially for repeat violations).
3. **Allocate sufficient funds to ensure adequate inspection and enforcement in the DOH budget.** There are not enough inspectors to spend the time needed to interview the many residents they should be interviewing . There are insufficient staff attorneys to handle the large number of cases. As a result, serious problems continue. In addition to being directly deleterious to residents, inadequate funding of inspection and enforcement is financially costly for the consumers and taxpayers who continue to pay for substandard services (not to mention, often, its repercussions).

Governor/Department of Health

To improve assisted living quality:

1. **Require better training of direct care staff in facilities, particularly for individuals dealing with medication by mandating a specific curriculum.** Currently, DOH only recommends a training program for direct care staff.
2. **Require licensure for administrators.** Running an adult home or assisted living residence, especially an impacted home or one that has special/enhanced needs certification, requires specific training and competencies.
3. **Require facilities to provide residents with additional hours of care per week for medication assistance in addition to the 3.75 now required.** Currently facilities are required to give all residents, whether on multiple medications or not, 3.75 hours of personal services per week. It is clear that more time is needed for help with medications, especially now that more and more residents are on medications.

To encourage compliance:

1. **Evaluate effectiveness of different approaches to encourage compliance.** DOH has inserted a number of different provisions into facility stipulations to encourage compliance such as: suspending one-half the fine if the facility stays in compliance or adding an additional fine if the facility reoffends. DOH should evaluate whether these approaches have in fact led to better compliance.

To improve inspections:

1. **Require inspectors to speak with more residents**. Given the purpose of the rules and regulations – to protect residents and ensure quality of services to them – resident input should be sought after and regarded as an essential component of the inspection process.
2. **Require investigations of complaints by residents to include interviews of large numbers of residents.** In order to encourage residents who are afraid of cooperating, inspectors should speak to a variety of residents when investigating a complaint so that the complainant's identify is not obvious.
3. **Train inspectors in how to interview residents and gain their trust.**

4. **Coordinate with both state and local ombudsmen.** Find out what types of complaints they are getting and focus surveys on those areas as well as resident services and environment (e.g., resident rights, discharge and personal funds and property).
5. **Evaluate consistency of survey process and outcomes and decisions to refer violations for legal action.**