

LTCCC Releases Report on Care and Oversight of Assisted Living Residences in New York State

Many Adult Homes, Enriched Housing And Assisted Living Residences Are Violating The State's Care Rules And Are Either Harming Their Residents Or Putting Them At Risk For Harm

Few Facilities Causing Harm or Risk of Harm Had An Enforcement Action Taken Against Them Unless They Actually Endangered their Residents

The report, which analyzed both Department of Health data from 2002 to 2011 and Ombudsmen complaint data from 2006 to 2011 indicates that:

- While the number of citations went down, the three areas most cited by the Department of Health have remained the same for nine years: resident care; medication and environmental issues.
- Medication issues are still rampant with almost a quarter of the medication citations repeats from previous years.
- Few violations cited led to enforcement actions unless they were “endangerment” violations. This may be due to state law that does not permit a fine if the facility corrects must be changed.
- Of the 86 facilities found to have endangered their residents during this time period 63 have been sanctioned; 20 cases are still pending, eight from three to five years ago.
- The mentally ill are still suffering. Even after the investigations of the early 2000's and the succeeding state workgroups, the impacted homes (adult homes with 25 percent or more mentally disabled) still have many problems. Department of Health surveyors are now finding twice as many violations in the impacted homes as the non-impacted homes.

"We had hoped that care had significantly improved for our state's assisted living residents," said Cynthia Rudder, director of special projects and the study's primary investigator. "It is unacceptable that the same areas are cited year after year and that almost a quarter of medication violations are repeated violations from previous years."

The study indicated that there are reasons these residences are in violations of the rules and recommended changes:

- The state does not require residences to train their care staff with a mandated training curriculum; better training of direct care staff must be encouraged, particularly for individuals dealing with medication by mandating a specific curriculum.
- Administrators are not required to be licensed; the state must require licensure; 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 and oversight.

- Facilities are now only required to give 3.75 hours of personal care per week to each resident. This is not enough time to care for those residents on multiple medications; the state must require facilities to provide residents with additional hours of care per week.

The study also indicated there are a number of obstacles facing the Department of Health as they attempt to hold providers accountable that must be changed:

- Many facilities violating the rules and regulations cannot be fined because state law does not permit the Department to sanction them if they correct within 30 days (except for an endangerment violation); social services law must be amended to permit such sanctions.
- State law permits only per day fines and only up to \$1000 a day fines for violations; per violation must be permitted in addition to per day fines and the amounts must be increased.
- There are two few attorneys to prepare enforcement cases; the Legislature and the Governor must allocate sufficient funds to ensure adequate inspection and enforcement in the Department's budget.

"State law must be changed," said Richard Mollot, executive director. "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 who have harmed their residents or put them at risk of harm (but not "endangered" their residents as defined by law) to be out of compliance, correct and then be out of compliance again and again without being held accountable. Residences must be sanctioned for each violation whether they correct or not. Residents must not continue to suffer."

For a copy of the executive summary, go to: <http://www.assisted-living411.org/documents/executivesummary.pdf>.

For the full report click on the title of this release or go to:
<http://www.assisted-living411.org/documents/ASSISTEDLIVINGFINALREPORT.pdf>.

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