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

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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 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 are 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 Social Services 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 Article 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 Social Services 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 Social Services Law (Enforcement Powers) to increase current limits on fines.** $1000 or less per day (or even per violation if 'a' 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.**

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CARE AND OVERSIGHT OF ASSISTED LIVING IN NEW YORK STATE

INTRODUCTION

Though the public generally views "assisted living" as a single type of entity, New York State is actually home to a diverse array of assisted living arrangements. The different types of assisted living licensed by the state include: (1) adult homes; (2) enriched housing; (3) assisted living residences (ALRs) (which must first be licensed as adult homes or enriched housing); and (4) Medicaid assisted living programs (ALPs)[2] 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").[3]

Given the diversity of licensure arrangements, it is not surprising that assisted living in New York State has had a chaotic history. While we have had mandated licensure for adult homes and enriched housing for decades, we did not have a legal requirement for licensure of so called assisted living residences until 2004 and no regulations implementing that law until 2008. At the same time (over the last 20 or so years), New York has had facilities that operate under these different names (adult homes, assisted living, enriched housing, etc…), with varying levels of quality and varying degrees of oversight (from none for unlicensed assisted living to a well-established system of mandated state oversight for licensed adult homes).

Prior to 2004, although many elderly and disabled were residing in assisted living residences, these residences were not licensed; they offered assisted living services to a private pay population, but had no requirements to comply with and no oversight by the state. For a number of years, the state studied the unlicensed market, working with advocates and providers to develop legislation that would

[2] 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 care and can be safely cared for in an adult home or enriched housing.
[3] See Appendix A for a detailed description of the different types of assisted living facilities.

require licensure. Finally, after many years of negotiation, in 2004, assisted living legislation was signed into law.[4]

One of the intents of the 2004 law was to encourage a model of residential care that reflected current understanding of what New York's elderly and disabled want in a residential care setting: a place that is not institutional, that fosters choice and dignity, and that provides care in a setting that has more freedom and less restrictions than the traditional nursing home or adult home.[5] In addition to outlining broad standards of care and disclosure, the law required the creation of a ten person state task force, to, among other things, advise the state Department of Health (DOH) on the promulgation of rules to implement the law. At the beginning, the task force included three representatives of consumers and seven representatives of providers. LTCCC was appointed as a consumer member. For most of its existence, to date, the task force has had only 1-2 representatives of consumers or the public at a time, while the supermajority of industry representation has remained constant.

After four years of working on this issue with the task force and after two periods of public comment, DOH finally promulgated the rules implementing the law in 2008. Immediately thereafter, two provider associations, the Empire State Association of Assisted Living and the New York Coalition for Quality Assisted Living (both represented on the state task force), and several individual adult home facilities sued the state to stop the imposition of the rules.

In September 2009, the Albany County Supreme Court issued its ruling, which granted virtually all of the industry's demands, invalidating key components of New York State's assisted living residence regulations. Importantly, from the consumer perspective, the court nullified the requirement for at least one professional caregiver on staff if a facility becomes certified to provide special care for those with dementia or enhanced needs (those aging-in), numerous structural and environmental standards in the regulations and rules related to resident notice of fee increase.

At the same time the state has been working to require licensure and better standards of care, there have been many studies and news media coverage demonstrating that there were major care problems in our state's licensed adult homes.

[4] NY Public Health Law Article 46B, Title I, §4650 Available at http://www.health.state.ny.us/facilities/assisted_living/docs/article-46.pdf.

[5] The legislative intent of the law states that "the philosophy of assisted living emphasizes aging-in place, personal dignity, autonomy, independence, privacy and freedom of choice." NY Public Health Law Article 46B, Title I, §4650. Available at http://www.health.state.ny.us/facilities/assisted_living/docs/article-46.pdf.

History of Poor Conditions

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. Following the Hynes report, legislation and regulations were put into place to address the conditions of the adult homes, including a requirement of joint inspection of homes by the New York State Office of Mental Health (OMH) and the New York State Department of Social Services (DSS).6

> Adult homes for the mentally ill had "…devolved into places of misery and neglect…." -*The New York Times*.

In 2001, the Long Term Care Community Coalition completed a three year study of the assisted living industry in New York State.7 The findings revealed a number of widespread problems. Among the findings: forty percent of the unlicensed facilities reported using nurse aides to administer medication to those individuals not self directing (instead of using professional nurses, as the law requires) and few of the facilities had procedures that assured fully informed consent related to residents' rights to refuse treatment.

In April 2002, Clifford Levy, reporter for The New York Times, investigated the adult home industry in New York and wrote a three part series on the poor conditions.8 Discussing the homes catering to the mentally ill, he wrote that many had "…devolved into places of misery and neglect…"9 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 that addresses separate aspects of a resident's life. But the whole, which is greater than the parts, is never addressed. Despite the investment of substantial public money, residents were being short-changed when the reality of their living conditions and services is examined."10

In October of that year, a workgroup set up by the New York State Department of Health to study the issue released its report.11 The report stated that problematic care and conditions at some adult homes is not a new phenomenon and that certain segments of the industry had a long history of problems stretching back at least as far the late 1970s. It was evident that over the past three decades a certain segment of the industry continued to be chronically deficient. It raised issues with

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[6] Schuyler Center for Analysis and Advocacy. "The Cause of Dignified Living: The Psychiatrically Disabled in Adult Homes," November, 2002. See Appendix B for a more detailed summary.

[7] LTCCC, "Assisted Living in New York State: A Summary of Findings, A Final Report of an In-Depth Three Year Study of Assisted Living," November, 2001. See Appendix B for a more detailed summary.

[8] *The New York Times*, April 28, 29, 30, 2002.

[9] *Id.*, April 28, 2002.

[10] New York Commission on Quality of Care for the Mentally Disabled, "Adult Homes serving residents with mental illness, a study on layering of services," August 2002. See Appendix B for a more detailed summary.

[11] "Report of the Adult Care Facilities Workgroup," Submitted to: Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner Department of Health, October 2002. See Appendix B for a more detailed summary.

medication management, stating that, "presently ACFs (adult homes) rely on unlicensed staff to manage this high volume of medications…Department of Health inspection reports cite the need for improved medication management in many of the adult homes to ensure that residents receive without interruption the correct medications as ordered by their physician." Other issues identified in the report concerned: service coordination, assessment and payment. In response to the report, New York implemented health and mental health assessments; additional care coordination; case management and peer support; a medication management initiative; a centralized hotline to report abuse; interagency joint inspection teams; and a new position to oversee coordination of adult home reform efforts.

In 2006, the Commission on Quality of Care released a new study on impacted adult homes.[12,13] The findings indicated continuing issues with medication; assessment; layering of services; and coordination of services. In 2007, the Commission released a study on Medicaid Assisted Living Programs (ALPs) in the impacted adult homes.[14] 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.[15] According to their report, 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 discusses the need to improve the state's adult home inspection process.

Monitoring Care in Assisted Living

There are regulations governing care for residents in adult homes and enriched housing and for those in ALP beds in adult homes and enriched housing. In addition, assisted living residences must first follow all of rules related to adult homes or enriched housing as well as the rules specific to assisted living residences. Those facilities which have enhanced or special needs certification (for aging-in place or significant dementia care) have some additional requirements. The rules govern resident services, environmental standards, food service, resident rights, admission and retention, personnel and disaster and emergency planning.[16]

[12] New York State Commission on Quality of Care and Advocacy for Persons with Disabilities, "Health Care In Impacted Adult Homes: A Survey," May 2006. See Appendix B for a more detailed summary.
[13] Facilities housing 25 percent or more residents with mental disabilities.
[14] NYS Commission on Quality of Care and Advocacy for Persons with Disabilities, "A Review of Assisted Living Programs in 'Impacted' Adult Homes," June 2007. See Appendix B for a more detailed summary.
[15] Schuyler Center for Analysis and Advocacy, "Action Plan for Dignity, Respect, Choice and Recovery for People Living in Adult Homes," February 2007. See Appendix B for a more detailed summary.
[16] See Appendix C for a detailed summary of all these rules.

The Department of Health has the responsibility to make sure that adult homes, enriched housing, assisted living programs and assisted living residences comply with all standards of care. Section 486 of Title 18 of New York State Codes and Regulations gives them this authority. The Department must conduct at least one full unannounced inspection of each adult home at least every eighteen months. It is up to the discretion of the area offices to decide if a facility needs to be inspected more often. In addition, the Department is required to conduct complaint, follow up and any other inspections where needed. To assure that adult care facilities are established and operated in compliance with all applicable provisions of law and regulation, the Department may take a number of different enforcement actions.[17]

The survey team is made up of a number of individuals that are responsible for assessing different aspects of the home.[18] It may include a:

- Social Worker;
- Nurse;
- Environmental Person;
- Fire Safety Person; and/or
- Nutritionist.

The survey includes the following activities:

- A walk-through of the home, including visits to resident rooms;
- A meeting with the operator and/or other staff;
- A review of the fire safety system to ensure that it is in working order;
- Observation of meals and examination of daily menus;
- Observation of medication distribution;
- Review of facility records, employee records and resident records including financial records;
- Interviews with at least five residents; and
- After the survey is completed, an exit interview with staff from the home, during which the survey team will discuss the initial findings of the inspection.[19]

All incidents of non-compliance with rules and regulations are divided into two categories: "violations," which are those whose severity or scope represent harm or risk of harm to residents and to resident quality of life and "findings," which are identified as having less significance (not rising to the level of a violation on an initial citing). Both violations and findings must be corrected; uncorrected findings are supposed to be cited as violations in the next inspection report.

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[17] See Appendix D for a list of the different enforcement actions that can be taken.

[18] See New York State Department of Social Services Adult Care Facility Informational Letter No. 1-95, March 31, 1995 for a description of the Department of Health's survey system.

[19] See New York State Department of Health "Annual Inspections and Your Rights as a Resident," February 2007. Available at http://www.health.state.ny.us/publications/1494/.

Violations can be "endangerment"[20] if the particular violation endangered or resulted in harm to a resident as the result of: (1) the total or substantial failure of the facility's fire protection or prevention systems, or the emergency evacuation procedures; (2) the retention of any resident who has been evaluated by the resident's physician as requiring placement in a hospital or residential health care facility (i.e., nursing home) and for whom the operator has not made and documented persistent efforts to secure appropriate placement; (3) the failure of the operator to take actions in the event of a resident's illness, accident, death or attempted suicide; and (4) the failure of the operator to provide at all times supervision of residents by numbers of staff at least equivalent to the required staffing requirements which is based upon the number of residents in the facility.[21]

Prior to this year, Assisted Living Program (ALPs) residents' care was overseen by the home care inspectors of the Department of Health. In the future, according to DOH staff, since the Department has added nurses to its teams, the same inspectors who inspect adult homes, enriched housing and assisted living residences as a whole will also be responsible for overseeing ALPs in the residences that have them.

Long Term Care Ombudsmen Program

The New York State Office for the Aging operates the state Long Term Care Ombudsman Program pursuant to the Older Americans Act.[22] The purpose of the state ombudsman program is to identify, investigate and resolve complaints made by or on behalf of residents of nursing and adult care homes. The New York State Ombudsman oversees forty-four sub-state Ombudsman Coordinators and a corps of over 1,200 trained volunteer local ombudsmen. Local ombudsmen work to: address major issues which affect residents; educate residents, facility personnel and the public about residents' rights and other matters affecting residents; and performs other functions specified in the Act to protect the health, safety, welfare and rights of residents. Their purview includes both nursing homes and assisted living facilities.

THE STUDY

The current study was undertaken to identify the current state of the quality of care and life in the state's assisted living facilities. Data sources included the quarterly inspection reports posted on DOH's website; a random sample of nine percent of all the inspections of adult homes, enriched housing, ALPs and assisted living residences from 2002 to mid September 2010;[23] ombudsmen complaint data from 2007 through 2009; a survey of ombudsmen and consumers to find out their

[20] See NYS Code of Regulations, Title 18, 486.5 (a) (4).

[21] See NYS Code of Regulations, Title 18, 487.9 (f) 6-9.

[22] See 42 U.S.C. §35 (2006), Subsection §3058g.

[23] Since 2002 was the year that many of more recent problems were discovered and the state initiated its workgroup focusing on the problems, this year was chosen as the start date in order to see what, if anything had changed.

perceptions of quality of care and of life in the state's assisted living as well as of the state's oversight and enforcement; follow up interviews with a select group of ombudsmen and consumer representatives; and all DOH enforcements from 2002 through 2010.

Department of Health

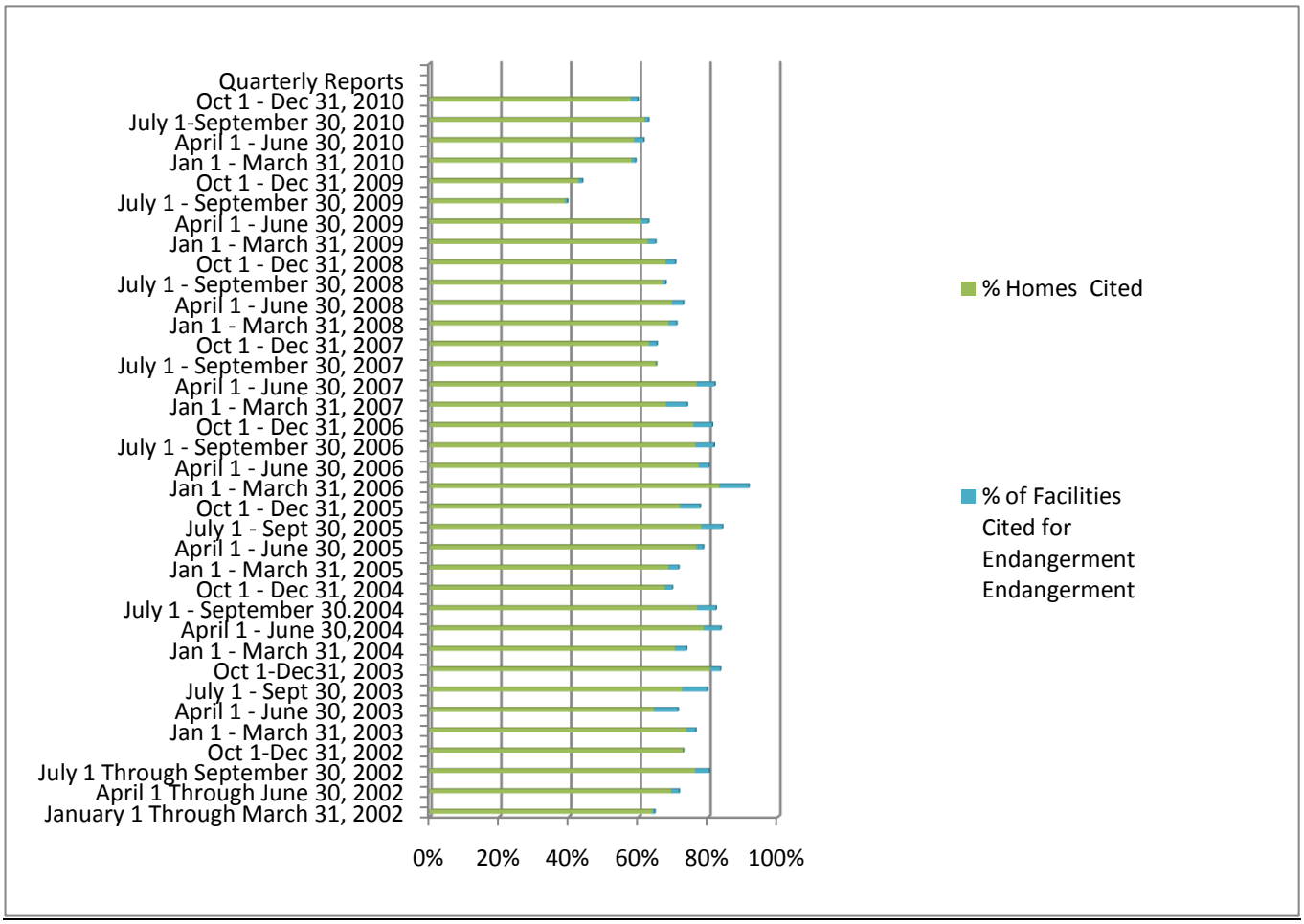
Inspections

Health Department Quarterly Reports: Most Facilities Violating the Rules

Health Department quarterly reports on inspections indicate that over the years 2002 to 2011, between 63 percent and 86 percent of all the facilities inspected were cited with serious non-compliance with the rules and regulations governing care.[24] These violations represented harm or risk of harm to residents and to resident quality of life and do not include "findings," which are identified as being of less serious nature. 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 ranges dropped to under one percent to almost three percent. See Table 1.

[24] New York State Department of Health, Adult Home Quarterly Survey Reports. Available at http://www.health.state.ny.us/facilities/adult_care/reports.htm.

TABLE 1: SUMMARY OF DOH INSPECTIONS: VIOLATIONS



Random Sample of Nine Percent of DOH Survey Inspections

Project staff analyzed a random sample of inspection results for nine percent of all facilities. All data were analyzed for the years 2002 - mid September 2010 and separately for the years 2007 - mid September 2010 in order to see if there are changes or differences in the more recent years.[25] The year 2002 was chosen as the start date for the sample since that is the year that *The New York Times* published its three part investigative report that identified serious and widespread problems (see discussion above) which led to the creation of a number of government advisory panels and commissioned studies with the goal of improving care and quality of life in the state's assisted living facilities. The following table provides an overview of the study sample.

[25] For the sake of brevity, the time periods of the study will be referred to as 2002-2010 and 2007-2010.

TABLE 2: STUDY SAMPLE

	MARO	CENTRAL	CAPITAL	WESTERN	TOTALS
Num. of Facilities Reviewed	19 (9.4%)	6 (7.23%)	7 (10%)	11 (10%)	43 (9%)
Sponsorship For Profit Not For Profit Public	 8 11 0	 2 3 1	 3 3 1	 4 7 0	 17 24 2
Impacted Homes	5	0	0	2	7 (13%)
Homes with ALPs	5	2	2	0	9
ALRs: Basic SNALR EHALR	4 2 2 2	0 0 0 0	4 2 2 1	6 2 0 4	14 6 4 7
Number of Individual Surveys Reviewed VIOLATIONS FINDINGS TOTAL SURVEYS	 145 143	 23 88	 62 26	 66 85	 296 242 538

Analysis of DOH Findings

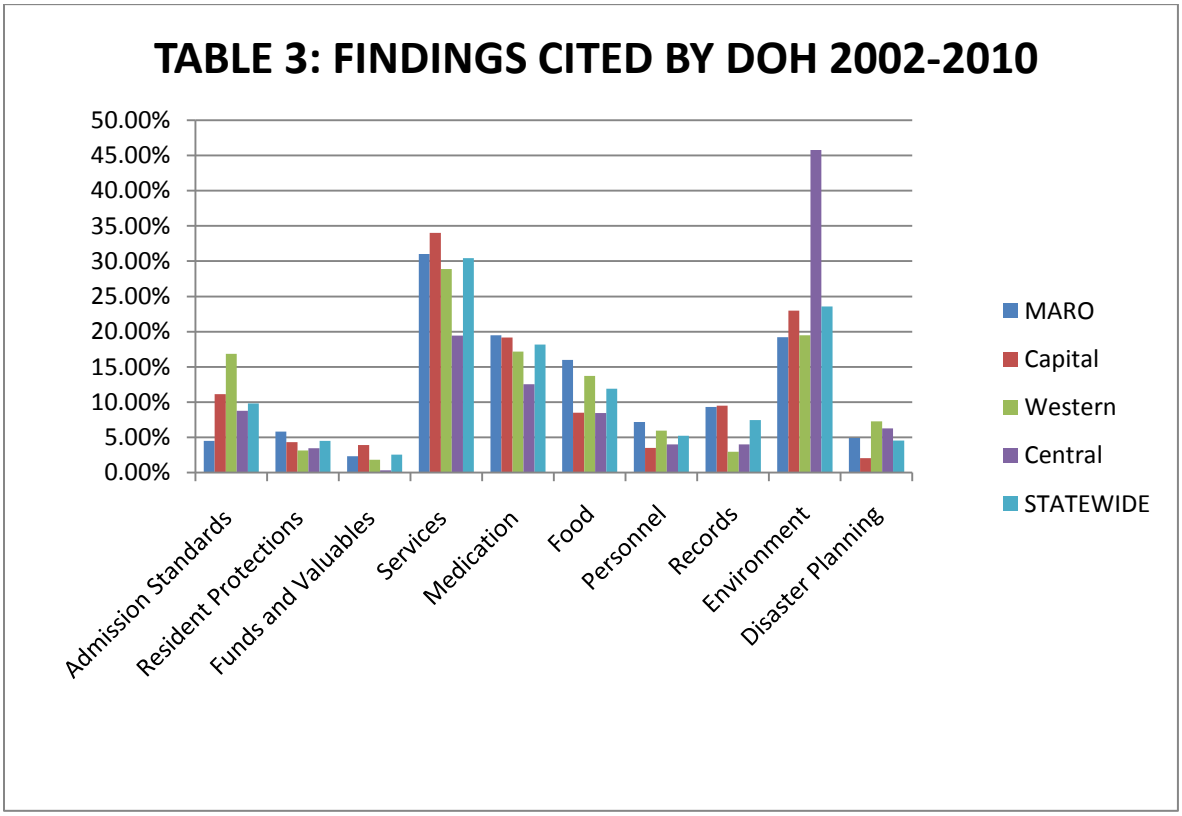
Project staff analyzed findings separately from violations. In the model utilized by DOH to monitor and enforce standards, findings (as noted above) are non-compliance that, due to their scope and severity and impact on the resident, do not reach the threshold for a violation. Identification of findings by inspectors is important because, even though they are not determined by DOH to reach the threshold for a violation, one would hope that by identifying and making providers aware of nascent or low-level problems in their facilities, providers would take action to resolve these problems, thus resulting in fewer problems rising to the level of violations (and, hence, fewer violations cited).

The three areas most cited are resident services, medication and environment.

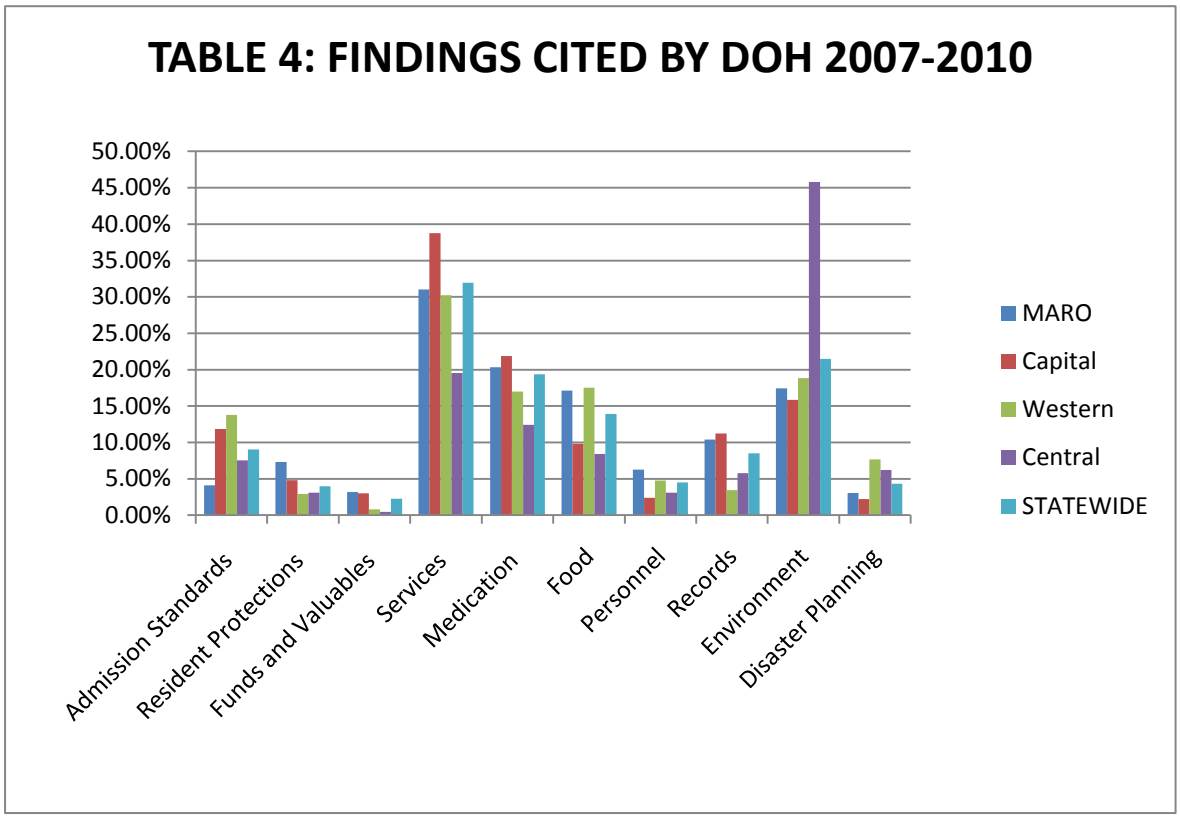
According to the Department of Health, findings must be corrected and uncorrected findings are to be cited as violations in the next inspection report.[26]

An analysis of the surveys statewide for the years 2002-2010 indicated that “resident services” (resident care) was the most cited finding, with over thirty percent of the findings in this area. Medication issues (part of "resident services") accounted for over half of all the statewide findings for resident care. Environmental issues were the third most cited findings. These percentages became greater in the more recent years analyzed (2007-2010).

Some of the regional differences: the MARO region found a high level of findings in the food area (16 percent in the early years and 17 percent in the later years). The Capital and Western regions cited, as findings, more admission issues (proportionally) than the other regions. The Central region cited more environmental issues as findings.



[26] See NYS Department of Social Services, Office of Housing and Adult Services, Adult Care Facility Informational Letter No. 1-95, March 31, 1995, p.4.



Analysis of DOH Violations

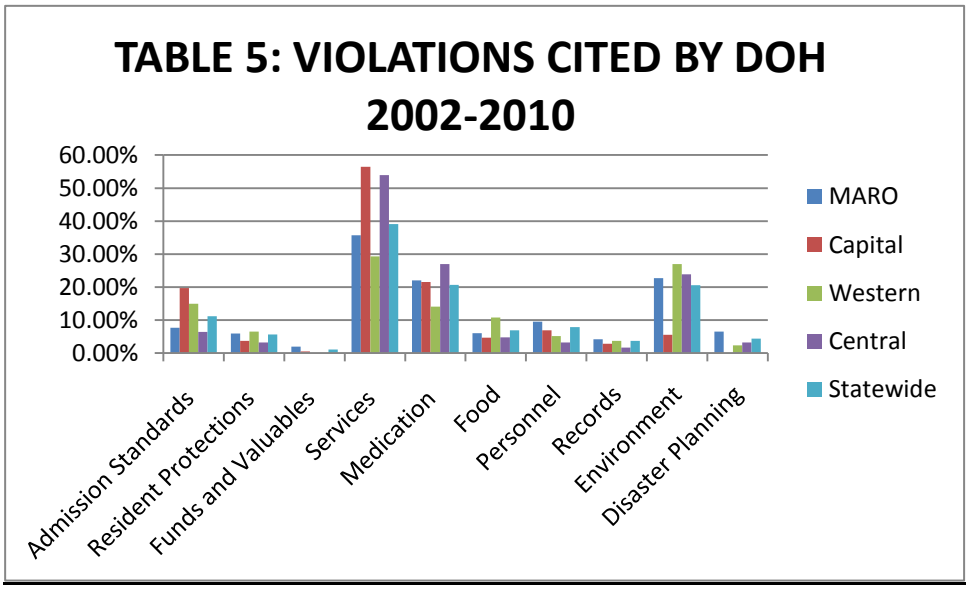
As opposed to findings, violations are non-compliance that is systemic **or** is so significant that it created conditions which directly caused or exposed residents to harm or risk to their health, mental health, or well-being **or** interferes with the Department's ability to monitor the facility **or** is a failure to correct previously identified findings in a timely manner.

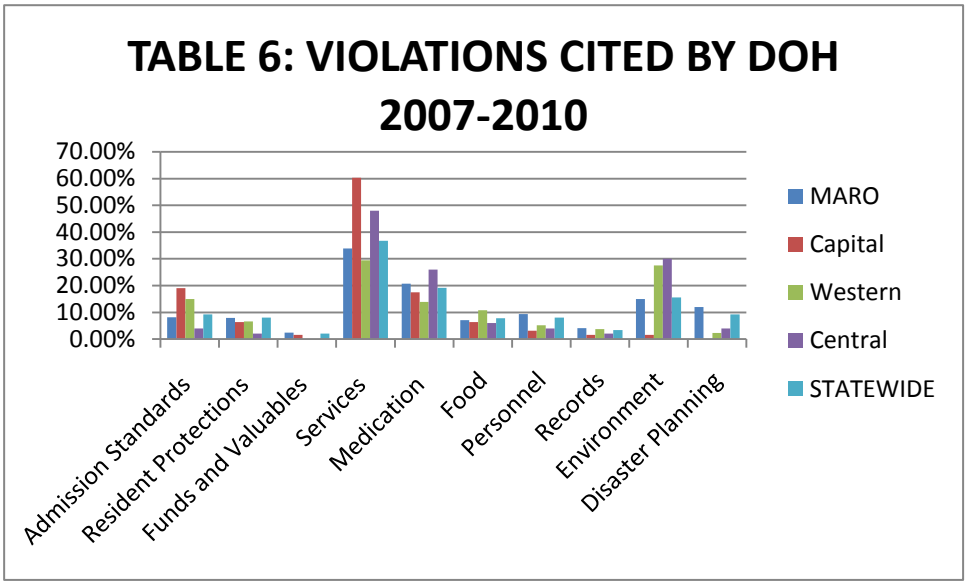
As stated above, one would hope that the many findings cited for the areas of resident services, medication and environment would mean that there would be fewer violations in these areas. This is not the case. According to the analysis of the surveys, “resident services” (resident care) was also the most cited violation, with almost forty percent of all the cited deficiencies statewide from 2002-2010 listed in this area. As with findings, medication issues (part of "resident services") here too accounted for over half of all the statewide violations for resident care (twenty-one percent of all the deficiencies). While these percentages dropped in the years 2007-2010, they still remained high and still remained the areas most cited. As with findings, the third most cited area was environmental issues both in the years 2002-2010 and 2007-2010.

The data indicated several regional differences. While statewide more than half of all resident care (services) violations were cited in the area of medication, this is not true for the Capital region in the more recent years studied (2007-2010). While medication violations were only 14 percent of all their

deficiencies, resident care was over 60 percent. This region identified more case management issues as part of the resident services area than the other regions.

Similar to the regions' performance in citing findings, the Capital and Western regions also identified more admission violations (proportionally) than the other regions in all the years. As the next table indicates, few violations were cited in the areas of resident protection, funds and valuables, or records in any of the regions for the entire period studied. Furthermore, insufficient staff was rarely cited. The MARO region cited more personnel issues (proportionally) throughout the study period than the other regions (at over nine percent of its citations). Notably, the areas most cited remained the same for nine years across the state, whether as findings or violations: resident care (services), medication and environment. Although DOH inspectors have cited fewer violations in recent years, these issues have continued to be the most often cited.





Repeated Findings and Violations

Another issue of great concern is that, according to surveyors' statements on the inspection results, the ***same*** medication violations and findings are repeated year after year. In the years 2002-2010, 72 of the same resident services violations were repeats from previous surveys. Of the 242 medication violations listed by surveyors during these years, 51 (21 percent) were repeated findings and violations from previous surveys. Most were repeated violations, i.e., non-compliance that is systemic **or** is so significant that it created conditions which directly caused or exposed residents to harm or risk to their health or mental health. In addition, 10 percent (25 of 252) of the violations identified for environment were repeats.

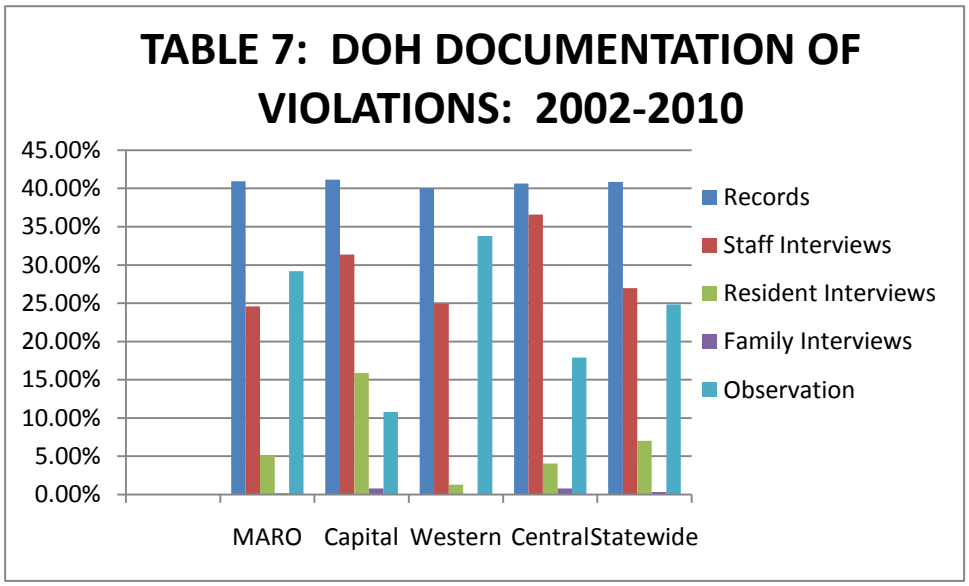
Almost one quarter of the medication violations and one fifth of the environment citations were repeats.

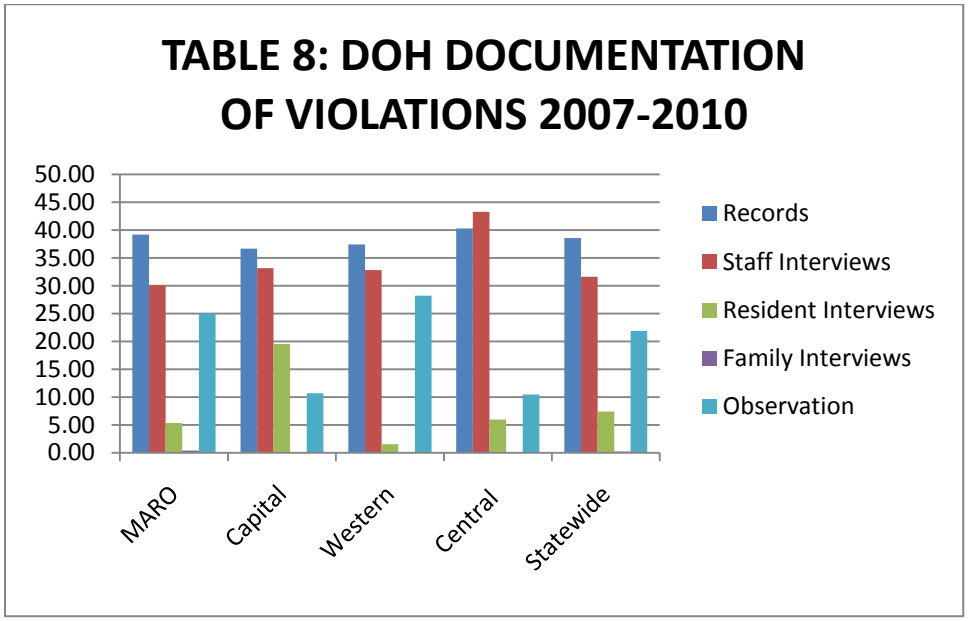
Unfortunately, the problem of repeat violations appears to be getting worse: our most current (2007-2010) data indicated that almost one quarter of the medication violations and one fifth of the environment citations were repeats.

Documentations of Violations

When Department of Health surveyors write up citations, they list the forms of documentation they have used to come to the conclusion of non-compliance. The forms of documentation listed by the inspectors are: looking at records; interviewing staff, residents and family members; and observation. Project staff examined the types of documentation listed by the inspectors on each statement of violations. Below is a table describing what was found. Statewide, for the random sample we examined, for the 2074 sources of data used for the years 2002-2010, the most often used source was examining records kept by the facilities. This was true for all regions. The most infrequently listed documentation for a violation, almost non-existent, was interviewing families. Interviewing residents

was also listed infrequently as a source of documentation for citations, accounting for under 10 percent of the listed documentation statewide. Only the Capital region listed a larger number of resident interviews as documentation, with over 15 percent.





Examples of Citations in the More Recent Years

Resident Services: The facility did not call 911 immediately when a 91 year old resident with a heart condition, who was deteriorating over the past two weeks, complained of chest pains. The resident expired in the hospital due to congestive heart failure. It was at the resident's family insistence that 911 was finally called. The resident had a prior history of a hospital visit was for acute onset shortness of breath with increasing lethargy.

Medication: The facility failed to provide medications to five residents and allowed staff to provide the incorrect medication dosage to one resident. In addition, in the dementia unit, out of 11 records reviewed, six had medication issues such as residents not receiving their medications, residents refusing medications and a resident receiving the incorrect medication dosage.

Environment: The operator did not ensure the maintenance of consistently safe hot water temperatures at faucets for bathing, showering and hand washing. In addition, the following problems were found:

- There were malfunctioning, non-latching corridor smoke barrier doors.
- There was a large open area through the sheetrock (plaster board) ceiling along a duct in the mechanical room.
- There was a dust/lint build-up behind the dryer in the A-wing laundry.

Food: The facility did not ensure that residents who were prescribed specific therapeutic diets were receiving foods consistent with their prescribed diet.

Resident Rights: An employee witnessed another employee grab a resident , shout at her and force her to sit in a chair, while the resident protested stating, "you are hurting me, please stop." However, the employee did not report this incident until the next day to two other employees. She said she was too busy to report it immediately.

Admission: The operator admitted and/or retained twelve residents who chronically required the physical assistance of another person to climb or descend stairs, but who were not assigned to a room on a floor with ground level egress.

Impacted Homes

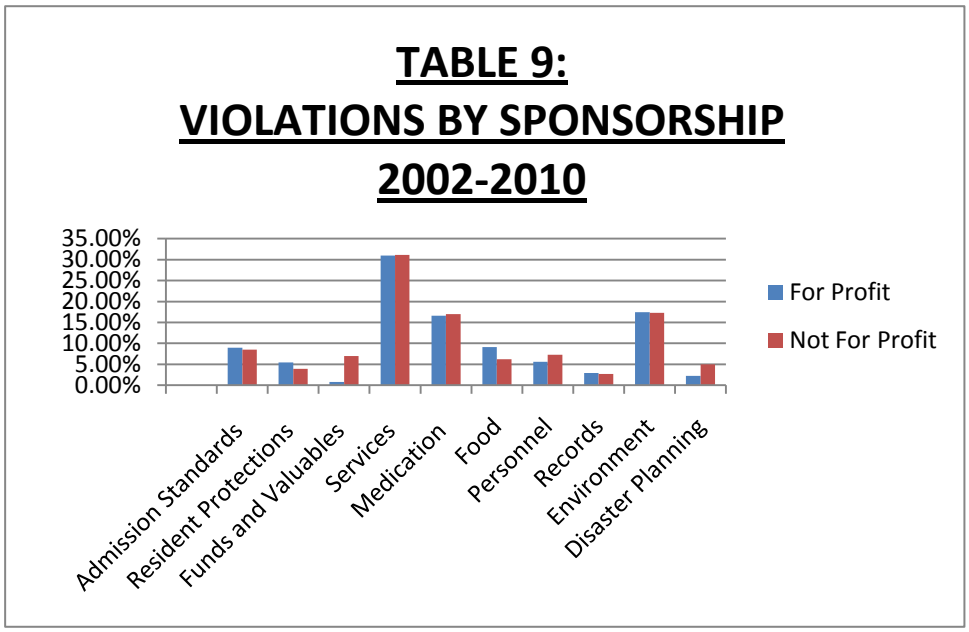
Facilities housing 25 percent or more residents with mental disabilities are known as "impacted homes." Findings for the impacted homes differ from those of the non-impacted adult homes, enriched housing and assisted living residences. This study analyzed surveys conducted at 13 percent (total of seven) of the impacted homes in the state. Similar to non-impacted homes, the three most cited areas were resident care, medication and environmental issues. However, in the years 2002-2010, the analysis indicated that the average number of violations for the impacted homes was over 34 per home (240 violations total for the seven homes) while the average for non-impacted homes was 26 (939 violations total for the 36 homes). And, in the 2007-2010, the impacted homes had an average of over 19 violations per home while the non-impacted homes had an average of almost nine and a half. Although citing less violations, DOH surveyors are now finding twice as many violations in the impacted homes as the non-impacted homes.

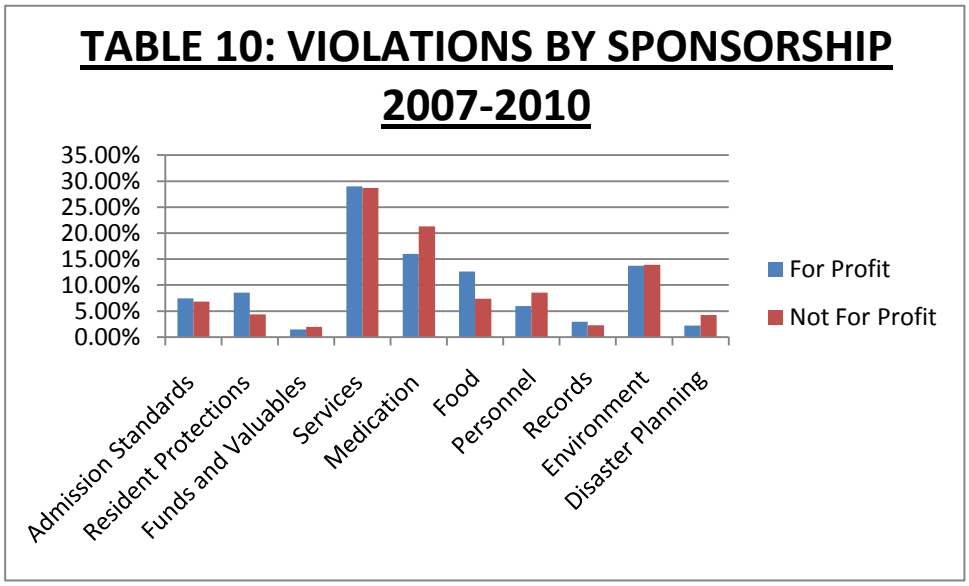
> Impacted homes have twice as many violations as non-impacted homes.

Sponsorship Differences

This study did not find many differences between the for-profit and the not-for-profit homes in terms of numbers of violations and in the three major areas cited, particularly in recent years. In the years 2002-2010, the for-profit facilities (17) averaged almost 37 violations per home; for the years 2007-2010 they averaged almost 16 per home. The not-for-profit homes averaged almost 31 violations per home for the years 2002 - 2010; almost 15 for the years 2007 - 2010.

However there are some differences in the other areas. The for-profits had more violations in the food area, and resident protections (rights); the not-for-profits had more issues related to disaster planning, personnel and funds and valuables in the years 2002-2010. In the more recent years, the not-for-profits had more violations in medication, personnel and disaster planning while the for-profits continued having issues in resident protections (rights) and food.

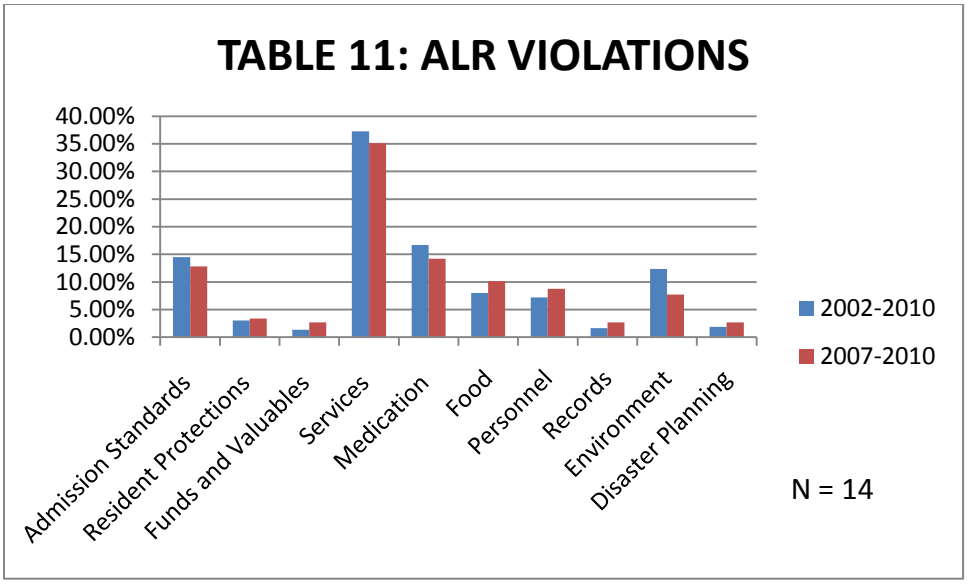




Assisted Living Residences

The sample contained 14 licensed assisted living residences (ALRs).[27] Inspectors cited the same three areas the most as for all assisted living facilities (overall): resident services, medication and environment. However, admission standards was a very close fourth area, cited almost 15 percent of the time during the years 2002-2010 and almost 13 percent in the more recent years studied. The average citations per ALR during the years 2002-2010 was over 26 per home; from 2007 - 2010, the average rate dropped to just over 10. This is similar to the numbers of all non-impacted homes (irrespective of their licensure).

[27] This is 56 percent of all the licensed ALRs in the state at the time the data were being collected.



DOH Enforcement

According to the data received from the Department under the freedom of information law, although a majority of facilities received violations for non-compliance, not counting "findings," the Department brought few enforcement actions unless the violations were considered endangerment. Since all incidents of non-compliance are divided into two categories: "findings," which are identified as having less significance and "violations," which are those whose severity or scope represent harm or risk of harm to residents and to resident quality of life, we had hoped that all facilities with violations, the more severe non-compliance, would be sanctioned. Over the years 2002 -2010, the Department found violations 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 if a facility corrects within 30 days of DOH notice unless the violation is considered to have "endangered" a resident. Thus, many of these facilities might have corrected within 30 days. In addition, because the state permits DOH to levy only "per day" fines, violations that are not endangerment are not referred for enforcement action until it has been cited on a second inspection to get evidence that the fine is continuing and that the violation has not been corrected within 30 days. It would be important for DOH to examine why some facilities were not sanctioned: were they all because of the state law?

In cases where DOH did sanction a facility, DOH attempted to encourage future compliance by either suspending part of the fine if the facility remained in compliance or by threatening an additional fine if the facility did not remain in compliance. In a number of cases, DOH required facilities to report on a periodic basis.[28] It would also be important for DOH to examine whether these strategies were effective in encouraging future compliance. Below is a table showing all enforcement actions taken by DOH from 2002 to 2010.

[28] For a detailed list of the facilities and penalties, see Appendix E.

TABLE 12: DOH ENFORCEMENT ACTIONS: 2002-2010

Enforcement Actions	Amount Collected in Fines	Suspended Operating Certificates	Revocations	Barred from Operating in NYS	Additions to Stipulations: Required to Report	Additions to Stipulations: Suspended Fines for Future Compliance	Additions to Stipulations: Additional Fines for Future Non-Compliance
158	1,109,020	1	2	2	3	12	10

Since endangerment violations are the most severe level of violation, project staff examined sanctions for these separately.[29] In addition, only the years 2006 to the present were included in the study due to a case DOH lost in 2003 that invalidated a number of the pending cases. That case was lost because the notice to permit facilities to correct within 30 days, given to facilities at the time, was non-compliant with DOH's own rules for notice.[30] We believe that by 2006, the consequence of this case should not have affected any enforcement actions. The table below indicates the number of times DOH has instituted sanctions against assisted living facilities that have endangered their residents. Given that state law does permit DOH to fine a facility even if it corrects within 30 days of a survey finding if the citation endangered a resident(s), we would expect that every endangerment would be referred for an enforcement action and that every endangerment would lead to a fine or other sanction. However, this is not the case. As the data in the following table indicate, of the 116 endangerment citations for 86 facilities during the years 2006 to 2010, DOH fined or sanctioned 63 facilities for 86 instances of substantiated endangerment (74 percent of the cited endangerments). Some facilities were held accountable more than once because they had endangered their residents more than once. Some of the cases never reach the legal staff for action or were withdrawn because a decision was made that the violation did not meet the definition of endangerment. Some of those cases are still pending with DOH counsel working on preparing for hearings or awaiting hearing action.

[29] For a detailed list of facilities endangering their residents or penalties, see Appendix F.
[30] See Bayview vs. Novello , Supreme Court, Albany County Special Term, RJI#01-02-ST3182, 8/20/03.

TABLE 13: FACILITIES SANCTIONED BY DOH FOR ENDANGERING THEIR RESIDENTS: 2006-2010

Facilities	Endangerments	Sanctions*	% of endangerments with enforcement actions	Range of fines	Average fine	Withdrawn	Never referred by program staff
86	116	86	74	$500-$88,000	$8,796	8	10

*Sanctions include fines, revocation of operating certificate, put on Do Not Refer List; closings on DOH Commissioner's orders and placement of a receiver.

The table below indicates how many endangerment cases are pending and the length of time they are pending. The data indicate that 17 percent of the endangerment citations are still awaiting closure with 8 (7 percent) pending for three to five years.

TABLE 14: DOH CASES STILL PENDING

Pending Endangerment Citations	Percent Pending	Pending Facilities	Percent Pending	2006	2007	2008	2009	2010
20	17	16	18	3	1	4	4	8

A number of cases were not pursued because the facility voluntarily closed.

The Long Term Care Ombudsmen Program

Complaint Data

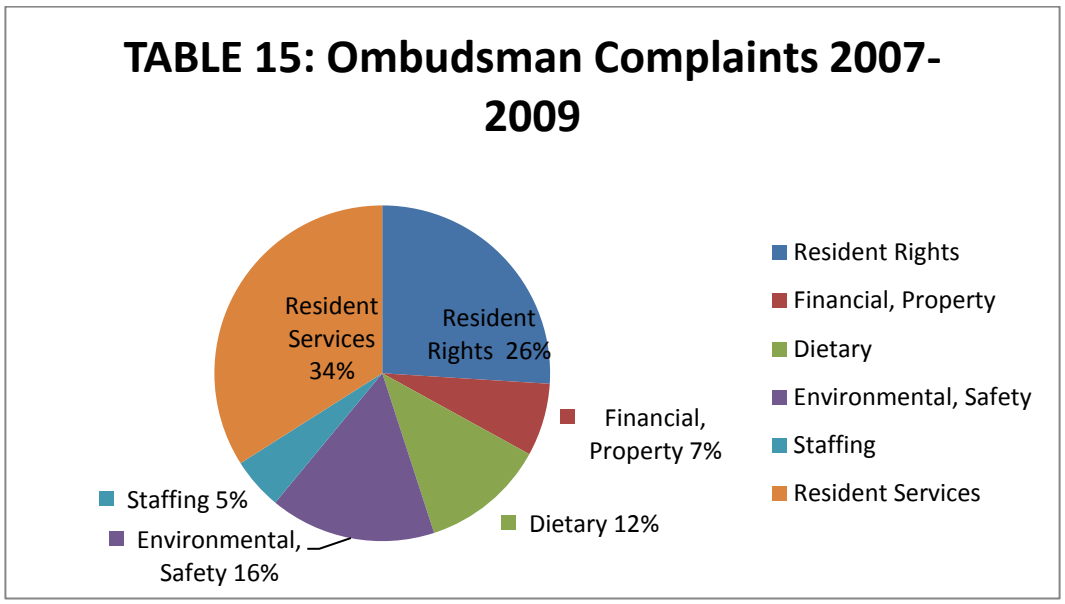
In order to discover the types of complaints ombudsmen were receiving, project staff analyzed all reports of assisted living complaints made to ombudsmen across the state over a three year period (2007-2009).[31] Statewide, 93 percent of the complaints ombudsmen received were verified.

[31] According to the state ombudsman, data were not reliable before this date.

Verification is defined as a determination, after interviews, record inspection, observation, etc…, that the circumstances described in the complaint are generally accurate.[32]

Categories with Most Complaints in NY State

Three-years of complaint data indicated that, statewide, resident services was the area with the most complaints (34 percent of all complaints). "Resident rights" was the area with the second most complaints (26 percent of all complaints).



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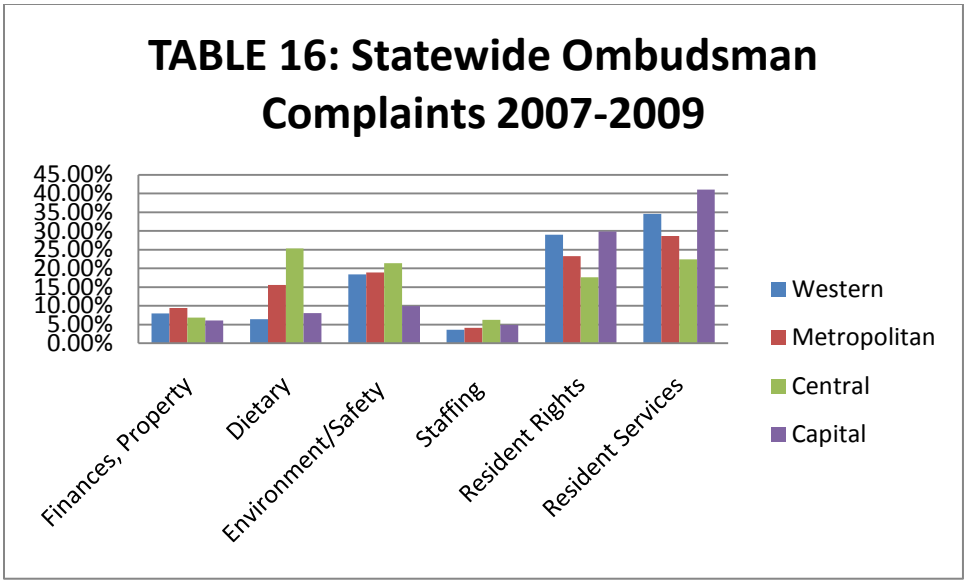
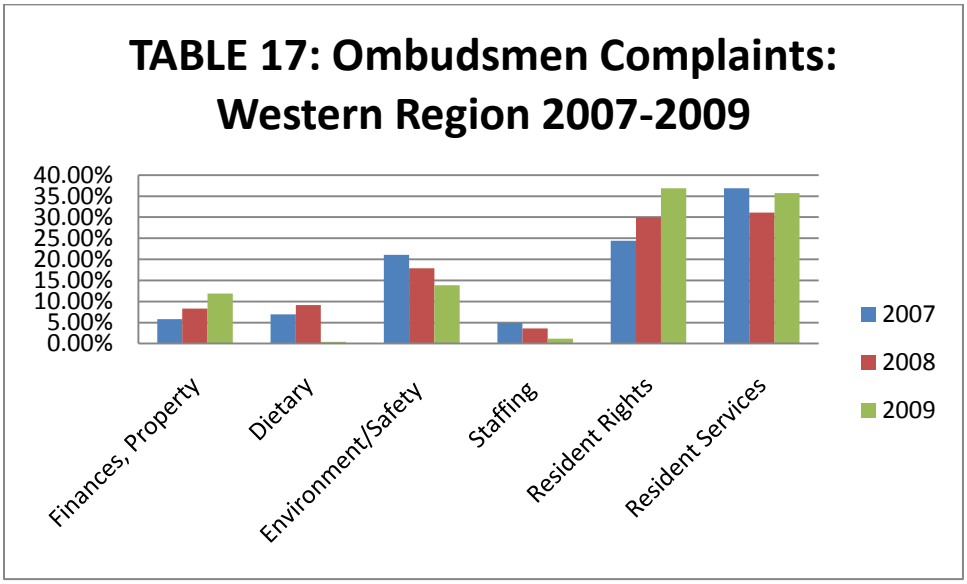
Regional Comparisons

Project staff separated the statewide data into the four ombudsman regions of New York State: Western, Metropolitan, Central and Capital. These data showed that the complaints in the resident services and resident rights categories were more often reported in the Capital region (41 percent and 30 percent, respectively) and the Western region (34 percent and 29 percent, respectively) with the Central and Metropolitan regions reporting far fewer complaints in these areas. Similarly, dietary complaints were reported at significantly higher rates in the Central region with 25 percent of all their complaints in this area.

[32]The National Ombudsman Reporting System, Instructions for Completing the State Long Term Care Ombudsman Program Reporting Form . Available at www.aoa.gov/aoaroot/AoA_Programs/Elder_Rights/Ombudsman/docs/Instructions_Final.doc.



Project staff next analyzed the data by region and by year. The year-to-year data indicate that residents rights complaints have steadily increased over time. There was also an observed general trend of decreased reporting of dietary and environmental complaints from 2007 to 2009, except in the Central region where the percentage of complaints in these categories was fairly constant.



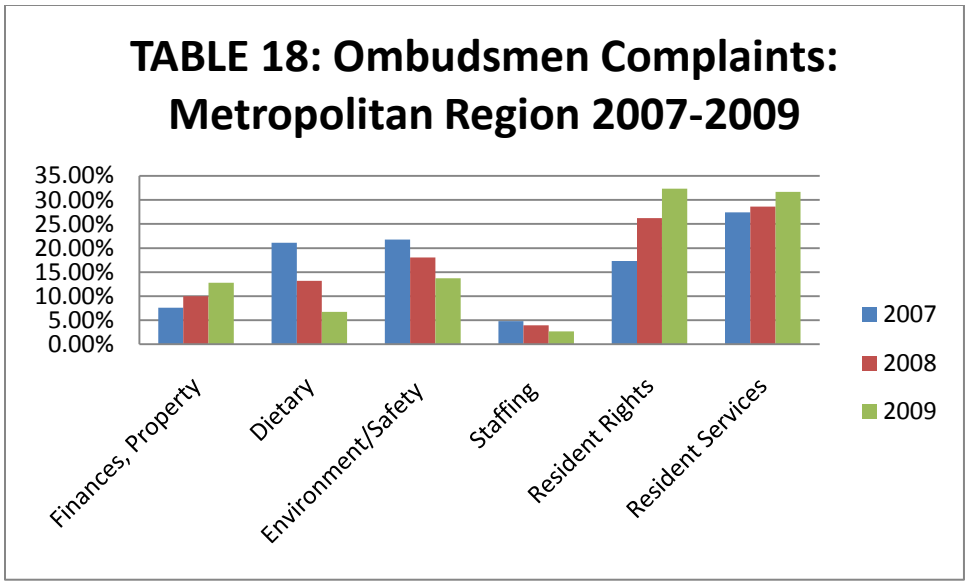


TABLE 18: Ombudsmen Complaints: Metropolitan Region 2007-2009
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Finances, Property
Dietary
Environment/Safety
Staffing
Resident Rights
Resident Services
2007
2008
2009

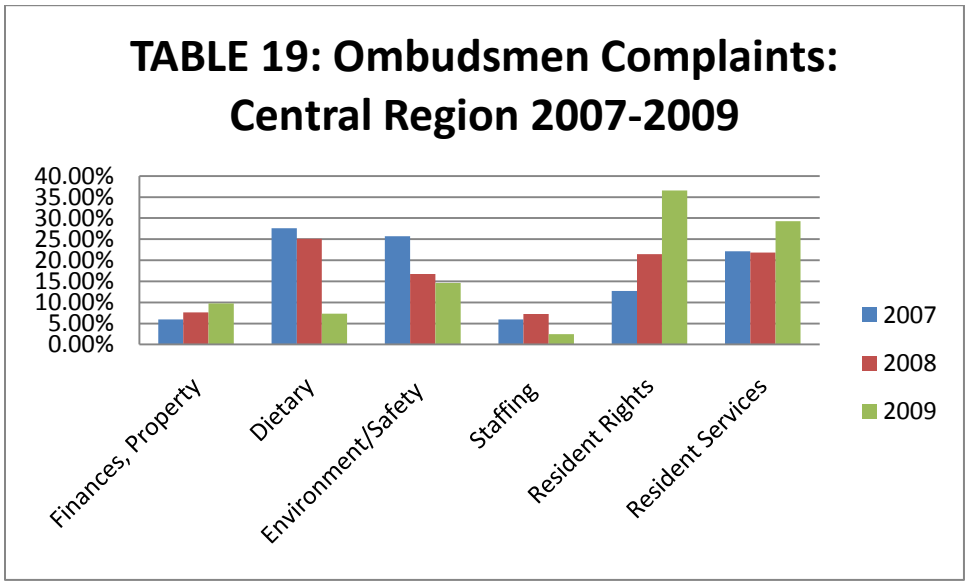
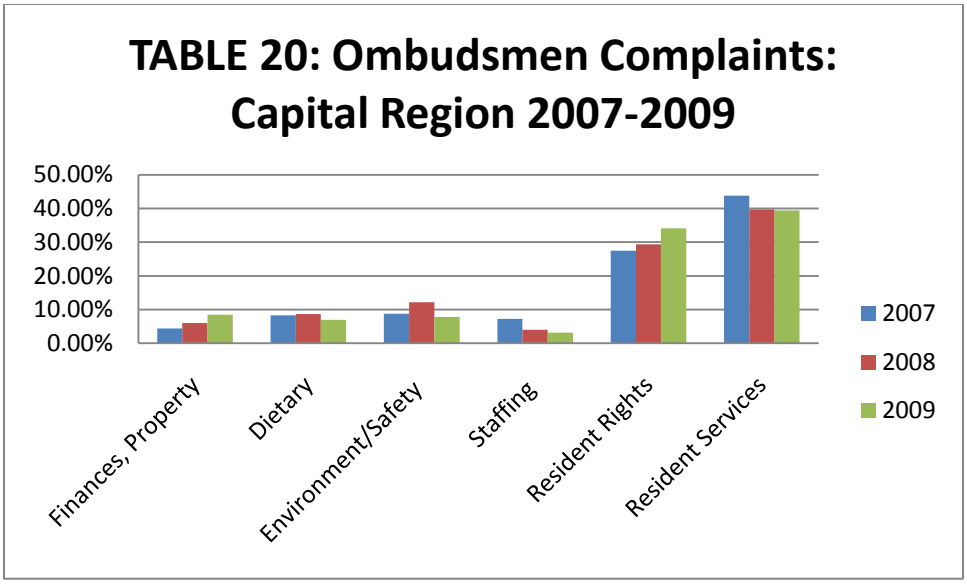


TABLE 19: Ombudsmen Complaints: Central Region 2007-2009
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Finances, Property
Dietary
Environment/Safety
Staffing
Resident Rights
Resident Services
2007
2008
2009



On-Line Survey

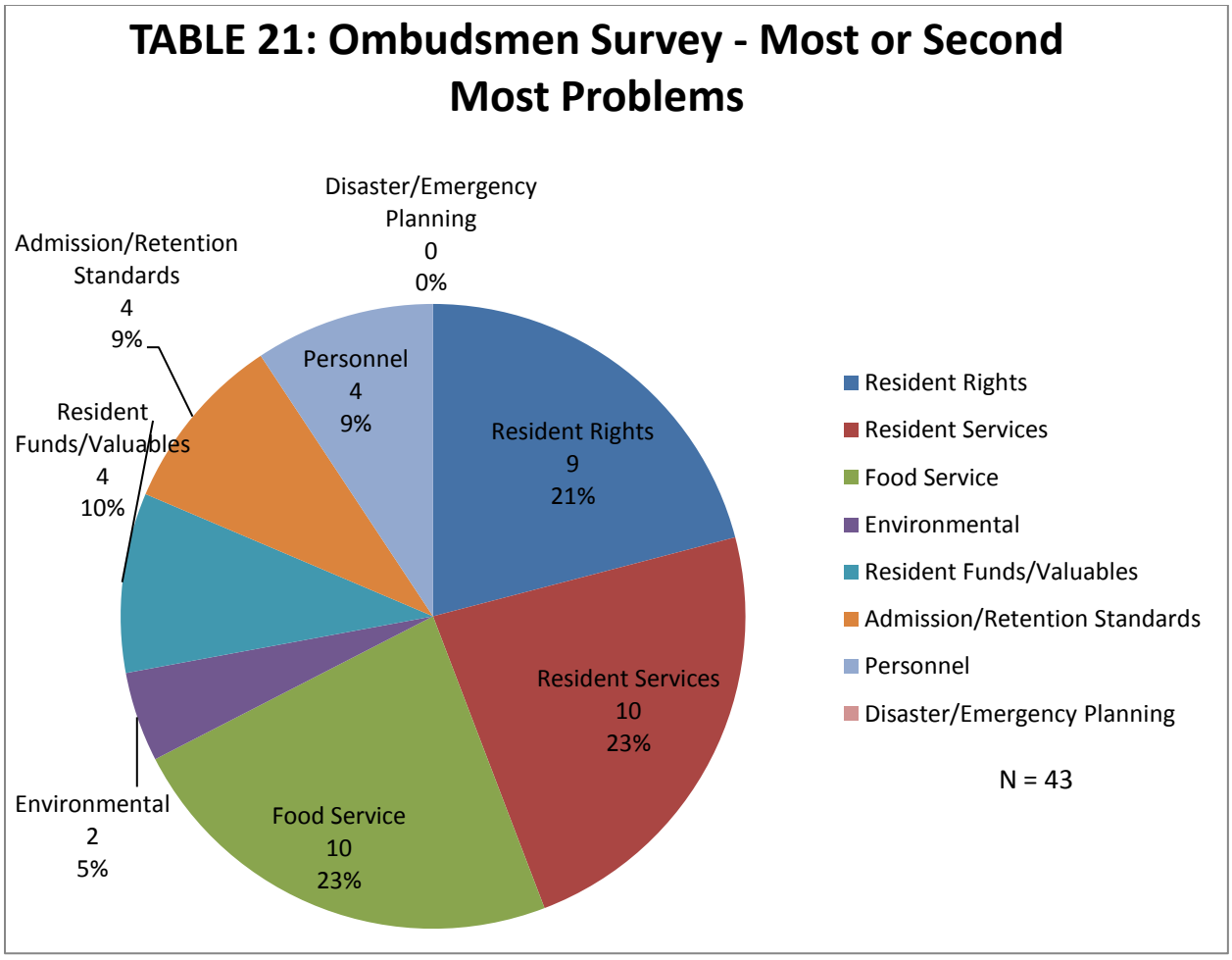
To better understand the complaint data, LTCCC developed an online survey for ombudsmen (see appendix G). Requests to fill out the survey were sent to all local ombudsmen in the state. Thirty-two ombudsmen, representing 37 counties in the state, responded to the survey. Ombudsmen were asked to describe the complaints made to them (using the categories used by DOH when DOH monitors assisted living facilities)[33] and provide their perceptions of DOH oversight and of the effectiveness of state regulations.

Ombudsmen Report Most Complaints are in the Areas of Resident Rights, Food and Resident Services

Ombudsmen were first asked to state the top category in which they received the most complaints. Then they were asked to list the category receiving the second most complaints. Twenty two ombudsmen responded to these two questions, giving a total of 43 responses.[34] Taken together, 23 percent of respondents identified food service as either the number one or number two most problematic area. Similarly, 23 percent of respondents also reported that resident services was the area with the most or second most problems. Resident rights totaled 21 percent of all responses. Thus, 67 percent of the respondents indicated resident rights, resident services and food as either the most or second most area receiving complaints.

[33] As determined by state law and regulations.

[34] One ombudsman listed the same category for the first question and the second question. Project staff counted only his/her first response and discounted the second repeated response.



Examples of resident rights complaints:

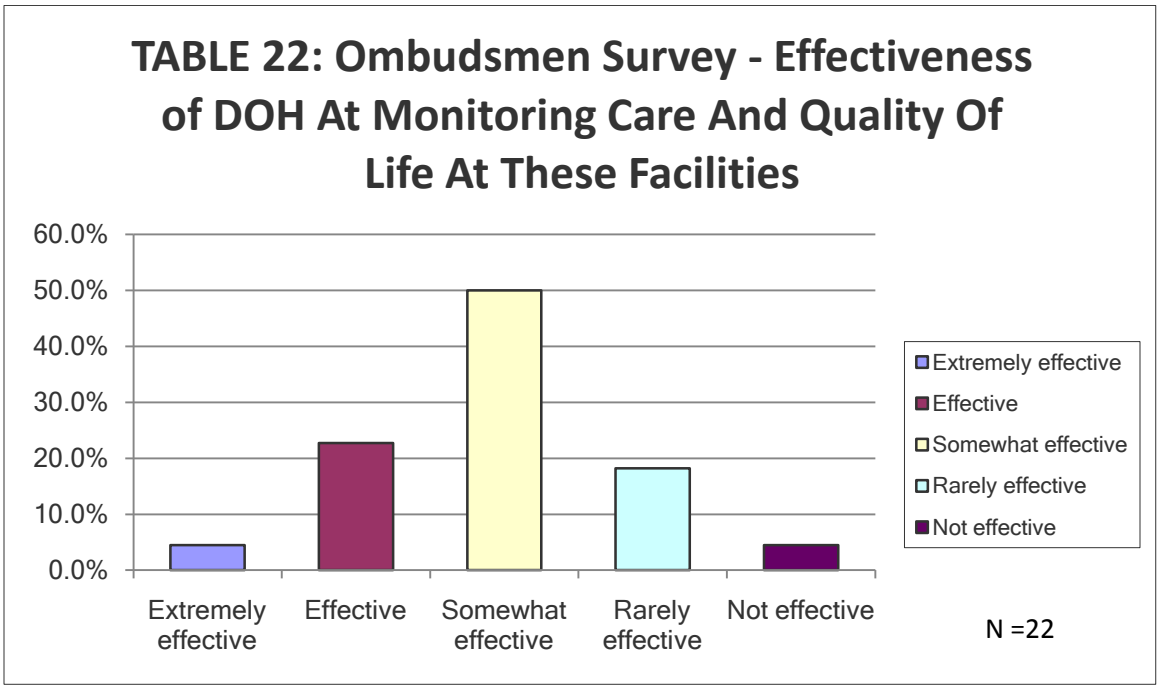
- "[r]esidents not having recourse when facing rights issues such as admission contracts, medical and health related care, complaints, choice and grievances."
- "complaints [are] discouraged, [there is a] fear of retribution" and "free movement [is] controlled [as well as] boredom causing irritability."

Ombudsmen cited specific deficiencies in medication management, case management, the monitoring of residents with dementia, mental health services, and activities.

Overall, Ombudsmen Find the Department of Health to be Moderately Effective

The ombudsmen were asked to rate the effectiveness of DOH oversight, from "extremely effective" to "not effective." Half of the respondents found the DOH to be "somewhat effective" (the middlemost

choice) in monitoring care and quality of life. The other responses ranged from extremely effective (two respondents) to effective (five respondents) to rarely effective (four respondents) to not effective (two respondents).



Taking a closer look, most ombudsmen respondents (81.8 percent) reported that they had referred complaints to DOH and, of those, 94.4 percent received a response upon referral. Although a majority of those ombudsmen who referred a complaint and received a response from DOH were satisfied with the response (64.7 percent), a large minority (35.3 percent) were not. When asked to identify why DOH's actions had been unsatisfactory, one ombudsman reported that he/she has "reported several violations to the DOH that we're told 'are old news' or 'too small to count' when in reality they're things that are just never fixed. We have also informed them of major issues (like sexual assaults) which it appears do not get that much attention immediately either."

"DOH needs to put some teeth in their enforcement."

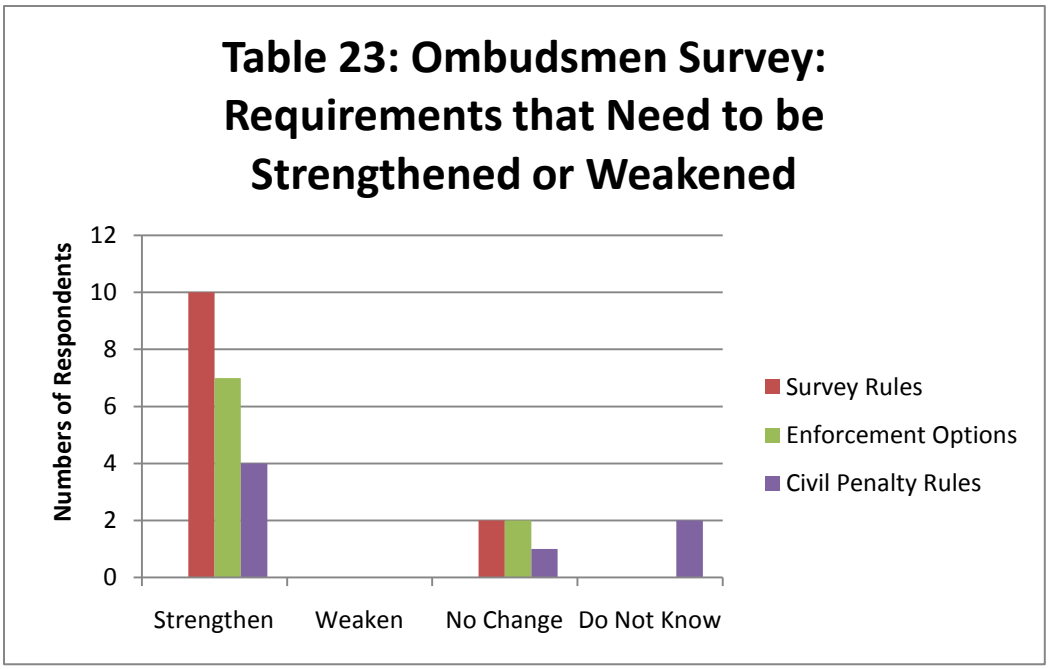
Ombudsmen Want DOH to Have Increased Survey Effectiveness and Enforcement Options, but are Less Sure about Modifying Civil Penalties

When asked whether the authority of DOH should be expanded to provide DOH with increased authority to survey facilities, enforce the rules, or levy civil penalties, most ombudsmen thought that the authority of DOH should be strengthened. However, fewer ombudsmen thought that the authority of DOH to levy civil penalties should be strengthened. This may reflect an ombudsmen focus on the actual inspections themselves rather than on sanctions.

Some comments gathered in response to this question included,

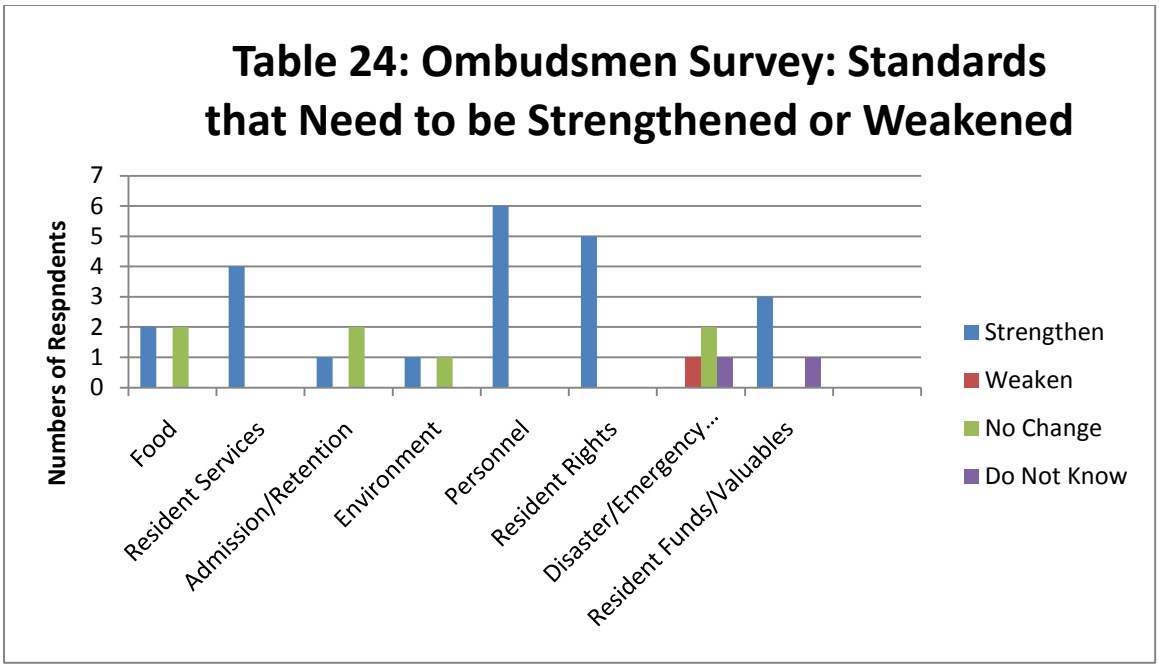
- "[Facilities] know when the inspectors are coming."
- "DOH needs to put some teeth in their enforcement of findings."

When asked what changes they would like to see and how ombudsmen would like to see these changes made, their suggestions ranged from increasing fines and scheduling more unannounced inspections to interviewing more residents and implementing a six-month self-assessment for facilities. Specific recommendations included calling for "[a]t least two unannounced inspections per year" and "[i]nterviews with 30 percent of residents during each survey visit as well as random interviews during complaint visits."



Ombudsmen Want Stronger Rules and Regulations for Resident Services, Personnel, and Resident Rights

In the survey, ombudsmen were asked which of the survey categories they felt needed increased regulation or strengthening of rules. The strongest calls for strengthening were seen in resident services, personnel, and resident rights. (See the graph below). Ombudsmen noted that they would like to see increased staffing, improved staff training, and more resident engagement in decision-making.



Consumer Advocates

An on-line survey was developed for representatives of consumer organizations (see appendix H). Since there are a limited number of consumer organizations working in the area of assisted living in New York State, it was not expected that there would be many respondents (i.e., sufficient to provide valid information). Rather, these data were collected and are presented in order to provide additional, consumer-oriented perspectives on quality of life and care issues.

A total of nine representatives of consumer organizations responded to the survey, most answering only a few of the questions (presumably based on their experience, interest and expertise). Six of the respondents reported having experiences with impacted homes; three with non-impacted homes; one with adult homes/enriched housing with ALP beds; and five with licensed assisted living residences.

Overall, the responses of the consumer advocates were similar to those of the ombudsmen for a number of the questions. When asked where, in their experience they have found the most problems, three said food service, two said resident services and two said resident rights. Two respondents skipped the question. When asked what the second biggest problem was, the respondents gave varied answers: one said food service; three said resident services; one said resident rights and two said resident funds/valuables. Taking these two questions together, five people listed resident services as the number one or two problem; four listed food service; three listed resident rights. Thus resident services, food service and resident rights were listed more often than the other areas. This is similar to the information collected from the ombudsmen. Resident services and resident rights issues being the

top one and two problem area; although environment was the third area cited in the ombudsmen survey, dietary was a close fourth.

Problems Found

Some of the examples of the type of problems found by consumer advocates were similar to those of the ombudsmen particularly in the area of resident rights:

Care:

- "Many residents have reported that their case managers refuse to help them with discharge planning, coordinating their medical benefits, and/or obtaining other services."

Food:

- "There are few adult home residents who do not complain about food. Residents complain that the food has too much starch, making it difficult to maintain or reach a healthy weight."
- "Residents with diabetes complain that the food is not appropriate for the type of diet they need, that there aren't separate meals for diabetic residents except, in some instances, sugar-free desserts."
- "Food not cooked enough or undercooked; no steak or good cuts of meat."

Rights:

- "Many residents experience retaliation when they speak up about problems or are generally fearful to speak up in the first place."
- "Many resident councils are controlled by the administration or staff of the home and residents, even when they know they have the right to meet on their own, do not feel comfortable asking staff/administration not to attend resident council meetings."
- "Residents are often illegally evicted ("discharged" without commencing an eviction proceeding in court) or threatened with illegal eviction if they do not do what the administration wants."
- "(There are) roommate issues, trying to change roommates and personality problems"
- "Residents do not [get a chance to] shower frequently that is, a month or two may go by...."

Rule Changes

When asked which, if any, of the areas needed strengthening, weakening or remaining the same, one respondent said resident rights needed strengthening; two said resident services and two said resident funds and valuables, the three top areas of ombudsmen complaints. These responses are similar to those of the ombudsmen. One major difference is one of the areas receiving the most votes for strengthening by the ombudsmen was personnel (six of the 22 respondents listed this).

Effectiveness of the Department

When asked how effective DOH is at monitoring care and quality of life, similar to the ombudsmen, the respondents gave different answers: two said effective; four said somewhat effective and one said rarely effective.

Three of the respondents said that DOH has not been responsive to them; one said that he/she has been satisfied with the results of DOH action and two stated they were not satisfied.

Among the comments:

- "DOH has been responsive occasionally, but for the most part, does not seem to take resident complaints seriously."
- "In most instances, resident complaints are not thoroughly investigated, i.e. DOH does not always interview residents to investigate a complaint, which in most instances, would be integral to verifying the truth of a complaint."
- "When it does substantiate a complaint, DOH does not usually take enforcement action that would prevent future violations by adult home operators."

When asked if the rules giving DOH authority should be strengthened/weakened/remain the same, two stated that the civil penalty rules should be strengthened; one said that the enforcement options should be strengthened and one felt that these options did not need to be changed.

One respondent said, " A change in requirements is not needed so much as strict adherence to these requirements and use of enforcement action/penalties available to the Department."

In-depth Interviews With Ombudsmen and Consumer Advocates

Problems Found

Follow up interviews with those ombudsmen and consumer respondents willing to be interviewed indicated that they believe there are major differences between the impacted homes and the non-impacted homes. Although they found some problems common to all types of assisted living facilities, they felt the impacted homes had more problems. In addition, some felt that the higher end homes either had less problems or were more responsive to solving them.

Among the problem areas cited for facilities generally were:

- Discharge and eviction.
- Food - quality, choice and quantity.
- Funds and property - not having access to personal funds; co-mingling of funds; being forced to do what administrator wants before getting personal allowance; facility having no responsibility for replacing lost or stolen items.
- Dignity, respect and staff attitudes - privacy violations.
- Resident fear of retaliation.

- Medication issues and the need for more qualified staff dealing with medication. Need more stringent rules on medication training, professional staff.
- Inability of some administrators to properly supervise staff and manage the facility. Need more stringent rules on who can be an administrator.
- Lack of activities in impacted homes.

A few of the interviewees felt that one of the most common problems is the fear that residents had of retaliation. This fear may be justified. One of the reasons given for not citing resident interviews as documentation for citations by the Department was fear of reprisal to the resident. Thus, the Department seems to be validating this issue.

An example of retaliation was found in one statement of violations:

It was determined that "residents, whom employee # 1 suspected as having been a part of the eleven residents who cooperated with the surveyor in the original complaint investigation, were subsequently subjected to various acts of retaliation and or reprisal by the operator and his staff, including: eviction from the home; being forced to leave the home because of the threatening and harassing behavior of employee #1; being treated to ongoing mistreatment, and being threatened with eviction, hospitalization or transfer to a homeless shelter or nursing home...."

Effectiveness of the Department

- "Surveyors do not interview or speak to enough residents."
- "If you interview more you will find more problems."
- "If surveyors interviewed more residents, residents would be less afraid to come forward. There are safety in numbers."
- "Surveyors do not seem to find residents credible."
- "Inspectors are not in the home enough to identify problems and to gain the trust of the residents."
- "Care regulations should be more focused on outcome rather than on paper compliance."
- "Inspectors seem to just check to see if an impacted home has a contract for case management, not if the case management is effective. Some residents report not even knowing who their case manager is."
- "It takes so long for the Department to enforce the rules and then the effect is so small."
- "The Department was inconsistent from area office to area office."
- "The system is too one-sided. Operators have a number of opportunities to tell 'their side' of the story. Who is the system serving?"

"The rule that if a facility corrects within 30 days they cannot be fined is **an even bigger slap in the face.** (emphasis added)"

- "There should be an appeal process for residents to appeal unsubstantiated complaints."

DISCUSSION

After a long history of problems, the assisted living industry in New York State still has serious issues related to resident care and quality of life. It is unacceptable that the very same problem areas identified over the last few decades are still causing harm to residents of assisted living. It is particularly outrageous, from the perspectives of consumers and the general public, that two of the three major identified issues are oftentimes repeated year after year by 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, especially given the impact these failures have on the lives of residents, who are in general very vulnerable. Adding to that concern is the likelihood that the number of problems may in fact be underreported by DOH. Some ombudsmen and resident advocates believe that DOH is not identifying major problems related to resident rights, discharge and transfer, personal funds and property.

The data indicate that even after the scandal and investigations of the early 2000s, the impacted homes still have many more problems when compared to non-impacted homes. The impacted homes have twice the number of violations as the non-impacted homes. When one considers the longstanding public knowledge of these issues, and their impact on a vulnerable population, this too is (or we believe should be) 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 are being interviewed by inspectors, 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 homes often are not being held accountable for their violations in a timely fashion. Findings, or non-compliance that do 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 a home that has gone out of compliance time and time again for years can avoid *ever* being fined simply by correcting the individual violations within 30 days of their being cited.

There are other reasons that few homes are 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.

The recommendations listed below attempt to remedy the problems found in this study by improving the quality of assisted living in the state through an improved inspection system and strong and timely enforcement of regulations

RECOMMENDATIONS

Legislature

To improve assisted living quality:

1. **Amend Section 461-a of the Social Services 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 Article 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.
   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 strong, speedy enforcement:

1. **Amend Section 460-d of the Social Services 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 Social Services Law (Enforcement Powers) to raise the amount a fine can be assessed.** $1000 or less per day (or even per violation if 'a' above was adopted) may be too low a fine 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 results is financially costly for the consumers and taxpayers who continue to pay for substandard services and 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 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 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 both formally and informally 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.
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.**

APPENDICES

Appendix A: Types of Assisted Living in NY State

Adult Home (AH): an adult care facility established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator. Currently, there are 376 AHs in New York State.

Enriched Housing (EH): an adult care facility established and operated for the purpose of providing long-term residential care to five or more adults, primarily persons 65 years of age or older, in community-integrated settings resembling independent housing units. Such programs must provide or arrange for the provision of room, and provide board, housekeeping, personal care and supervision. Currently, there are 105 EHs in New York State.

Medicaid Assisted Living Program(ALP): an entity which is established in some adult homes and enriched housing, 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 and, either possesses or is eligible to apply for: (a) licensure as a home care services agency; (b) authorization as a long-term home health care program; or (c) a certificate of approval as a certified home health agency. ALPs may be located in AHs, EHs and, in the future, to some approved nursing homes. Currently, there are 5036 ALP beds allocate to adult homes and enriched housing across the state. . All individuals in this program must be assessed as eligible for nursing home care but able to be treated in the AH or EH.

Assisted Living Residence (ALR): a licensed AH or EH that has received additional certification in order to call itself "assisted living" and provide assisted living services (outlined as follows):

Basic: A basic assisted living residence is required to provide or arrange for housing, 24 hour on-site monitoring, and personal care services and/or home care services (either directly or indirectly), in a home-like setting to five or more adult residents unrelated to the assisted living provider. As of April 2011 there are 43 licensed assisted living facilities in New York State.[35] Basic ALRs may, if it chooses and is approved, hold one or both of the following certifications.

Enhanced Assisted Living Residence (EALR): A basic ALR which has received a certificate issued by the Department of Health which authorizes an assisted living residence to provide aging-in place by retaining residents who desire to continue to remain in the residence as they become more frail, including those who: (i) are chronically chairfast and unable to transfer, or chronically require the physical assistance of one or more persons to transfer; (ii) chronically require the physical assistance of

[35] This number will increase as DOH approves current and future applications for licensure.

one or more persons in order to walk; (iii) chronically require the physical assistance of one or more persons to climb or descend stairs; (iv) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or (v) have chronic unmanaged urinary or bowel incontinence.[36]

Special Needs Assisted Living Residence (SNALR): A basic ALR which has received a certificate issued by the Department which authorizes them to serve persons with special needs in accordance with a special needs plan approved by the Department of Health. At this time, all facilities with special needs certificates are serving people with some form of dementia.

Appendix B: Summaries of Referenced Reports

1. Assisted Living in New York State: A Summary of Findings, LTCCC (2001) (http://www.ltccc.org/publications/documents/ALinNYSSummaryofFindings.pdf).

This study, conducted by LTCCC with The HealthCare Management Program, School of Business and Management at Temple University and the Coalition of Institutionalized Aged and Disabled, included a statewide survey of assisted living administrators and an environmental assessment. Telephone interviews were conducted with a total of 470 administrators and coordinators of assisted living facilities, including a few unlicensed facilities. [37] In addition, ten on-site visits were made to a diverse group of assisted living facilities: they varied by licensure type, sponsorship, size and geographical location. In-depth case studies were written describing these visits.

Among the findings:

The results of the telephone interviews indicated a number of concerns:

- Forty percent of the unlicensed facilities (28) reported using nurse aides, not professional nurses, to administer medication to those individuals *not* self directing.
- Twenty percent of the licensed facilities (out of a total of 419 adult homes and enriched housing) reported having a facility policy that prohibits the self-administration of medications.
- The unlicensed facilities reported the lowest level of current resident needs, but had more flexible admission practices. They were willing to admit higher care residents (if the resident could afford the rate).
- Few of the facilities had procedures that assured fully informed consent related to refusal of treatment. Although 59 percent did document refusal, almost half did not formally inform the

[36] Although EALRs are permitted to serve such residents, not all do so.

[37] At the time, there was no licensure of assisted living facilities. Only adult homes and enriched housing were licensed. These facilities were primarily those that came into NYS and were built as private pay assisted living facilities. The results of this study helped lead the pressure for licensure of assisted living in NYS.

resident of the consequences; and only a small number (less than seven percent) notified a doctor or the family of the refusal.

- Consumers were not getting the information they needed to make an informed choice and were not given the information they needed on the contracts they sign or other material they received.

The case studies were conducted to see if the "promise" of assisted living was being met: "How Well Does the Rhetoric Match the Realities?" The in-depth visits looked at: aging-in-place, autonomy, risk taking, staffing, finances, regulation and licensure.

The results of the detailed case studies of the ten facilities include:[38]

- Aging-In: Consumers were often led incorrectly to believe that they could "age-in." Most facilities were operating on the most basic level of care. In some places, residents were becoming more and more dependent (some staff said they were like nursing home residents), yet few facilities were planning for these changes. In addition, evidence of financial pressure and lack of organization and planning seemed to indicate that residents were not aging-in safely in some of the facilities. Increased competition to keep beds filled and continued staffing problems challenges safe aging-in.
- Autonomy: The residents' and the staff view of what resident autonomy means seemed to be at variance with one another. Most staff seemed to believe that if residents were given a few choices at meal times or a few choices of staff-developed activities, a resident's autonomy and independence was being promoted. Residents seem to believe that autonomy means more than being offered choices decided by staff. Most facilities offered choices in food and activities. Although all permitted residents a choice of physicians, many facilities encouraged the doctor used by most of the residents because of greater efficiency. Few facilities offered a choice in home care agency.
- Risk-Taking: Competent residents who understood the consequences of their behavior were often discouraged from doing something the staff considered risky. Most of the staff practiced "persuasion," to convince a resident not to take a risk, even if the resident understood the consequences. At times, the threat of calling the "daughter or son" was enough to stop the resident from taking what staff believed was a too risky action.
- Staffing: There were many problems finding and keeping well trained staff.

Among the Recommendations:

- The state should require uniform licensure.
- The state should have a set of minimum standards for which they monitor compliance.
- Licensure standards should reflect the assisted living mission to permit aging-in place safely and to encourage resident autonomy and decision-making.
- Providers must live the mission by planning for the dependency of residents, have sufficient levels of staff, and designs should encourage independence.

[38] This part of the study was released in July, 2001.

- Providers should provide full disclosure of costs, services, ownership and resident rights.
- Providers should empower residents.
- Providers should adapt the facility to the residents so they can feel like it is a home.

2. Adult Homes Serving Residents With Mental Illness, New York State Commission On Quality Of Care For The Mentally Disabled, August 2002 - *A Study On Layering Of Services (http://cqc.ny.gov/uploads/Publications/layering.pdf).*

The Commission's study looked at the cost and quality of the Medicaid-funded services provided to residents of adult homes under the jurisdiction of the Commission.[39] It chose the 11 largest adult homes in the greater New York City area. In these homes, some 90 percent of the residents are persons with histories of mental illness.

The study analyzed the cost of care for the residents who had continuously resided in these homes for at least the one-year period October 1999 to September 2000, by reviewing Medicaid cost data. It also audited a sample of Medicaid claims and Commission staff visited the homes, reviewed the available medical and mental health records of 60 residents, and interviewed providers and adult home administrators. Finally, the study concluded with a review of each home's finances.

The study concluded that many residents were receiving multiple layers of services from different providers that were costly, fragmented, sometimes unnecessary, and often appeared to be revenue-driven, rather than based on medical necessity. Services provided to residents were often characterized by their lack of individualization. The breadth of services-- from home health aides helping residents bathe and doing laundry to occupational therapists teaching numbers by having residents play solitaire on a computer; as well as the volume of services -- with residents seeing primary care, specialty physicians and other practitioners for services of questionable medical necessity -- could be attributed to easy accessibility and the absence of a gatekeeper or service coordinator.

In addition, although considered a "community-setting," some homes appeared to be more institutional in nature, with residents treated as a "class" rather than in accord with their capacities and characteristics as individuals. Instead of a normalizing experience arising out of residents availing themselves of services in the community, practitioners were renting space from the adult home operators and regularly providing services on-site. In most instances, the home had no arrangements in place to coordinate services, and the responsibility for coordinating medical services was left, by default, to residents' private physicians who often did not know all of the services the resident was receiving.

[39] Adult homes in which 25 percent or more of the residents receive or have received services from a mental hygiene provider.

In short, residents were often poorly served, and resources were not utilized cost-effectively. The Commission found a fundamentally flawed service system that addresses separate aspects of a resident's life rather than the individual as a whole. Despite the investment of substantial public money, residents were being short-changed when the reality of their living conditions and the services they were given was examined.

3. Report of the Adult Care Facilities Workgroup, Submitted to: Antonia C. Novello, M.D., M.P.H., Dr.P.H., Commissioner Department of Health , October 2002. (http://www.health.state.ny.us/facilities/adult_care/workgroup_report/10-2002/pdf/workgroup_report.pdf)

In the Spring of 2002, at Governor Pataki's direction, the Commissioners of Health and Mental Health, and the Chairman of the Commission on Quality of Care for the Mentally Disabled, embarked upon a comprehensive review of Adult Care Facilities (ACF) policy, program and financing. The overall goal of the review was to modernize the program of housing, supportive services and care so that it reflects current long term care policy objectives to: (1) maximize New Yorkers' autonomy, privacy, dignity, choice and community integration; (2) obtain the best possible outcomes for consumers in terms of quality of life and quality of care; and (3) hold providers accountable for producing these outcomes.

An Adult Care Facility Workgroup was appointed to evaluate the strengths and weaknesses of the current ACF model of housing plus services, and to develop recommendations for new approaches that would be more effective.

The findings and recommendations of the report include:

General Findings

The report states that problematic care and conditions at some ACFs is not a new phenomenon and that certain segment of the industry has a long history of problems stretching back as far the late 1970's. It is evident that over the past three decades a certain segment of the industry continues to be chronically deficient.

Specific Findings

Medication Management

One of the issues that has long been a concern has been the issue of medication management. Many of the people who live in ACFs have chronic medical conditions that require treatment and monitoring. Approximately 41% also have a diagnosis of serious and persistent mental illness and require the attention of mental health professionals. It is common to see individuals in ACFs with diabetes, chronic respiratory problems, cardiac conditions or high blood pressure treated with medication.

Those receiving mental health services are often treated with psychotropic medications to relieve symptoms as well. Studies have shown that ACF residents, on average, receive six to nine medications daily. Presently ACFs rely on unlicensed staff to manage this high volume of medications, which in some homes require pharmacy deliveries daily, and sometimes more than once a day. Department of Health inspection reports cite the need for improved medication management in many of the adult homes to ensure that residents receive without interruption the correct medications as ordered by their physician.

Recommendation

The immediate implementation of a medication management system using nursing professionals to correct the problems and risks inherent in the current system of aides assisting with medication administration. Options for providing this service range from use of a Home Care Services Agency to authorizing operators to hire nurses on facility staff.

Service Coordination

In addition to room, board and some assistance in daily living, residents of ACFs receive an array of other services, including general and specialty medical care, nursing services, mental health care, rehabilitation services and others. These services are frequently provided by independent practitioners or licensed agencies that have no organizational ties to each other, thereby creating difficulties in service coordination. While ACFs are required and expected to provide case management services, it is generally acknowledged that the increasing care needs of today's ACF residents makes the provision of case management complex and the coordination of such services extremely difficult for ACF staff. There are numerous examples of ACF residents who experience duplicated or fragmented services due to poor case management. In some cases, perverse financial incentives result in over-utilization, poor service delivery or unnecessarily expensive levels of care.

Recommendation

Immediate implementation of an independent service coordinator (ISC) initiative to ensure that residents in all facilities receive the residential, health, mental health, rehabilitation and recovery services necessary and appropriate to meet their needs and to ensure that such services are of high quality and delivered in a coordinated fashion. Case management services need to be improved. The use of the Office of Mental Health "blended" case management program should be considered for the provision of this and other case management services to residents with psychiatric disabilities.

Assessment

The adult home resident population is diverse. ACFs serve the young and old, the cognitively intact and cognitively frail, the psychiatrically disabled, the physically well and the physically disabled. It is widely recognized, however, that little uniform and reliable data about the residents of adult homes exists. This is due to the to the existence of more than a dozen different instruments currently in use across programs.

Recommendation

Immediate implementation of an initial assessment of all residents to gather information about resident demographics, strengths and care needs, health, mental health and functional status, and the entities engaged in providing care and services. The on-going assessment will be utilized over time to provide care-planning information including resident goals.

Model of Congregate Care

A model of congregate care designed more than 30 years ago for the frail elderly is not appropriate or effective for many of the types of residents who now live in ACFs, especially those with mental illnesses.

Recommendations

- *Move those residents with mental illnesses (for whom it is appropriate) to:*
  - *scattered site housing;*
  - *single site mixed use facilities; or*
  - *congregate housing.*
- *NYS should encourage existing adult care facilities, particularly those over 120 beds, to reconfigure to include small, home-like environments within the facility; and include such housing options as apartments licensed by the Office of Mental Health, single room occupancy residences, respite beds and mixed-use housing.*
- *NYS should develop a comprehensive housing vacancy list to ensure that adult care facility residents, hospitals, OMH facilities and others are fully informed about available housing options.*
- *Make trained individuals with successful mental health recovery histories available to provide personalized support to help designated residents move toward recovery, in coordination with the case management plan and goals.*

Service Payment

Current payment for services in adult care facilities includes outside agencies such as home care providers and mental health providers who directly bill various payers. Concerns with these arrangements have been raised in regard to: (1) overutilization and duplication; (2) lack of coordination and accountability; and (3) unreasonable profits.

Recommendations

- *The annual financial report submitted by adult care facilities should be revised to include more appropriate data to facilitate monitoring of these facilities. Such revisions should be consistent with generally accepted accounting principles.*
- *Periodic financial audits of adult care facilities should be conducted.*
- *Written protocols for adult care facility contracts with outside providers which include fair market value standards for space rental arrangements in the facility should be established and enforced.*

- *In order to ensure meaningful transparency, and prevent fraud and abuse, the Department of Health's and the Office of Mental Health's , enforcement of adult care facilities and mental health service/clinics regulations should include an annual reporting requirement of all financial and controlling interest relationships with service providers in an effort to make the system more transparent.*
- *NYS must enact new laws to require review for character and competence of all ACF applications, changes in ownership, conversions and license renewals by the Public Health Council (PHC).*

Low Income Residents

In New York, many ACF residents pay for room and board through the Supplemental Security Income (SSI) program. ACF rates for SSI recipients are established in state statute and cover room, board and other required services. Additional support services for SSI-eligible residents such as personal and home health care, and mental health and medical care, are reimbursed through Medicaid.

Recommendations

NYS should contract with an independent organization to review the current SSI rate paid to adult care facilities for adequacy and accountability to assure the best possible service to residents. The review should be used to guide development of the Executive Budget as well as the work of the Commission on Adult Care Facilities.

NYS should augment personal resources for all residents receiving SSI through increases in the Personal Needs Allowance and a to-be-created clothing allowance in order to foster self-sufficiency and responsibility.

"Some individuals were seen by their doctors monthly, though they had not requested it nor had an apparent need. Some received screening by specialists even when they had no documented need. Yet, "[t]he percentage of the CQC sample having had an annual gynecological visit, dental visit and colon cancer screening was considerably less than for the general population." - *New York State Commission on Quality of Care and Advocacy for Persons with Disabilities*

4. Health Care In Impacted Adult Homes: A Survey, New York State Commission on Quality of Care and Advocacy for Persons with Disabilities, May 2006. (http://cqc.ny.gov/uploads/Publications/HealthCareStudy.pdf)

In 2003 the Commission undertook a study of the health care provided to a selected sample of 69 residents of 13 impacted adult homes.[40] On site at the adult homes, the study included a review of the residents' adult home record (including emergency room and hospital discharge papers), interviews with the selected residents, and an interview with the person at the adult home who was responsible

[40] Facilities housing 25 percent or more residents with mental disabilities.

for securing medical services for residents. In addition, with the written permission of the individuals, Commission staff reviewed the medical record maintained by the individual's primary care practitioner.

Findings

1. The medical and adult home records of the sample individuals revealed that in several disease categories, the incidence among adult home residents far exceeded the incidence in the general population. All persons in the sample carried multiple diagnoses. Twenty percent of the sample carried between two and four diagnoses, while the remainder carried more. Over one-third of the sample (36%) carried more than eight diagnoses. The most prevalent diagnoses related to cardiac conditions, pulmonary disease and digestive problems, including reflux disorders.
2. Of the 58 persons carrying a diagnosis of schizophrenia, two-thirds were receiving one of the newer anti-psychotic medications, either singly or in combination with an anti-depressant, anti-anxiety drug or other newer antipsychotic medication. Over 80 percent were treated with multiple medications.
3. The assessment form serves a dual purpose for many individuals in adult homes. In addition to asserting that an adult home is an appropriate residential setting, the form constitutes the individual's annual medical evaluation. In this capacity it is inadequate and fails to capture significant medical information. In addition, many forms examined were incomplete and failed to provide even the minimal information required leading a reader to misjudge the current health status of the individual. Ninety three percent did not contain all of the individual's diagnoses. Twenty three of the 69 forms lacked five or more individuals' diagnoses.
4. Between approximately 50-60 percent of the relevant sampled individuals had received exams/screenings for dental care and eye care and tuberculosis. A similar percentage of women had gynecological exams and mammograms and men, prostate exams or PSA screening. Screening for colon cancer was significantly less frequent. The percentage of the CQC sample having had an annual gynecological visit, dental visit and colon cancer screening was considerably less than for the general population. The percentage of persons in the sample reporting mammograms and prostate exams was the same as for the population at large.
5. At least 80 percent of the relevant persons in the Commission sample were receiving medical attention for chronic medical conditions under review. The care often included the attention of a specialist. The study found numerous instances where individuals were being treated by specialists or in specialized clinics for serious medical conditions. However, ten persons in the sample were taking medications for which there was no corresponding diagnosis. Some primary care physicians and specialists were providing on-site services at the adult home. As identified in the Commission's Layering of Services Study, this sometimes meant that individuals were seen monthly by their primary care physician even when they had no complaints and had made no request to see him/her. It also sometimes meant that individuals were screened by specialists when they had no documented need for such.
6. Consistent with the finding that the persons studied had multiple health problems and were taking numerous medications, the study found that they used medical services frequently. Specifically, the sampled persons used emergency department services significantly more often than the general population, and they were admitted to hospitals at four times the rate of the general NYS population.

7. The study revealed evidence of a shift in health care coordination for persons in the adult homes studied. Increasingly, responsibility for coordination of health services had shifted from the case manager at the home to the provider of health services. Health information available to the case manager varied considerably.
8. A short interview with the persons in the sample indicated general satisfaction with their health care and comfort in reporting symptoms to staff when they were feeling ill.

Recommendations

- *The Department should review with surveillance staff, as necessary, the de facto changing locus of control for the coordination of mental and physical health treatment observed by the Commission, so that staff will assure that case management documentation clearly states the identity of the party responsible for coordination, particularly if it is not the adult home, and reflects receipt of essential health information necessary for the home to meet its obligation to an individual.*
- *The assessment form should be revised to include additional information necessary to present an accurate and complete portrait of the individual's health status. Additionally, the Department should hold homes accountable for ensuring that physicians fill in all required areas on the forms.*
- *As a protection to adult home residents, the Department should consider requiring TB testing when an individual is admitted to an adult home, as well as when there is a clinical trigger for testing.*

5. A Review of Assisted Living Programs in "Impacted" Adult Homes, NYS Commission on Quality of Care and Advocacy for Persons with Disabilities, June 2007. (http://cqc.ny.gov/uploads/Publications/ALPRpt.pdf)

This report describes the Commission's review of the programmatic and financial practices of Assisted Living Programs (ALP) operated in 13 adult homes which serve individuals who receive mental health services ("impacted" homes). The programmatic study involved an in-depth look at 78 residents residing in these homes, while the fiscal review involved an examination of the revenues, expenses and staffing patterns.

Findings

At the thirteen homes reviewed by the Commission, Medicaid payments for ALPs averaged $60 per day per resident, while the ALP programs spent about one-half that amount on resident care. The disparity between the funds received and money spent by providers was greatest at homes in New York City, where providers received higher rates, despite spending less than the rest of the state. The plain result is extraordinary profits for providers and systemically inefficient use of public funds.

The Commission believes that in some instances Medicaid payment levels were inflated due to unsupported level of need assessments that indicated residents needed substantial assistance with toileting. The Commission also found: substantive disparities between level of need ratings and plans

of care and between plans of care and actual services provided and that the annual financial reports filed with the Department of Health by the homes did not contain adequate disclosures on related party transactions, thus diminishing the usefulness of the report.

Recommendations

- *The Department of Health should evaluate the Medicaid funding levels for ALPs statewide. This evaluation should include an analysis which determines the actual costs that are obscured by related party transactions. If the Department's findings are consistent with the findings made by the Commission in the course of this review, i.e., Medicaid ALP payment levels greatly exceeded the actual costs of providing ALP services, the Department should propose appropriate adjustments to the rate methodology to more closely align funding with the program costs.*
- *Regarding the concern that the assessments which are used to determine Medicaid rates, particularly around toileting assistance, was unjustifiably inflated in the programs reviewed, the Commission recommends that the Department of Health review this matter and issue guidelines to impacted adult homes which are ALP clarifying its expectations related to the components of this assessment (interviews, observations and documentation review). These guidelines should include a requirement for a narrative section on the assessment tool in which the nurse provides a rationale for all scores above the base score, citing both personal observations and findings from reviewing patient records. Reassessments should address the success or lack of success of bladder incontinence training.*
- *The Department of Health should identify and implement enhanced surveillance protocols that address discrepancies among assessments, , plans of care, and services provided in impacted adult homes which are ALP providers.*

Appendix C: Standards of Care

All licensed facilities in New York State must comply with standards of care. The Department of Health monitors compliance with the rules by conducting inspections. Below are the required standards of care and the numbers of citations or deficiencies found at inspections for all types of facilities from 2002 to 2010.

Resident Services

Operators of AHs, EHs, ALPs and ALRs must provide services including, but not limited to, room, board, personal/home care, and case management services in compliance with the regulations set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.7, 488.7, and 494.5, and Title 10 Part 1001.10, respectively.

AHs: Must provide room, board, housekeeping, supervision/monitoring, personal care, medication management, case management, and activities. The regulations set out the minimum specific services that must be provided, including: maintaining knowledge of general whereabouts of each resident; recording a daily census; monitoring residents to identify changes in behavior or appearance; monitoring and guidance to assist with basic activities of daily living; at least one staff person per shift

must be designated as responsible for conduct and supervision of any evacuation or implementation of the disaster and emergency plan; assistance with personal care functions such as grooming, dressing, bathing, toileting and eating. In addition, if necessary, assisting residents with self-administration of medication and providing residents with proper dosage of medication at designated times; evaluation of resident needs; assisting residents with arranging for services such as health, mental health, and dental services; and planning and making available to residents a minimum of 10 hours per week of activities, including activities for group and individual participation, activities within the facility, community-based activities outside the facility, physical activities, intellectual activities, social interaction, and activities with opportunities for both passive and active involvement.

EHs: Similar to adult home standards, but must also provide housekeeping services, such as: maintenance and cleaning of all individual and congregate spaces; provision of clean towels and linens at least once per week; provision of and assistance with laundry services.

ALPs: Must provide or arrange for, at a minimum: room, board, housekeeping, supervision, personal care, case management activities and home health services.

ALRs: In addition to following AH and EH rules depending on whether the facility is certified as an AH or EH program, they must develop an individualized service plan for each resident and coordinate with service providers selected by the resident.

SNALRs: In addition, must provide: frequent individual and group activities geared towards individuals with special needs; must have sufficient trained staff to ensure activities are available throughout every day and evening; weather permitting, residents must have an opportunity to be outdoors each day with sufficient supervision.

Environmental Standards

Operators of AHs, EHs, ALPs and ALRs must ensure that their facilities are in compliance with the environmental standards set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.11, 488.11, and 494.7, and Title 10 Part 1001.13, respectively.[41]

AHs and EHs: Must comply with similar standards to provide a safe and comfortable environment for residents. The regulations include specific provisions for smoke and fire protection, safety procedures for toilet and bathing areas, furnishings and equipment, housekeeping and building maintenance.

ALPs: Must comply with the standards set forth for AHs and EHs, as well as some additional smoke and fire safety requirements. For example: where residents share all space other than bedrooms, the building must have a supervised smoke detection system, an automatic sprinkler system throughout

[41] Due to the settlement of provider associations' lawsuit against the Department of Health, a workgroup consisting of experts in the field of adult care facility operations and architectural standards will be created to review all existing standards. The standards listed are in effect as of April 2011.

the building, smoke stops in all corridors 100 feet long or greater, and a centralized emergency call system in all resident bedrooms, toilet areas, and bathing areas.

ALRs: Must comply with all applicable standards set forth for AHs, EHs, as well as some additional standards for existing[42] and new structures.[43] For example, in an existing structure: fire protection systems directly connected to the local fire department, handrails on both sides of any resident-use corridor, and a centralized emergency call system in all bedrooms easily reachable from bedside, and in all resident-use toilet and bathing areas, easily reachable from each fixture.

EALRs and SNALRs: Must comply with the applicable AH or EH regulations and the fire safety feature requirements for existing structures listed above. Must also provide the Department of Health with written documentation that the local code enforcement agency approved the structure as it exists, or as proposed in the architectural submission to the Department, for the facility's intended use, and the Department must believe the safety and welfare of the residents will not otherwise be compromised. In addition, if the capacity is 17 or more residents, the facilities must have smoke barriers to divide each floor into at least two smoke compartments with corridors of at most 100 feet in length.

Food Service

Operators of AHs, EHs, ALPs and ALRs must provide food services for residents in compliance with the regulations set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.8, 488.8, and 494.5, and Title 10 Part 1001.10, respectively.

AHs: Must provide three balanced, nutritious meals and a nutritious evening snack which are adequate in amount and content to meet the daily dietary needs of residents. The regulations list specific details as to how this must be carried out, including variety, posting of information and advanced planning of menus.

EHs: Must serve at least one hot midday or evening meal in a congregate setting every day. In addition, operators must assist residents to the extent necessary with meals taken without the full group, including shopping, preparation and clean-up.

ALPs: Must comply with the food service regulations of the AH or EH in which they are situated.

[42] Any adult care facility licensed as of July 15, 2010 that seeks licensure as an assisted living residence (but not as an enhanced/special needs ALR) must only be in compliance with the adult home or enriched housing program regulations, as applicable, as well as the building code standards under which its certificate of occupancy was issued.

[43] Applicants for a new Adult Care Facility seeking licensure as an assisted living residence (but not as an enhanced/special needs ALR) must be in compliance with the applicable adult home or enriched housing program regulations, as well as applicable New York State or New York City Building Codes, and any additional requirements imposed by their local code enforcement officer.

ALRs: Unless a residency agreement states otherwise, must provide food service in compliance with their underlying licensure as an AH or EH.

Admission/Retention Standards

Operators of AHs, EHs, ALPs and ALRs must adhere to resident admission and retention standards set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.4, 488.4, and 494.4, and Title 10 Part 1001.7, respectively.

AHs: Must not admit or retain individuals who: need continual medical or nursing care; have a serious mental disability; have behavioral symptoms which impair the well-being, care or safety of the resident or other residents, or which substantially interfere with the orderly operation of the facility; refuse prescribed treatment plans, which causes or is likely to cause life-threatening danger to the resident or others; suffer from a communicable disease or condition which is a danger to others; are chronically bedfast, chair fast, or otherwise require physical assistance to walk or climb/descend stairs; are chronically incontinent; are dependent on medical equipment (unless the equipment is not a safety hazard, it doesn't restrict the individual to his room or impede the activities of other residents, requires only occasional assistance from medical personnel, and medical evaluations show the individual can use and maintain the equipment).

EHs: In addition to adult home standards, EHs must not admit or retain individuals who: have chronic personal care needs that cannot be met by staff or approved community providers; require constant supervision or are not capable of making choices about activities of daily living.

ALPs: May admit only individuals who: are medically eligible for placement in residential health care facility (i.e., nursing home) (thus ALP residents will require more care for daily needs than an adult care facility provides to its non ALP resident) ; are able to take action sufficient to assure self-preservation in an emergency; and participate voluntarily. They must NOT accept or retain an individual who: requires continual nursing/medical care; is chronically bedfast or chair fast and requires lifting equipment or the assistance of two persons to transfer; or is impaired to a degree which endangers the safety of the individual or others.

ALRs: In addition to the preceding standards for AHs or EHs: may not admit individuals in need of 24 hour skilled nursing/medical care; if a resident eventually needs 24 hour skilled nursing/medical care, the resident must be discharged (unless the facility is certified as an EALR and: it is determined the resident can be safely cared for in the residence, the resident hires the appropriate staff, the operator agrees to retain the resident and coordinate care and the resident is otherwise eligible to remain). In addition, must develop an individualized service plan, in accordance with the medical, nutritional, rehabilitation, functional, cognitive and other needs of the resident, and such plan must be implemented within 30 days of admission. The plan must be developed with the resident, resident's representative(s), the assisted living operator, and an approved home care services agency or

equivalent staff (unless resident's physician determines home care services are not required), and must be reviewed and revised at least every six months or as frequently as necessary to reflect the changing needs of the resident.

EALR: May admit and retain persons who exceed the admission and retention standards of an ALR, if the EALR can provide or arrange an adequate and safe plan of care. This includes persons who: chronically require physical assistance to walk, climb/descend stairs, or transfer in and out of a chair; are dependent on medical equipment; or have chronic incontinence.

Personnel

Operators of AHs, EHs, ALPs and ALRs must be staffed in compliance with the personnel standards set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.9, 488.9, and 494.6, and Title 10 Part 1001.11, respectively.

AHs and EHs: Must provide a sufficient number of staff with the proper training and experience to provide the resident services mandated by statutes or regulations. The operator must appoint an administrator who will be responsible for operating and maintaining the facility in compliance with the applicable requirements. The regulations set out specific requirements for staff training, qualifications, screening and staffing levels of direct care staff, administrators, case management staff, activities directors, food staff and personal care staff.

ALPs: In addition to the requirements of AHs or EHs, ALPs must also assure that all staff performing personal care functions are trained in home health aide services or have successfully completed an equivalent exam approved by the Department of Health.

ALRs: Must provide staff sufficient in number and qualifications to perform the functions required for AHs and EHs. The regulations also set out a number of staffing requirements that deal specifically with the care of residents in an assisted living residence such as requiring an on-site case manager for a number of hours per week. In addition, resident aides must receive 40 hours of initial training and 12 hours of yearly on-going training.

EALRs and SNALRs: Must give aides training in first aid and medication assistance as specified by DOH.

Resident Rights

Operators of AHs, EHs, ALPs and ALRs must comply with standards for resident rights set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.5, 488.5, and 494.3, and Title 10 Part 1001.8, respectively.

AHs, EHs and ALPs: Must adopt a statement of resident rights and responsibilities, and treat residents in accord with the principles of the statement. Operators must encourage and assist with the

creation of resident organizations, execute a detailed admission agreement with each resident stating the services to be delivered and the costs, and maintain a system to receive and respond to grievances and recommendations for change submitted by residents. The regulations set out specific rights and responsibilities to be enjoyed by each resident such as: the right to terminate the admission agreement, right to 30 days notice if the operator chooses to terminate the agreement and discharge the resident, right to object to a termination to the Department of Health and the right to a subsequent court proceeding to determine whether the termination will stand. An operator may not terminate an admission agreement and involuntarily discharge a resident except under specific circumstances and when the basis for transferring or discharging a resident no longer exists and the resident is deemed appropriate for placement in the facility, the operator must readmit him.

ALRs: In addition to the standards for AHs, EHs, and ALPs, the residency agreement for ALRs must include disclosure on a number of other issues including: the criteria used to determine who may be admitted and may continue to reside in the residence and procedures in the event the resident (or resident's representative) is no longer able to pay for services provided in the agreement or for additional services/care needed by the resident. In addition, the operator must provide certain information to prospective residents prior to admission, and to any current resident if such information has not been previously disclosed to them, such as: the consumer information guide developed by the commissioner; a statement listing the residence's licensure (i.e., enhanced/special needs assisted living certification), availability of enhanced/special needs beds and the maximum number of enhanced/special needs beds the operator is approved to provide; the right of a resident to receive services from providers with whom the operator does not have an arrangement; a statement that residents have the right to choose their health care providers; a statement regarding the availability of public funds for payment of residential, supportive, or home health services; and the Department of Health's toll free number for reporting of complaints. The operator must use the Model Residency Agreement for ALRs developed by the Department of Health, or a Department-approved substitute.

EALRs and SNALs: In addition to the requirements above, EALRs and SNALRs must inform the residents, at least once a month by posting the information prominently, of the current vacancies, if any, under their enhanced/special needs assisted living certification(s).

Disaster and Emergency Planning

Operators of AHs, EHs and ALRs must comply with standards for disaster and emergency planning set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.12 and 488.12, and Title 10 Part 1001.14, respectively.

AHs: Must have a written plan, approved by the Department of Health, with detailed procedures for protecting patients and staff in case of a disaster or emergency. The regulations set out a list of specific information that must be included in the plan, such as: staff responsibilities, evacuation procedures including designation of staff to supervise, training for staff in evacuation procedures,

evacuation procedures for residents with need for individual procedures, and plans for relocation and maintenance of service. The operator must have monthly fire drills for staff and volunteers, in which residents take part at least once every calendar quarter, including at least one total evacuation per 12 months.

EHs: Similar to adult home standards, but must also provide: easy access to a telephone by all residents, with information posted at each telephone including the operator's emergency coverage number to call in case of a crisis, the address and telephone number of the unit, the name and telephone number of the physician and the nearest relative of each resident in the unit. The operator is not required to conduct fire drills in a building that does not allow them, but must provide individual training on fire and safety procedures for new residents.

ALPs: Must comply with the applicable AH or EH standards for the type of facility in which it is located.

ALRs: Must comply with the applicable AH or EH standards. In addition, emergency plans must coordinate the roles and responsibilities between assisted living residence employees and employees of each home care services agency that admitted a resident.

EALR: Must update written plan at least twice a year, and review plan with staff at least annually.

Resident Funds and Valuables

Operators of AHs, EHs and ALRs must comply with standards for resident funds and valuables set forth in Title 18 of the New York Codes, Rules and Regulations, Parts 487.6, 488.6, and Title 10 Part 1001.9, respectively.

AHs and EHs: Must issue receipts for: payments made for resident's base rate and other supplemental charges; deposits made to personal allowance accounts; and for any other funds held by the operator. Resident funds must not be commingled with the personal funds of the operator, the funds of the facility or the funds of other residents. At the time of admission and upon the first increase in the personal allowance in any calendar year, the operator must offer a Supplemental Security Income or Home Relief recipient an opportunity to place personal allowance funds in a facility-maintained account. In addition, they must provide safekeeping of personal allowance accounts, hold funds for the sole use of the resident, allow a minimum of four hours of access to personal allowance accounts from Monday through Friday, maintain a system of recordkeeping for all individual accounts, and provide each resident who has a personal allowance account with a statement at least each quarter showing all transactions. Operators may offer residents the opportunity to place property in the operator's custody, but must maintain inventory records, provide for security of all property held, keep the property separate from the operator's assets and maintain records of all transactions.

ALPs: Must comply with the applicable AH or EH standards.

ALRs: In addition to the requirements of an AH or EH, assisted living residence operators or employees who assume management responsibility over the funds of a resident must maintain such funds in a fiduciary capacity for the resident. Any interest earned on money held for a resident is the property of the individual resident.

Appendix D: Permitted Enforcement Actions Under State Law

The Department can take the following enforcement actions:

- determination, after a hearing, that civil penalties should be imposed;
- determination, after a hearing, to revoke, suspend or limit (i.e., limit the number of persons for which such facility is authorized to provide care; stop the admission of new residents after a specified date; or impose a limit on the type(s) of service to be provided) an operating certificate;
- issuance of a commissioner's order, or an order approved by a justice of the NYS Supreme Court, requiring an operator to immediately remedy conditions dangerous to residents; temporary suspension or limitation of an operating certificate for 60 days, without a hearing, upon finding that resident health, safety or welfare are in imminent danger;
- request the Attorney General to seek an injunction against an operator for violations or threatened violations of law or regulation;
- request the Attorney General to take such action as is necessary to collect civil penalties, seek criminal prosecution or to bring about compliance with any outstanding hearing determination or order;
- civil penalties of up to $1,000 per day may be assessed against adult care facilities for violation of standards of care after a hearing;[44]

No penalty can be imposed if, at the time of a hearing, the operator satisfactorily demonstrates that either the violations have been rectified within 30 days of receipt of the written report of inspection first citing the violation or an acceptable plan for rectification and monitoring to ensure that violations do not recur had been submitted to the Department within 30 days of receipt of such written report of inspection and the plan was being implemented in accordance with the procedures and time frames approved by the Department. However, even where correction of a violation has occurred, the Department may assess a penalty if it establishes at a hearing that the particular violation endangered or resulted in harm to a resident (unless the harm was caused "solely by an act of God, and the operator took immediate action to correct it").

[44] There is a schedule of penalties. Each regulation has a fine amount attached to it. For example, if a facility is cited for not posting a statement of rights in a conspicuous location in a public area of the facility, the facility could be fined $50 a day.

Appendix E: DOH Enforcements: 2002-2010

FACILITY	DATE OF SURVEYS/LIST OF CHARGES	FINE	OTHER ACTION	DATE OF STIP/HEARING
80th Residence	4/28/06; 6/28/07	$10,000		6/18/2008
80th Residence	8/23/04; 11/15/05	$5,000		12/21/2006
Abbey Island Park Manor	11/10/05; 7/31/06;4/3/07; 12/31/07; 9/5/08;1/22/09	$50,000		11/17/2009
Adirondack Manor - Scotia	11/10/05; 3/16/06; 5/22/06; 11/6/06	$8,000	1/2 first and 1/2 is suspended if in compliance - one year.	12/31/2007
Adirondack Manor - Scotia	9/14/07; 11/2/07; 4/23/08; 5/9/08; 8/6/08; 9/22/08; 10/31/08; 4/21/09; 8/26/09	$12,000	One year quarterly reports.	10/15/2009
Adirondack Manor - Ticond	4/17/07	$1,000	1/2 first and 1/2 is suspended if in compliance - one year.	12/31/2007
Adirondack Manor -Queensbury	12/15/04; 7/1/05; 11/9/05; 11/27/06; 7/12/07; 9/28/07	$4,500	1/2 first and 1/2 is suspended if in compliance - one year.	12/31/2007
Adirondack Manor-Peru	4/5/05; 1/26/06; 2/1/07; 11/13/07	$5,000	1/2 first and 1/2 is suspended if in compliance - one year.	12/31/2007
Adventist Home	1/26/04; 7/12/04	$1,685		4/25/2005
Alterra Clare Bridge - Ithaca	10/5/07	$2,000		4/16/2008
Alterra Clare Bridge - Niskayuna	5/15/07; 10/4/07; 4/3/08	$29,850		2/9/2009
Angel's Inn	12/17/04; 4/21/06	$3,000		10/13/2006
Anna Erika	2/13/04; 8/13/04	$1,800		4/6/2007
Atria - Briarcliff	7/19/05	$1,000		9/26/2006
Atria - South Setauket	10/14/04; 3/21/06; 10/31/06	$2,000	If w/in 12 mths, violations - add'l fine: $4,327.	11/19/2007
Atria- Crossgate	7/13/07; 12/26/07; 3/26/08; 7/22/08	$20,000		6/8/2009
Atria- Crossgate	12/18/02; 6/19/03; 11/9/04	$1,000		4/3/2006
Atria East - Northport	7/21/05	$1,000		9/26/2006
Atria-Great Neck	7/19/05; 1/4/06	$2,000		9/26/2006
Atria-Guilderland	6/26/07	$10,000		00/00/2007*
Atria-Huntington	10/15/04; 7/27/05	$5,000		9/26/2006
Atria-Shaker	12/15/03; 2/25/04	$800		3/25/2005
Atria-Shaker	2/3/05; 4/29/05; 7/27/05; 8/22/05; 12/16/05; 2/26/06	$21,000		9/26/2006
Atria-Shaker	9/15/06	$1,000		11/19/2007
Atria-Shaker	2/14/07; 7/17/07; 12/26/07; 3/26/08; 6/18/08; 6/30/08; 10/29/08	$20,000		8/19/2009
Atria-West Side	10/31/03	$20,000	$5,000 first; rest suspended if 3 years no violations; detailed list of needed environmental changes; must apply for licensure.	9/26/2006
Bassett Manor	5/22/06; 9/22/06; 1/24/07; 4/19/07	$2,930		2/21/2007
Beacon Pointe	11/21/08; 5/1/09; 9/14/09; 10/7/09	$8,000		1/14/2010

FACILITY	DATE OF SURVEYS/LIST OF CHARGES	FINE	OTHER ACTION	DATE OF STIP/HEARING
Birchwood	7/27/05; 5/11/06; 6/27/07	$5,000	License surrendered; no control over facility.	3/13/2008
Birchwood	9/17/08; 6/2/09	$88,000	1/2 w/in 60 days; 1/2 suspended if no problems w/in 3 years.	12/19/2010
Brentland Woods	6/14/04; 10/20/04	$2,625		2/22/2005
Brentland Woods	12/8/05; 4/14/06	$1,187.50	If w/in 12 mths, violations - additional fine: $500 unless mitigating circumstances.	10/10/2006
Brothers of Mercy	1/12/05; 5/19/05	$1,000		1/26/2006
Cedars Rest Home	8/4/04; 6/8/05; 12/15/05	$4,000		10/26/2006
Claddagh Care Enriched Housing Program #1	6/21/05; 11/29/06	$5,460		9/11/2007
Clare Bridge - Greece	5/19/00; 1/17/01; 4/18/01; 10/19/01; 1/29/02; 8/13/02; 11/15/02; 12/24/03; 3/24/04; 4/7/04; 7/23/04;	$12,000		3/21/2005
Clare Bridge - Niskayuna	6/28/05; 7/25/06; 4/23/07	$10,120		6/28/2007
Clare Bridge - Orchard Park	12/4/03; 4/9/04; 4/22/04	$11,000		3/21/2005
Clare Bridge - Perinton	11/18/03; 7/30/04; 9/18/06	$26,000		11/24/2006
Clare Bridge - Williamsville	9/26/02; 12/10/02;	for Perinton, Williamsville and Clinton		11/24/2006
Clarge Bridge Cottage at Clinton	5/31/01; 3/6/02; 12/23/02			11/24/2006
Cloisters - Warsaw	1/25/05	$1,000		6/6/2005
Cloverville	5/17/07	$1,000		10/23/2007
Colonie Manor	5/17/05; 6/14/05	$31,000		2/7/2006
Colonie Manor	6/15/06; 6/21/07; 12/7/07	$2,982		11/14/2008
Cook Adult Home	11/8/06; 2/26/07; 5/11/07; 10/22/07	$250	Another $250 fine if noncompliant.	2/00/2008*
Cook Adult Home	3/4/08	$1,000	Another $5,000 fine if noncompliant.	2/19/2009
Countryside Adult Home	2/6/04; 8/10/05	$5,000	Withheld from state reimbursement.	5/29/2007
Crimson Ridge	11/14/08	$2,000		4/28/2009
Crimson Ridge	10/11/05	$3,000		8/2/2006
Danforth Adult Care	7/1/05; 12/12/05	$2,700		00/00/2007*
Delmar Place	4/14/08; 8/26/08; 9/16/08; 3/4/09	$5,000		12/21/2010
Delmar Place	5/3/06	$1,000		8/7/2006
Elizabeth Brewster	1/29/07	$1,500		4/14/2008
Elsmore	1/28/04; 4/8/04	$1,200		4/16/2007
Emery	10/9/08	$500		7/8/2010
Evergreen Court	3/8/07	$3,500	Add'l $1,500 fine if violations w/in 12 mths.	12/31/2007
Evergreen Manor	4/12/11	$12,125	Submit annual financial reports.	2/22/2007
Family and Child Services - 10 Eyck	8/18/06; amended 10/11/06; 1/9/07; 7/9/07	$500	Add'l $1,000 fine if violations w/in 12 mths.	00/00/2007*
Family Services of Rochester EHP2 Jonathan Child Project	8/9/04	$10,000		1/3/2005
Family Services of Rochester EHP2 Jonathan Child Project	11/11/05; 3/22/06; 6/22/06	$1,930		2/28/2007

FACILITY	DATE OF SURVEYS/LIST OF CHARGES	FINE	OTHER ACTION	DATE OF STIP/HEARING
Fawn Ridge	3/30/05; 6/22/05; 5/1/06; 2/2/07; 3/28/07; 8/23/07; 12/7/07; 2/1/08; 2/5/08	$30,000		4/7/2008
Folts Adult Home	11/1/04; 2/2/06; 3/3/06	$5,000	Add'l 1,$000 fine if violations within 12 mths.	11/7/2006
Fountain View	8/10/05	$1,000		5/24/2006
Fredonia Place	11/21/08	$1,000		5/18/2009
Gables Home	12/3/08; 3/24/09	$100		8/16/2010
Golden Villa	11/19/04	$1,000		12/6/2006
Golden Years	10/14/05	$10,000	For operating an unlicensed home - cannot accept residents; $3,000 first; suspend if until in compliance.	11/21/2005
Grande Vie	6/25/04; 10/18/04	$1,000		6/29/2005
Grande Ville	11/12/03	$1,000		1/13/2005
Grande Ville	9/27/05	$4,500		6/23/2006
Green Hills	12/30/03; 6/10/04	$575	If same violations as 6/10/04 - more fines will be calculated from June 10.	4/26/2006
Green Meadows at Painted Post	3/10/06; 3/24/06; 7/17/06	$34,612		8/00/2007*
Greenpoint Special Needs	4/23/04; 5/3/05 7/20/05	$3,500		9/19/2006
Greenpoint Special Needs	10/23/07	$1,000		1/3/2007
Hampshire House	4/30/08; 8/7/08	$2,435		9/29/2008
Harbor Crossings of Clifton Park	11/7/03; 10/7/04; 12/23/04	$4,900		10/11/2005
Heartwood	9/25/08; 12/5/08; 12/29/08; 3/25/09; 5/29/09; 7/8/09; 9/30/09; 10/27/09; 12/2/09;	$1,000	If 2 bed bugs in a year, no new admissions until solved.	1/12/2010
Heartwood Terrace	5/14/04; 1/20/05	$1,045		8/18/2006
Heather Hgts	1/26/06; 5/26/06	$2,500		1/3/2008
Heather Hgts	2/17/06	$5,000		12/19/2006
Heather Hgts	7/1/05;10/25/05	$2,100		9/1/2006
Heritage Home for Women	8/19/05	$2,000		8/00/2007*
Heritage Manor	1/19/06; 5/26/06; 11/20/06; 5/23/07	$10,000	Monthly reports on compliance for 6 mths; then one after 9 mths; then after 12 mths; then 15 mths; then 18 mths.	7/8/2010
Hilton East Assisted Living	12/9/05	$1,000		4/19/2006
Home of Good Shepard at Highpt	2/7/06	$2,500		11/19/2007
Hudson Valley	5/27/08; 9/25/08; 4/21/09	$5,000		1/17/2010
Huntington Terrace	6/22/04; 6/6/05	$4,020		2/17/2006
Ingersoll Mem	8/30/06; 2/9/07	$1,150		8/21/2008
Jeffersonville	1/20/06; 11/14/06	$4,214		9/1/2007
Johnson's Adult Home AND Underwood	5/31/02;9/22/05	$2,000		00/00/2006*

FACILITY	DATE OF SURVEYS/LIST OF CHARGES	FINE	OTHER ACTION		DATE OF STIP/HEARING
Kelly's Home (Narrowsburg) H	5/12/04; 1/28/05; 3/30/05	$5,000			00/00/2005*
Kelly's Home (Narrowsburg) H	12/26/07	$2,500			4/18/2008
Kelly's Home (Narrowsburg) HEARING	11/30/05; 9/21/06	$2,500			4/14/2008
Kelly's Home (Narrowsburg) HEARING	3/4/09; 5/11/09;	$18,700			6/30/2010
Kirkside	5/7/04; 11/22/04; 4/13/05; 9/13/05	$4,850			1/4/2007
Landing at Queensbury	6/20/07; 2/14/08; 5/22/08	$9,550			5/18/2009
Landing at Queensbury	2/15/06	$6,000			8/1/2007
Landing at Queensbury	7/1/05	$5,000			4/1/2005
L'Dor	6/17/02; 1/8/03	$2,300			7/22/2005
Leroy Manor **HEARING**	4/9/09	$1,000		8/4/2009	8/4/2009
Lincoln Elms	5/9/07	$4,000			1/23/2007
Lockport Pres	3/6/07	$1,000			1/11/2010
Loretto Village Apts	12/15/05	$1,000			6/19/2007
Loyalton at Lakewood	4/19/06	$5,900			2/26/2008
Luthern Church Home of Buffalo	6/22/05; 10/24/05	$2,325			9/26/2006
Luthern Church Home of Buffalo	10/4/10	$3,000			12/20/2010
Manor Hills	1/20/06	$4,000			4/3/2006
Marjorie Doyle	2/22/06	$500			9/18/2006
Massry Residence	12/23/04; 4/27/05	$3,200			00/00/2005*
Massry Residence	10/5/05; 6/21/06; 11/08/06	$9,375			8/16/2007
Mater Dei	2/23/06; 6/27/06	$2,150			4/3/2007
Millview of Latham	11/16/05	$2,000			00/00/2006*
Montecello and Roscoe Manor	7/3/01; 6/18/02; 1/30/03; 8/12/03; 2/9/04; 5/8/04; 5/20/04; 7/29/04	$20,000	$10,000 suspended w/correction & compliance.		3/19/2007
Morgan Estates	1/7/05; 5/19/05	$2,160			8/18/2006
Moses Ludington	4/21/04; 10/18/04	$2,200			5/22/2006
Mountain View Manor	6/16/04; 8/30/04; 12/30/04; 3/16/05; 11/18/05; 4/27/06	$4,000			6/21/2006
New Brighton Manor	3/14/02; 9/16/02; 6/13/03	$2,000			2/22/2005
New Monsey Park Home	5/17/05; 7/28/05; 9/29/05; 4/26/06; 8/11/06; 3/30/07; 5/8/07; 7/20/07; 10/22/07; 2/28/08	$8,000			1/12/2009
North Brook Heights Home for Adults	9/30/08	$2,000			4/3/2009
Oceanview Manor	2/20/02; 8/2/02; 2/23/04; 5/26/04	$1,500			00/00/2005*
Orchard Heights	2/6/09	$1,000	$800 suspended.		5/8/2009
Park Terrace Adult Home	11/19/04; 9/20/06	$3,000			4/16/2007
Parkview Home for Adults - HEARING	1/25/05; 9/25/05	DOH Lost Hearing			5/14/2007

FACILITY	DATE OF SURVEYS/LIST OF CHARGES	FINE	OTHER ACTION	DATE OF STIP/HEARING
Perinton Park Manor	1/23/06	$1,000		1/17/2008
Pineview Commons Home for Adults	5/12/04; 4/28/05	$3,150		4/3/2007
Presbyterian Residential Community	10/11/07	$2,000		1/3/2008
Renaissance Plaza	all surveys thru May 09		Operating certificate suspended.	8/10/2009
Rodden Home	6/9/05; 11/23/05; 7/12/06	$3,764	$300 monthly payments: $250 goes to previous fine effective 3/14/05, $50 to principal of 1/30/07 stipulation.	1/30/2007
Rodden Home	9/12/00; 1/6/03; 5/3/04	$6,000		3/14/2005
Rosewood Terrace Home	2/18/05; 5/16/05; 8/11/05; 3/31/06; 9/7/06; 12/8/06; 3/13/07	$5,000		5/29/2007
S.S. Cosmas and Damian Adult Home	6/15/07	$4,650	Add'l $4,650 fine if not in compliance during any inspection within 12 mths.	9/17/2007
Sage Harbor at Baywinde	12/20/03; 5/27/04; 9/23/04	$12,000		1/13/2005
Sarah Jane Sanford Home	3/6/08; 6/20/08	$7,500		9/9/2009
Schuyler Guest Home	2/18/05; 6/14/05	$2,250		11/16/2005
Schuyler Guest Home	2/23/06	$1,000		4/16/2007
Seabury Woods	9/15/04; 1/14/05	$2,350		6/16/2005
Sedgewick Hts	10/22/2009	$1,000		1/21/2010
Shire at Culverton Adult Home	7/15/05	$1,000		12/29/2006
South Kortright Rest Home	5/10/05; 9/15/05; 9/30/05; 12/21/05; 6/21/06		Operating license revoked; administrator barred from applying for new license.	2/26/2008
St. Columban's on the Lake	2/16/07; 6/27/07	$500	add'l 500 if not in compliance w/in 12 mths.	4/14/2008
St. Elizabeth's Home	12/30/04	$1,000		08/00/07
Sterling Glen Bay Shore	4/13/05; 2/7/06; 10/31/06; 5/21/07	$15,850		5/5/2005
Summit Lodge of Moravia	5/3/06; 2/21/07	$40,000	Must obtain license, $37,500 of fine held in abeyance if they obtain license &/or transfer appropriate ppl.	1/3/2008
Summit of Brighton	6/21/06	$1,000		9/6/2006
Sweetflag Estates Enriched Housing Program	7/3/01; 11/8/01	$2,200		6/3/2003
Tennyson Court Senior Care Community	7/14/03; 11/21/03; 3/17/04	$6,000		2/10/2005
Tennyson Court Senior Care Community	3/17/04; 6/16/04; 10/25/04; 2/3/05; 5/13/05; 9/22/05	$25,000	Add'l $5,000 if not in compliance w/in 12 mths.	8/18/2006
Terrace at Beverwyck	1/24/07	$3,000		5/29/2007
The Bristal at North Hills	8/29/2005	$10,000	Apply for licensure; plan for evacuation; $2,000 first; suspend rest if in compliance.	1/13/2006
The Falls Home for Adults	2/6/06; 6/14/06	$2,425		8/1/2007

FACILITY	DATE OF SURVEYS/LIST OF CHARGES	FINE	OTHER ACTION	DATE OF STIP/HEARING
The Pearl	1/27/05	$12,500	$10,000 suspended for 2 years; until 8/1/07 corp & pres & bd chair may not be operator of any facility; temporary manager appointed.	4/1/2005
Updyke's Willow Ridge Quality Care Facility	7/19/06	$8,000		11/1/2006
Welcome Home for Adults	1/9/06; 7/25/06; 1/31/07; 5/3/07; 11/23/07; 3/19/08	$5,000		9/29/2008
West Side Manor	5/21/04; 9/23/04; 4/27/05; 8/15/05; 3/3/05; 7/25/06	$63,350		8/1/2007
White House Home for Adults	1/7/05	$500		1/4/2006
Wiltshire House	8/26/04; 12/20/04	$1,000		6/29/2005
Woodcrest Home	12/14/06	$2,000	Plan of closure.	6/19/2007

*00 means the actual date was illegible.

Appendix F: Enforcement of Endangerments: 2006-2011

Facility	Date of Endangerment	Endangerment Type	Date of Enforcement Action	Amount of Fine	Other Action
Abbey Island Park Manor	4/2/07; 8/1/06	environmental standard, resident services	11/17/09	$50,000	
Adirondack Manor - Queensbury	11/27/06	resident services	12/31/07	$4,500	
Adirondack Manor - Ticonderoga	4/17/07	supervision	12/31/07	$1,000	
Adirondack Manor - Peru	1/26/06	resident services	12/31/07	$5,000	
Atria Briarcliff	4/8/10	supervision	NO REFERRAL FROM PROGRAM**		
Atria-Guilderland	6/26/07	environmental standards	00/00/07*	$10,000	
Atria-Shaker	3/26/08	supervision	8/19/09	$2,000	
Atria-Shaker	9/1/06	resident services	9/26/06	$21,000	
Altria-Shaker	9/15/06	resident services	11/19/07	$1,000	
Atria-South Setauket	10/31/06	maintenance	11/19/07	$2,000	Additional fine of $4,327 if not compliant for 12 months.
Basset Manor	2/26/10	supervision	PENDING***		
Bayview Manor	3/7/08	supervision	WITHDRAWN****		
Bayview Manor	10/19/07	supervision	WITHDRAWN		
Beacon Pointe Memory Care	6/18/08	supervision	1/14/10	$8,000	
Belle Harbor Manor	3/9/07	resident services	PENDING		
Bellevue Manor	1/25/06	resident services	PENDING		
Birchwood Rest	6/3/09	environmental standards	12/19/10	$88,000	1/2 suspended if no problems within 3 years. License surrendered.
Birchwood Rest	5/7/07; 6/27/07	supervision	3/13/08	$5,000	
Bronxwood	12/1/10	supervision	PENDING		
Bronxwood	4/9/10	resident services	PENDING		
Cambridge Guest Home	6/27/08	supervision	FACILITY CLOSED	RECEIVER	
Cambridge Guest Home	4/14/08	supervision	FACILITY CLOSED		
Camillus Ridge Terrace	1/29/10	supervision	NO REFERRAL FROM PROGRAM		

Facility	Date of Endangerment	Endangerment Type	Date of Enforcement Action	Amount of Fine	Other Action
Cedars Rest Home for Adults	1/29/07; 3/30/07	resident services	WITHDRAWN		
Claddagh Care	11/29/06	resident services	9/11/07	$5,460	
Clare Bridge Cottage of Ithaca	10/5/07	supervision	4/16/08	$2,000	
Clare Bridge of Niksayuna	4/23/07; 5/15/07	supervision	6/28/07	$10,120	
Clare Bridge of Perinton	9/18/06	resident services	11/24/06	$26,000 (for three Clare Bridges)	
Cloverhill Adult Home	4/9/07	supervision	10/23/07	$1,000	
Countryside Adult Home	2/22/06	resident services		Will hold $5,000 from appropriation	
Crestview Manor	10/26/06	resident services	WITHDRAWN		
Crimson Ridge Gardens	11/14/08	supervision	4/28/09	$2,000	
Delmar Place	3/4/09	supervision	12/21/10	$5,000	
Delmar Place	5/3/06	resident services	8/7/06	$1,000	
Duchess Adult Residence	11/9/07	resident rights	WAITING FOR HEARING DECISION		
East Side Manor	5/5/10	admission + retention	PENDING		
Elijah House of Leicester	6/1/09	supervision	FACILITY CLOSED		
Elizabeth Brewster House	1/29/07	resident services	4/14/08	$1,500	
Evergreen Court	5/16/07; 5/25/07	supervision	FACILITY CLOSED	$12,125	
Evergreen Court	3/8/07	resident services	*12/31/07*	$3,500	Additional $1,500 if not compliant for 12 months.
Fairlawn Adult Home	3/5/08	supervision	WITHDRAWN		
Fawn Ridge Assisted Living	2/2/07; 3/28/07	resident services, food service	4/7/08	$30,000	
Folts Claxton	3/3/06	resident services	11/7/06	$5,000	
Fountains at River Vue	4/7/10	resident services	PENDING		
Fredonia Place	11/21/08	supervision	5/18/09	$1,000	
Glen at Maple Pointe	8/3/09	supervision	PENDING		
Great Adult Neighbors	5/20/09	resident rights	NO REFERRAL FROM PROGRAM		
Green Meadows	3/10/06; 10/23/07	administration, resident services	8/00/07	$36,612	
Greenpoint Special Needs	10/23/07	supervision	1/3/07	$1,000	

Facility	Date of Endangerment	Endangerment Type	Date of Enforcement Action	Amount of Fine	Other Action
Hampshire House	4/30/08	environmental standards	9/29/08	$2,435	
Hawthorne Ridge	9/14/10	resident services, supervision	PENDING		
Heartland on the Bay	3/12/08	supervision	FACILITY CLOSED		
Heartland on the Bay	3/1/07	disaster and emergency planning	FACILITY CLOSED		
Heather Heights of Pittsford	2/17/06	resident services	12/19/06	$5,000	
Heritage Manor of Le Roy	4/17/08	supervision	8/14/09	$1,000	
Hilton East Assisted Living	3/6/09	supervision	PENDING		
Hilton East Assisted Living	1/4/06	resident services	4/19/06	$1,000	
Ideal Senior Living	7/7/10	resident services, supervision	PENDING		
Johnson's Adult Home	2/26/09	environmental standards			PUT ON DO NOT REFER LIST*****
Johnson's Adult Home	3/25/09	supervision	SEEKING REVOCATION		
Keepsake Village	9/7/10	personnel , supervision	NO REFERRAL FROM PROGRAM		
Kelly's Home for Adults	11/24/10	resident rights	3/1/11	$18,700	
Kelly's Home for Adults	11/24/10	resident rights	OPERATOR TERMINATED		
Landing of Queensbury	2/15/06	resident services	5/18/09	$6,000	
Lincoln Elms II	5/28/08	supervision	FACILITY CLOSED		
Lockport Presbyterian	3/6/07	resident services	1/11/10	$1,000	
Loyalton at Lakewood	4/19/06	resident services	2/26/08	$5,900	
Lutheran Church Home of Buffalo	10/4/10	supervision	12/20/10	$3,000	
Manor Hills	1/20/06	environmental standards	4/3/06	$4,000	
Marjorie Doyle Rockaway	2/22/06	resident services	9/18/06	$500	
Mary McClellan Guest Home	5/11/07	supervision	FACILITY CLOSED ON COMMISSIONER ORDER		
Mary McClellan Guest Home	3/1/07	resident services	FACILITY CLOSED		
Mary McClellan Guest Home	10/24/06	resident services	FACILITY CLOSED		
McClelland Home for Adults	10/14/08	supervision	NO REFFERAL FROM PROGRAM		
North Brook Heights Home for Adults	9/30/08	supervision	1/12/09	$2,000	
Northfield	11/3/10	supervision	3/11/11	$3,000	
NY Foundation Senior Citizens #2 Brown Gardens	2/18/09	supervision	PENDING		

Facility	Date of Endangerment	Endangerment Type	Date of Enforcement Action	Amount of Fine	Other Action
Orchard Heights	2/6/09	supervision	00/00/05	$1,000	
Park Hill Adult Home	4/7/10	administration	3/7/11	$25,000	
Park Hill Adult Home	5/27/10	administration, supervision	SURRENDER OF OPERATING CERTIFICATE		
Park Hill Adult Home	5/28/10	resident services	SEE ABOVE		
Park Manor Adult Home	4/23/07	supervision	WITHDRAWN		
Park Terrace Adult Home	9/20/06	environmental standards	5/8/09	$3,000	
Perinton Park Manor	1/23/06	resident services	4/3/07	$1,000	
Pine Harbor	11/18/08	supervision	1/21/10	$1,000	
Presbyterian Residential Community	10/11/07	supervision	1/17/08	$2,000	
Regency of Boro Park	10/21/08	admission + retention	WITHDRAWN		
Regency of Boro Park	3/10/08	admission + retention	PENDING		
Regency of Boro Park	4/27/06	resident services	PENDING		
Renaissance Plaza	4/1/09	administration	SUSPENSION OF OPERATING CERTIFICATE		
	10/27/08	case management			
	9/4/08	case management			
	7/7/06	environmental standards			
Rockaway Manor HFA	10/12/10	supervision	NO REFERRAL FROM PROGRAM		
Rosewood Senior Citizens	4/6/07	supervision			PUT ON DO NOT REFER LIST.
Rosewood Terrace Home	12/8/06	maintenance	SURRENDER OF OPERATING CERTIFICATE		
Rosewood Terrace Home	9/7/06	environmental standards			
S.S. Comas and Damien	6/15/07	supervision	9/9/09	$4,650	Inspection within 12 months.
Sage Harbor	12/6/10	supervision	3/11/11	$1,000	
Schuyler Guest Home	6/9/09	administration	RECEIVER		
Schuyler Guest Home	6/19/08	supervision			
Schuyler Guest Home	10/18/07	supervision	CLOSED		
Schuyler Guest Home	2/23/06	resident services	4/19/07	$1,000	
Seabury Woods	5/1/09	supervision	PENDING		
Somerset Gardens	5/8/07; 6/15/07	supervision	NO REFERRAL FROM PROGRAM		
South Kortright Rest Home	6/21/06	resident services	9/6/06		Revocation of operating

Facility	Date of Endangerment	Endangerment Type	Date of Enforcement Action	Amount of Fine	Other Action
Southside Home for Adults	7/17/06	resident services	FACILITY CLOSED ON COMMISSIONER ORDER		cert.
Summit Wolk Manor	6/21/06	resident services	9/6/06	$1,000	
Surf Manor	10/23/08	personnel	PENDING		
Surf Manor	5/13/08	resident rights	PENDING		
Surf Manor	8/25/06	resident services	PENDING		
Tappan Zee Manor	5/4/07	environmental standards	NO REFERRAL FROM PROGRAM		
Terrace at Beverwyck	1/5/07; 2/12/07	resident services, resident services	5/29/07	$3,000	
The Eliot at Erie Station	9/29/09	medication management	7/6/10	$10,000	
The Pavillion Senior Residence	6/27/08	supervision	PENDING		
Underwood Manor	3/25/10	supervision	8/2/10	$1,000	
Updyke's Willow Ridge	7/19/06	resident services	11/1/06	$8,000	
Walden Place	10/2/09	supervision	NO REFERRAL FROM PROGRAM		
Welcome Home for Adults	11/3/10	supervision	PENDING		
Welcome Home for Adults	7/25/06; 1/9/06	resident services, resident services	11/1/06	$5,000	
West Side Manor	10/31/06; 3/3/06	resident services, resident services	9/29/08	$63,350	
Wiltshire House	6/13/06	resident services	FACILITY CLOSED		
Woodcrest Home	12/14/06	resident services, personnel	6/19/07	$2,000	

* Only the year was given.

** Regional office staff did not send a referral for legal action to Central Office.

***Pending includes: just referred to legal; legal working on preparation for hearing; legal has agreement to settle.

****Withdrawn: decision that this is not endangerment by informal internal appeal or by legal.

*****This list is a list of places that individuals should not be sent to.

*****State law requires the suspension of referrals to these facilities.

Appendix G: Ombudsmen On-Line Survey

ASSISTED LIVING 2010/OMBUDSMEN

1. Introduction

The Long Term Care Community Coalition (LTCCC) is gathering information on the status of care in our state's adult homes, enriched housing, assisted living programs (ALPs) and assisted living residences (ALRs). The information you give will be added to the data we are collecting from consumer groups and violations and findings of the Department of Health in surveys it has conducted from 2002 to the present. Your information is invaluable to the project. All the information will be confidential. Thank you for participating.

2. Background Information

We need to know a little about you and your experiences with assisted living facilties. Please answer the following questions

*** 1. Check the county (or counties) you cover.**

- [ ] Albany
- [ ] Allegany
- [ ] Broome
- [ ] Cattaraugus
- [ ] Cayuga
- [ ] Chautauqua
- [ ] Chemung
- [ ] Chenango
- [ ] Clinton
- [ ] Columbia
- [ ] Cortland
- [ ] Delaware
- [ ] Dutchess
- [ ] Erie
- [ ] Essex
- [ ] Franklin
- [ ] Fulton
- [ ] Genesee
- [ ] Greene
- [ ] Hamilton
- [ ] Herkimer
- [ ]

ASSISTED LIVING 2010/OMBUDSMEN

- [ ] Jefferson
- [ ] Lewis
- [ ] Livingston
- [ ] Madison
- [ ] Monroe
- [ ] Montgomery
- [ ] Nassau
- [ ] New York City
- [ ] Niagara
- [ ] Oneida
- [ ] Onondaga
- [ ] Ontario
- [ ] Orange
- [ ] Orleans
- [ ] Oswego
- [ ] Otsego
- [ ] Putnam
- [ ] Rensselaer
- [ ] Rockland
- [ ] St. Lawrence
- [ ] Saratoga
- [ ] Schenectady
- [ ] Schoharie
- [ ] Schuyler
- [ ] Seneca
- [ ] Steuben
- [ ] Suffolk
- [ ] Sullivan
- [ ] Tioga
- [ ] Thompkins

ASSISTED LIVING 2010/OMBUDSMEN

- [ ] Ulster
- [ ] Warren
- [ ] Washington
- [ ] Wayne
- [ ] Westchester
- [ ] Wyoming
- [ ] Yates

3. Quality Issues in Assisted Living

The first part of the survey will ask your opinions about quality issues in adult homes, enriched housing and assisted living residences. We are using the categories taken from the regulations that assisted living facilities must comply with and DOH uses to survey these facilities. Please note that these categories differ from the ombudsmen complaint categories. Please read the definition of each category carefully as you respond to each question. Some of the complaints you have received will fall into differently named categories. Thank you. Remember, all responses are confidential.

1. Using the following survey categories, please tell us, in your, or your volunteers' experience, where have you found the MOST problems? Check the box in the area where you have found the most problems.

◯ Food service - The provision of balanced, nutritious meals and a nutritious evening snack which are adequate in amount and content to meet the daily dietary needs of residents. This includes all dietary issues.

◯ Resident services - The provision of room, board, housekeeping, supervision/monitoring, personal care, medication management, case management, social services, home health (ALPs and ALRs with enhanced or special needs certificates) and activities.

◯ Admission/Retention standards - Rules governing who facilities can admit and retain and rules governing assessment of residents before admission. This does not include rights of residents. Discharge rights are below in resident protections.

◯ Environmental standards - The provision of a safe and comfortable environment for residents. This encompasses specific provisions for smoke and fire protection, safety procedures for toilet and bathing areas, furnishings and equipment, housekeeping, and building maintenance.

◯ Personnel - Provision of sufficient number of staff with the proper training and experience to provide the resident services mandated by statutes or regulations. This includes supervision issues, qualifications of administrator.

◯ Resident Rights - Adoption of a statement of resident rights and responsibilities; right to make complaints and have complaints responded to; admission agreements; right to form and be assisted with resident organizations; disclosure of rates and services; abuse; access to information; admission and discharge rights; autonomy and choice; resident/family councils; grievance procedures; and use of restraints.

◯ Disaster and Emergency Planning - Requirement of a written plan, approved by the Department of Health, with detailed procedures for protecting patients and staff in case of a disaster or emergency.

◯ Resident Funds/Valuables - Requirements of resident accounts, personal allowances; financial exploitation; billing charges; and personal property lost.

ASSISTED LIVING 2010/OMBUDSMEN

2. What types of problems have you found in this area? Please type in as much detail as you can.

*** 3. Using the following survey categories, please tell us, In your, or your volunteers' experience, where have you found the the SECOND most problems? Check the box in the area where you have found the SECOND most problems. All responses are confidential in the survey.**

◯ Food service - The provision of balanced, nutritious meals and a nutritious evening snack which are adequate in amount and content to meet the daily dietary needs of residents. This includes all dietary issues.

◯ Resident services - The provision of room, board, housekeeping, supervision/monitoring, personal care, medication management, case management, social services, home health (ALPs and ALRs with enhanced or special needs certificates) and activities.

◯ Admission/Retention standards - Rules governing who facilities can admit and retain and rules governing assessment of residents before admission. This does not include rights of residents. Discharge rights are below in resident protections.

◯ Environmental standards - The provision of a safe and comfortable environment for residents. This encompasses specific provisions for smoke and fire protection, safety procedures for toilet and bathing areas, furnishings and equipment, housekeeping, and building maintenance

◯ Personnel - Provision of sufficient number of staff with the proper training and experience to provide the resident services mandated by statutes or regulations. This includes supervision issues, qualifications of administrator.

◯ Resident Rights - Adoption of a statement of resident rights and responsibilities; right to make complaints and have complaints responded to; admission agreements; right to form and be assisted with resident organizations; disclosure of rates and services; abuse; access to information; admission and discharge rights; autonomy and choice; resident/family councils; grievance procedures; and use of restraints.

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◯ Resident Funds/Valuables - Requirements of resident accounts, personal allowances; financial exploitation; billing charges; and personal property lost.

4. What types of problems have you found in this area? Please type in as much detail as you can.

4. Department of Health Oversight

We now would like to know your opinion on DOH oversight and monitoring of adult homes, enriched housing and assisted living facilities.

ASSISTED LIVING 2010/OMBUDSMEN

*1. How effective do you believe DOH is at monitoring care and quality of life at these facilities?

- ◯ Extremely effective
- ◯ Effective
- ◯ Somewhat effective
- ◯ Rarely effective
- ◯ Not effective

*2. Have you ever referred a complaint or observation to DOH?

- ◯ YES
- ◯ NO

5.

*1. Has the DOH been responsive to you?

- ◯ YES
- ◯ NO

*2. In general, have the resulting actions taken by DOH been satifying to you?

- ◯ YES
- ◯ NO

3. Please explain why it has been satisfying or unsatisfying to you.

6. Rules and Regulations Facilities Must Comply With

We would like to ask you your opinions on the laws and regulations that facilities must comply with and how you might like to see them changed.

ASSISTED LIVING 2010/OMBUDSMEN

1. Which, if any, of the following areas would you like to see strengthened or weakened?

	Strengthen	Weaken	Do not need to be changed	Do not know
Food service - The provision of balanced, nutritious meals and a nutritious evening snack which are adequate in amount and content to meet the daily dietary needs of residents. This includes all dietary issues.	◯	◯	◯	◯
Resident services - The provision of room, board, housekeeping, supervision/monitoring, personal care, medication management, case management, social services, home health (ALPs and ALRs with enhanced or special needs certificates) and activities.	◯	◯	◯	◯
Admission/Retention standards - Rules governing who facilities can admit and retain and rules governing assessment of residents before admission. This does not include rights of residents in the facility or discharge rights.	◯	◯	◯	◯
Environmental standards - The provision of a safe and comfortable environment for residents. This encompasses specific provisions for smoke and fire protection, safety procedures for toilet and bathing areas, furnishings and equipment, housekeeping, and building maintenance.	◯	◯	◯	◯
Personnel - Provision of sufficient number of staff with the proper training and experience to provide the resident services mandated by statutes or regulations. This includes supervision issues, qualifications of administrator.	◯	◯	◯	◯
Resident Rights - Adoption of a statement of resident rights and responsibilities;	◯	◯	◯	◯

right to make complaints and have complaints responded to; admission agreements; right to form and be assisted with resident organizations; disclosure of rates and services; abuse; access to information; admission and discharge rights; autonomy and choice; resident/family councils; grievance procedures; and use of restraints.				
Disaster and Emergency Planning - Requirement of a written plan, approved by the Department of Health, with detailed procedures for protecting patients and staff in case of a disaster or emergency.	◯	◯	◯	◯
Resident Funds/Valuables - Requirements of resident accounts, personal allowances; financial exploitation; billing charges; and personal property lost.	◯	◯	◯	◯

2. If you would like change, how would you like to see things changed? Please give as much detail as possible.

7. Authority of DOH to Monitor Care and Quality of Life

Finally, we would like to ask your opinion about the rules and regulations giving DOH authority to survey and enforce standards. Following are summaries of three principal areas of DOH authority. Please review and, below, check if you think they need to be strengthened or weakened.

ASSISTED LIVING 2010/OMBUDSMEN

1. Survey and Inspections:

DOH is required to conduct at least one full unannounced inspection of each adult home annually, except that facilities in substantial compliance can be inspected once every 18 months, surveying the medical, dietary and social services records of the facility, as well as the minimum standards of construction, life safety standards, quality and adequacy of care, rights of residents, payments and all other areas of operation. An additional inspection (which may be partial) must be conducted each year in the private proprietary homes. In addition, the Department must conduct complaint, follow up and any other inspections where needed.

Enforcing the Rules:

In addition, to assure that adult care facilities are established and operated in compliance with all applicable provisions of law and regulation, the Department may take the following enforcement action: after a hearing, civil penalties, revocation, suspension or limitation of operating certificate, stop the admission of new residents after a specified date; or a limit on the type(s) of service to be provided; require an operator to immediately remedy conditions dangerous to residents; temporary suspension or limitation of an operating certificate for 60 days, without a hearing, upon finding that resident health, safety or welfare are in imminent danger; request to the Attorney General to seek an injunction against an operator for violations or threatened violations of law or regulation; or request to the Attorney General to take such action as is necessary to collect civil penalties, seek criminal prosecution, or to bring about compliance with any outstanding hearing determination or order.

Civil penalties:

Fines of up to $1,000 per day may be assessed against adult care facilities for violation of standards of care after a hearing. No penalty can be imposed if at the time of a hearing, the operator satisfactorily demonstrates that either (i) the violations have been rectified within 30 days of receipt of the written report of inspection first citing the violation, or (ii) an acceptable plan for rectification and monitoring to ensure that violations do not recur had been submitted to the department within 30 days of receipt of such written report of inspection and the plan was being implemented in accordance with the procedures and time frames approved by the department. However, even where correction of a violation has occurred, the department may assess a penalty if it

establishes at a hearing that the particular violation endangered or resulted in harm to a resident (unless the harm was caused "solely by an act of God, and the operator took immediate action to correct it").

Do you think these requirements need to be strengthened or weakened?

	Strengthen	Weaken	No change necessary	Do not know
Survey rules	◯	◯	◯	◯
Enforcement options	◯	◯	◯	◯
Civil penalty rules	◯	◯	◯	◯

2. Please explain, in detail your answer above. If you would like to see a change, how would you like to see things changed?

8. Ending

Thank you for participating in this survey.

1. If you would like the results of this survey sent to you, please fill out the following information. All of this information will be kept confidential.

Name:
Company:
Address:
Address 2:
City/Town:
State:
ZIP:
Country:
Email Address:
Phone Number:

Appendix H: Consumer On-Line Survey

ASSISTED LIVING 2010/CONSUMERS

1. Introduction

The Long Term Care Community Coalition (LTCCC) is gathering information on the status of care in our state's adult homes, enriched housing, assisted living programs (ALPs) and assisted living residences (ALRs). The information you give will be added to the data we are collecting from ombudsmen and violations and findings of the Department of Health in surveys it has conducted from 2002 to the present. Your information is invaluable to the project. All the information will be confidential. Thank you for participating.

2. Background Information

We need to know a little about you and your experiences with assisted living facilties. Please answer the following questions

*** 1. Please check all the facilities you have experience with.**

- ☐ adult homes - impacted (25% or more of the residents have a diagnosis of mental illness).
- ☐ adult homes - not impacted
- ☐ enriched housing
- ☐ adult homes/enriched housing with ALP beds (Medicaid Assisted Living Program beds)
- ☐ assisted living residences (ALRs)
- ☐ do not know designation

*** 2. Please check the box that best describes you.**

- ◯ A resident of an adult home, enriched housing or assisted living residence
- ◯ An advocate for residents of an adult home, enriched housing or assisted living residence

3. Quality Issues in Assisted Living

The first part of the survey will ask your opinions about quality issues in adult homes, enriched housing and assisted living residences. We will use categories taken from the regulations that assisted living facilities must comply with and DOH uses to survey these facilities. Remember that all responses are confidential.

ASSISTED LIVING 2010/CONSUMERS

*** 1. Using the following survey categories, please tell us, In your experience, where have you found the most problems? Check the box in the area where you have found the MOST problems.**

◯ Food service - The provision of balanced, nutritious meals and a nutritious evening snack which are adequate in amount and content to meet the daily dietary needs of residents. This includes all dietary issues.

◯ Resident services - The provision of room, board, housekeeping, supervision/monitoring, personal care, medication management, case management, social services, home health (in adult homes with ALP beds and in ALRs with enhanced or special needs certification) and activities.

◯ Admission/Retention standards - Rules governing who facilities can admit and retain and rules governing assessment of residents before admission. This does not include rights of residents. Discharge rights are below in resident protections.

◯ Environmental standards - The provision of a safe and comfortable environment for residents. This encompasses specific provisions for smoke and fire protection, safety procedures for toilet and bathing areas, furnishings and equipment, housekeeping, and building maintenance.

◯ Personnel - Provision of sufficient number of staff with the proper training and experience to provide the resident services mandated by statutes or regulations. This includes supervision issues, qualifications of administrator.

◯ Resident Rights - Adoption of a statement of resident rights and responsibilities; right to make complaints and have complaints responded to; admission agreements; right to form and be assisted with resident organizations; disclosure of rates and services; abuse; access to information; admission and discharge rights; autonomy and choice; resident/family councils; grievance procedures; and use of restraints.

◯ Disaster and Emergency Planning - Requirement of a written plan, approved by the Department of Health, with detailed procedures for protecting patients and staff in case of a disaster or emergency.

◯ Resident Funds/Valuables - Requirements of resident accounts, personal allowances; financial exploitation; billing charges; and personal property

2. What types of problems have you found in this area? Please type in as much detail as you can.

ASSISTED LIVING 2010/CONSUMERS

*** 3. Using the following survey categories, please tell us, In your experience, where have you found the the SECOND most problems? Check the box in the area where you have found the SECOND most problems.**

◯ Food service - The provision of balanced, nutritious meals and a nutritious evening snack which are adequate in amount and content to meet the daily dietary needs of residents. This includes all dietary issues.

◯ Resident services - The provision of room, board, housekeeping, supervision/monitoring, personal care, medication management, case management, social services, home health (ALPs and ALRs with enhanced or special needs certificates) and activities.

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◯ Resident Rights - Adoption of a statement of resident rights and responsibilities; right to make complaints and have complaints responded to; admission agreements; right to form and be assisted with resident organizations; disclosure of rates and services; abuse; access to information; admission and discharge rights; autonomy and choice; resident/family councils; grievance procedures; and use of restraints.

◯ Disaster and Emergency Planning - Requirement of a written plan, approved by the Department of Health, with detailed procedures for protecting patients and staff in case of a disaster or emergency.

◯ Resident Funds/Valuables - Requirements of resident accounts, personal allowances; financial exploitation; billing charges; and personal property

4. What types of problems have you found in this area? Please type in as much detail as you can.

4. Department of Health Oversight

We now would like to know your opinion on NY State Department of Health (DOH) oversight and monitoring of adult homes, enriched housing and assisted living facilities.

ASSISTED LIVING 2010/CONSUMERS

*1. How effective do you believe DOH is at monitoring care and quality of life at these facilities?

- ◯ Extremely effective
- ◯ Effective
- ◯ Somewhat effective
- ◯ Rarely effective
- ◯ Not effective

*2. Have you ever referred a complaint or observation to DOH?

- ◯ YES
- ◯ NO

5.

*1. Has the DOH been responsive to you?

- ◯ YES
- ◯ NO

*2. In general, have the resulting actions taken by DOH been satisfying to you?

- ◯ YES
- ◯ NO

3. Please explain why it has been satisfying or unsatisfying to you.

6. Rules and Regulations Facilities Must Comply With

We would like to ask you your opinions on the laws and regulations that facilities must comply with and how you might like to see them changed.

ASSISTED LIVING 2010/CONSUMERS

1. Which, if any, of the following areas would you like to see strengthened,weakened or remain the same?

	Strengthen	Weaken	No need to change	Do not know
Food service - The provision of balanced, nutritious meals and a nutritious evening snack which are adequate in amount and content to meet the daily dietary needs of residents. This includes all dietary issues.	◯	◯	◯	◯
Resident services - The provision of room, board, housekeeping, supervision/monitoring, personal care, medication management, case management, social services, home health (in adult homes with ALP beds and in ALRs with enhanced or special needs certification) and activities.	◯	◯	◯	◯
Admission/Retention standards - Rules governing who facilities can admit and retain and rules governing assessment of residents before admission. This does not include rights of residents. Discharge rights are below in resident protections.	◯	◯	◯	◯
Environmental standards - The provision of a safe and comfortable environment for residents. This encompasses specific provisions for smoke and fire protection, safety procedures for toilet and bathing areas, furnishings and equipment, housekeeping, and building maintenance.	◯	◯	◯	◯
Personnel - Provision of sufficient number of staff with the proper training and experience to provide the resident services mandated by statutes or regulations. This includes supervision issues, qualifications of	◯	◯	◯	◯

administrator.				
Resident Rights - Adoption of a statement of resident rights and responsibilities; right to make complaints and have complaints responded to; admission agreements; right to form and be assisted with resident organizations; disclosure of rates and services; abuse; access to information; admission and discharge rights; autonomy and choice; resident/family councils; grievance procedures; and use of restraints.	◯	◯	◯	◯
Disaster and Emergency Planning - Requirement of a written plan, approved by the Department of Health, with detailed procedures for protecting patients and staff in case of a disaster or emergency.	◯	◯	◯	◯
Resident Funds/Valuables - Requirements of resident accounts, personal allowances; financial exploitation; billing charges; and personal property	◯	◯	◯	◯

2. If you did want to change the rules, how would you like to see things changed? Please give as much detail as possible.

7. Authority of DOH to Monitor Care and Quality of Life

Finally, we would like to ask your opinion about the rules and regulations giving DOH authority to survey and enforce standards. Following are summaries of three principal areas of DOH authority. Please review and, below, check if you think they need to be strengthened or weakened.

ASSISTED LIVING 2010/CONSUMERS

1. Survey and Inspections:

DOH is required to conduct at least one full unannounced inspection of each adult home annually, except that facilities in substantial compliance can be inspected once every 18 months, surveying the medical, dietary and social services records of the facility, as well as the minimum standards of construction, life safety standards, quality and adequacy of care, rights of residents, payments and all other areas of operation. An additional inspection (which may be partial) must be conducted each year in the private proprietary homes. In addition, the Department must conduct complaint, follow up and any other inspections where needed.

Enforcing the Rules:

In addition, to assure that adult care facilities are established and operated in compliance with all applicable provisions of law and regulation, the Department may take the following enforcement action: after a hearing, civil penalties, revocation, suspension or limitation of operating certificate, stop the admission of new residents after a specified date; or a limit on the type(s) of service to be provided; require an operator to immediately remedy conditions dangerous to residents; temporary suspension or limitation of an operating certificate for 60 days, without a hearing, upon finding that resident health, safety or welfare are in imminent danger; request to the Attorney General to seek an injunction against an operator for violations or threatened violations of law or regulation; or request to the Attorney General to take such action as is necessary to collect civil penalties, seek criminal prosecution, or to bring about compliance with any outstanding hearing determination or order.

Civil penalties:

Fines of up to $1,000 per day may be assessed against adult care facilities for violation of standards of care after a hearing. No penalty can be imposed if at the time of a hearing, the operator satisfactorily demonstrates that either (i) the violations have been rectified within 30 days of receipt of the written report of inspection first citing the violation, or (ii) an acceptable plan for rectification and monitoring to ensure that violations do not recur had been submitted to the department within 30 days of receipt of such written report of inspection and the plan was being implemented in accordance with the procedures and time frames approved by the department. However, even where correction of a violation has occurred, the department may assess a penalty if it

establishes at a hearing that the particular violation endangered or resulted in harm to a resident (unless the harm was caused "solely by an act of God, and the operator took immediate action to correct it").

Do you think these requirements need to be strengthened or weakened?

	Strengthen	Weaken	No change necessary	Do not know
Survey rules	◯	◯	◯	◯
Enforcement options	◯	◯	◯	◯
Civil penalty rules	◯	◯	◯	◯

2. Please explain, in detail your answer above. If you did want change, how would you like to see things changed?

8. Ending

Thank you for participating in the survey.

1. If you would like the results of this survey sent to you, please fill out the following information. All of this information will be kept confidential.

Name:
Company:
Address:
Address 2:
City/Town:
State:
ZIP:
Country:
Email Address:
Phone Number:

Appendix I: Table of Tables

Contents