Informational Hearing:

Increasing Accountability in Assisted Living Facilities:
State Oversight of Care in Residential Care Facilities for the Elderly (RCFEs)

Joint Hearing of the Senate Human Services Committee and
Assembly Human Services Committee

February 11, 2014

Background Paper

Introduction

A spate of poor-care issues involving residents of licensed RCFEs, brought to light in recent months, have raised questions about the adequacy of oversight provided by the California Department of Social Services (CDSS). In some cases, RCFEs were found to be operating with continuous unresolved violations that endangered the health and wellbeing of residents. In one Castro Valley facility, 19 elderly residents with physical and cognitive impairments were essentially abandoned, first by their licensed care providers, and then by CDSS staff, and were left under the care of an unpaid cook and janitor for two days after the facility was shut down by CDSS. In San Diego over the last six years, a reported 27 seniors died in connection with what has been characterized as abuse and neglect sustained in licensed RCFEs.[1] These and other recent incidents highlight longstanding complaints of inadequate regulatory oversight over the approximately 8,000 Assisted Living, Board and Care, and Continuing Care Retirement homes that are licensed as RCFEs in California.

The purpose of this joint hearing between the Senate Human Services Committee and the Assembly Human Services Committee is to examine the regulatory structure employed by CDSS in overseeing these facilities. This includes the frequency and scope of onsite visits by CDSS, sufficiency of penalties and fines, timely response to complaints, resolution and enforcement of citations, and other concerns. One specific issue the committees will ask CDSS to address is their ability to track and respond to repeated violations and provide public access to citation information. Other issues include training and licensing requirements for facility owners and staff, tracking of licensees with facilities in multiple locations, and practices when a licensee or administrator consistently fails to meet or outright abdicates their responsibilities.

The same oversight concerns pertain to childcare centers and homes, foster care group homes and foster family homes, social rehabilitation facilities and others, which also are regulated by the department's Continuing Care Licensing Division (CCL). All of these facilities are governed by similar statutes, with generally the same schedule of visits. Information generated from visits

[1] San Diego Union Tribune, "Deadly Neglect." September 2013.

to all of these facilities lacks transparency and is not easily accessible to the public, nor easily compiled for use by policy makers or CDSS.

This is the first of two legislative hearings today to investigate state oversight of residential long-term care facilities, and those who provide care in them. This hearing will focus on regulatory oversight of assisted living homes that fall under the scope of the CDSS, specifically RCFEs. The Senate Health and Senate Business and Professions and Economic Development committees will hold a subsequent hearing to look at regulatory oversight of care providers overseen by the California Department of Public Health (CDPH) and boards and commissions within the Department of Consumer Affairs.

Last month, the Assembly Aging and Long Term Care Committee and Assembly Health Committee convened a hearing entitled "Department of Public Health: Licensing and Certification Division," to look at the adequacy of oversight by CDPH. Public Health licenses and certifies health facilities including skilled nursing and intermediate care facilities, congregate living health facilities, and adult day health care centers. The hearing revealed significant gaps in CDPH oversight of the facilities and of health professionals.

Background

California's aging population

This state's aging population, fueled by retiring baby boomers, is expected to grow significantly between now and 2025, when more than 7 million Californians will be older than 65. According to the Public Policy Institute of California, in 2010, 11 percent of Californians were aged 65 and older, or about 4.2 million residents. This compares to just 9 percent of the state's population in 1970. By 2025, 17 percent of the state's population will be 65 or older.

At the same time, the rate of seniors with Alzheimer's disease or other memory issues is anticipated to grow exponentially. Currently, Alzheimer's disease affects about 11 percent of all Californians aged 65 or older. California's population of individuals with Alzheimer's disease is expected to increase by 37.5 percent between 2010 and 2025 according to a recent report by the Senate Office of Research. In comparison, there was a 9 percent increase in Alzheimer's disease between 2000 and 2010.[2]

Continuum of care

California's system of long term care includes a broad network of providers and facilities delivering a range of medical and non-medical services to seniors or persons with disabilities

[2] "Understanding Alzheimer's Disease: A Review of Medical Advancements and Efforts to Address the Societal, Economic, and Personal Toll of an Impending Public Health Crisis," Senate Office of Research, June 2013

who have medical, physical or cognitive limitations that require assistance. Such services are provided within a spectrum of settings that include (from least restrictive to most restrictive) a person's home, community residential settings, or institutional settings. Each setting comes with its own regulatory oversight structure. The spectrum of services and facilities generally seeks to establish a "continuum of care" with increasing levels of care corresponding to increasing health acuity. However there is significant overlap in the scope of services provided as people seek to remain in place as their needs increase.

Residential Care Facilities for the Elderly

Within that continuum, situated between in-home care and skilled nursing facilities, is the RCFE, also commonly called Assisted Living, Board and Care, or Residential Care. These residences are designed to provide homelike housing options to residents who need some help with activities of daily living, such as cooking, bathing, or getting dressed, but otherwise do not need continuous, 24-hour assistance or nursing care. Among RCFEs, there is no uniform care model and a wide variation in the level of services and independence available to residents.

The RCFE licensure category includes facilities with as few as six beds to those with hundreds of residents, whose needs may vary widely. Typically, the smaller facilities are homes in residential neighborhoods while the larger facilities resemble apartment complexes with structured activities for their residents. Residents may reside in their own apartment, or may share a bedroom. Generally, residents are free to leave the facility if they choose, and may entertain guests, and otherwise maintain a high level of independence. However, facilities licensed to serve residents with dementia or Alzheimer's disease, also known as "memory care units" may maintain a secure perimeter.

Nationally, RCFEs experienced explosive growth in the 1990s, more than doubling the number of beds between 1990 and 2002,[3] and continued to grow 16 percent between 2001 and 2010.[4] Nationwide, states reported 1.2 million beds in licensed RCFEs in 2010.[5] In 2010, the national Centers for Disease Control reported that 40 percent of RCFE residents needed help with three or more activities of daily living and three-fourths of residents had at least two of the 10 most common chronic conditions.[6]

[3] Flores and Newcomer, "Monitoring Quality of Care in Residential Care for the Elderly: The Information Challenge". Journal of Aging and Social Policy, 21:225-242, 2009.
[4] SCAN Foundation. "Long Term Care Fundamentals: Residential Care Facilities for the Elderly." March 2011. http://thescanfoundation.org/sites/thescanfoundation.org/files/LTC_Fundamental_7_0.pdf
[5] "Assisted Living and Residential Care in the States in 2010," Mollica, Robert, AARP Public Policy Institute
[6] "Residents Living in Residential Care Facilities: United States, 2010, Caffrey, Christine, et al., US Centers for Disease Control, April 2012

Federal Protections for Persons with Disabilities

One reason for this exponential growth has been a change in this country's approach to treating individuals who are infirm or disabled. On June 19, 1999, the United States Supreme Court issued a landmark decision in the Olmstead vs LC case requiring states to avoid needless segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to meet their needs. Justices wrote that confining people to institutions who could handle and benefit from community settings "perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Since then, states have developed plans to shutter mental hospitals and other large institutions and to ensure that individuals living in Skilled Nursing Facilities who wish to live in less restrictive settings have the opportunity to do so. The Olmstead decision was based, in part, on two tenets of individual freedom: The 1990 Americans with Disabilities Act (ADA) and the Fair Housing Amendments Act of 1988.

The ADA requires public entities to administer services "in the most integrated setting appropriate" and to "make reasonable modifications in policies, practices, or procedures…to avoid discrimination on the basis of disability, unless [the state] can demonstrate that making the modifications would fundamentally alter the nature of the services, program or activity," such as requiring new expenditures or closing institutions.[7] Congress defined the most integrated setting as one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

The Fair Housing Amendments Act of 1988 prohibits discrimination in housing against persons with disabilities, granting the right to reasonable accommodations.[8] Federal law also requires state regulatory agencies to include reasonable accommodations in licensing requirements.

Financial Structure

More than 90 percent of RCFE licenses in California are held by for-profit providers, the majority of which have six or fewer beds.[9] Most residents pay privately or with long-term care insurance since there is very little public funding available through Medi-Cal, Supplemental Security Income (SSI/SSP) or Medicare, and fees can range from $2,500 to more than $8,000 per month. A very few beds are available to seniors who pay their entire SSI/SSP checks in rent. In 2013 the maximum SSI/SSP grant was $866.40. Residents who rely solely on Social Security

[7] Olmstead v L.C.
[8] 42 U.S.C. §§ 3601–3619
[9] "Residential Care in California: Unsafe, Unregulated & Unaccountable," California Advocates for Nursing Home Reform, 2013

Income may have a maximum payment of $2,642 per month in 2014,[10] although that amount varies widely based on the recipient's prior income while working.

As a result, low-income seniors and middle-income seniors who do not have long term care insurance are largely unable to afford to reside in an RCFE. Most low-income seniors may receive services through In Home Supportive Services or a skilled nursing facility if they are Medi-Cal eligible. A small number of Medi-Cal patients who are eligible for nursing home care may be placed in an RCFE through the state's Assisted Living Waiver, which began in 2006. According to state data, 172 RCFEs currently participate in the waiver program benefitting 2,200 residents. There are an additional 3,700 slots available.

Increasingly, complex corporate mergers and acquisitions have meant that many RCFEs are owned by national corporate chains that control more than one facility. Administrators employed by these chains may also oversee multiple facilities. This development has led to regulatory challenges since CCL citations and other licensing reports are facility specific, and management problems common to multiple RCFEs with the same owner may easily go unnoticed.

Recent events

A series of recent events has drawn attention to questions about the adequacy of CCL oversight and the state's ability to protect people who receive services within CDSS-licensed facilities.

In July 2013, ProPublica and Frontline reporters wrote and produced a series of stories on Emeritus, the nation's largest RCFE provider.[11] Featured in the article was a woman who died after receiving poor care at in a facility in Auburn, California. The series documented chronic understaffing and a lack of required assessments and substandard care.

Reports in September 2013, prompted by a consumer watchdog group that had hand-culled through stacks of documents in San Diego, revealed that more than two dozen seniors had died in recent years in RCFEs under questionable circumstances that went ignored or unpunished by CCL.[12]

In late October 2013, 19 frail seniors were abandoned at Valley Springs Manor in Castro Valley after the state had revoked the home's license. After two days of working around the clock, the two unpaid staff, who had remained after the facility was closed, called 911 for help. Prior to the closure CDSS had issued a series of citations against the facility, and said it also was concerned about two other facilities owned by the same licensee. When CDSS finally moved to shut down Valley Springs Manor on October 21, the state had lost contact with both the administrator and licensee. On October 24, the facility was officially closed. The next day, a Friday, CDSS

[10] http://www.ssa.gov/pressoffice/factsheets/colafacts2014.pdf

[11] http://www.propublica.org/article/life-and-death-in-assisted-living-single

[12] "Care Home Deaths Show System Failures," San Diego Union Tribune, Sept.7, 2013

licensing staff noted that there was not enough food for the 19 remaining residents, nor could the remaining unpaid staff – a cook and janitor – find the residents' medications to dispense. The licensing analyst handed the cook a $3,800 fine for operating an unlicensed facility and left for the weekend.[13] The next day sheriff's deputies and paramedics sent the patients to local hospitals.

Last month, in a related oversight issue pertaining to CDSS, concerns about parents' lack of ability to see what sanctions may have been levied against child care providers renewed debate around CCL's ability to know which facilities are repeatedly cited, or for what citations.

Licensing of RCFEs

In 1985, the California Residential Care Facilities for the Elderly Act established a regulatory structure for RCFEs that stands apart from other adult community care facilities.[14] The statute acknowledges the importance of providing residential options for seniors that are not primarily medically oriented and that allow older persons with a variety of health care needs to remain as independent as possible.

Level of Services

RCFEs are required by California statute to provide a basic level of services including assistance with activities of daily living without which the resident's physical health, mental health, safety or welfare would be endangered. State law also requires that RCFE staff help residents access supportive services in the community, be aware of the residents' whereabouts, monitor residents' activities while residents are in the facility to ensure their health and safety and encourage participation in planned activities. Administratively, facilities are required to maintain current records of residents including name, ambulatory status, physician contact information, and any person responsible for the care of the resident. RCFEs also are required to assess a resident's mental capabilities and to seek information about the resident's likes and dislikes.

Facilities are required to conduct the following assessments:

- A pre-admission appraisal to determine the care needs of the applicant and whether those needs may be met in the facility;
- A medical assessment, describing the patient's medical history and diagnoses, signed by a physician;
- A functional capabilities assessment identifying the assistance with activities of daily living needed by the resident.

[13] "Reports show state worker left Castro Valley care facility in hands of a cook and two others" Oakland Tribune, Nov. 1, 2013
[14] HSC 1569

RCFEs are permitted to provide incidental medical and dental care services which may include transportation to medical appointments, assistance with durable medical equipment, and assistance with the self-administration of medications, which may be centrally stored. An RCFE is required to create a level of care plan that includes guidelines for meeting the level of care needs of residents including the use of community and professional supports, assessment procedures for evaluating each resident, and a process to ensure the facility is able to meet the levels of care needed.

Prohibited Conditions

Existing law prohibits RCFEs from admitting residents with the following needs:

- 24-hour, skilled nursing or intermediate care.
- Patients who have active communicable tuberculosis.
- Patients who require care and supervision due to a mental disorder.
- Bedridden such that the resident is not able to turn or reposition in bed, other than for a temporary illness or surgery recovery, unless there is sufficient care staff and only if fire safety requirements are met or alternative methods of protection are approved by CDSS.
- Patients with dementia, unless the facility meets special dementia care standards.[15]

Waivers and Exceptions

Licensing requirements governing RCFEs include a provision permitting the granting of waivers of licensing requirements to enable residents, who wish to age in place without moving to a skilled nursing facility, to do so if appropriate. Waivers may be granted for Alzheimer's / dementia care, as well as hospice care for terminally ill residents. Additionally, RCFEs may permit incidental medical services to be provided through a home health agency. This can occur if CDSS grants a prohibited condition exception under which the department determines that the facility has the ability to provide appropriate care and supervision, the contracted home health agency has been advised of regulations pertaining to RCFEs, the facility has an agreed-upon protocol with the home health agency and there is ongoing communication between the two entities.[16]

Over the past decade, more residents of RCFEs have chosen to age in place with increasing medical needs. While statutes and regulations have largely responded to those needs for change, advocates have criticized – and CDSS has acknowledged – that the regulatory structure has not adequately responded to oversee quality and safety in this changing environment.

[15] CDSS BCP page 3
[16] HSC 1569.725

Licensee and administrator requirements

California statute differentiates between facility licensees, who often are the business owners and may be property owners, and administrators, who are charged with overseeing the quality of the day-to-day operations and are generally required to be present at the facility during normal working hours.

State law requires prospective RCFE licensees to provide evidence that he or she is of "reputable and responsible character"[17] including a criminal background clearance, employment history and character references. Licensees must document sufficient financial resources to maintain the standard of care required by law, must disclose any prior role as an administrator or owner of any community care facility and any prior disciplinary action. In order to be certified, each licensee must complete at least 40 hours of classroom instruction covering relevant laws and regulations, management of staff, physical and psychosocial needs of elderly residents, and other issues.

Administrators are required to hold a department-approved certificate, similar to the licensee certificate, which must be renewed every two years. Other requirements for administrators are that they must be at least 21 years of age, have a high-school diploma and undergo a criminal record clearance. Those working in larger facilities are required to meet additional educational or experience requirements. Facility administrators may lose certification if they are found to have "engaged in conduct which is inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the facility or the people of the State of California."[18]

Staff Requirements

A broad range of staff are employed in RCFEs including administrators, facility managers, and personal care aides, as well as support staff such as housekeepers and food service workers. Facilities are not required to employ licensed medical staff in light of the non-medical nature of the care model; however many facilities do employ Registered Nurses, Licensed Vocational Nurses, Certified Nurse Assistants and Certified Medication Aides. Additionally, some individuals living in RCFEs may receive care from staff with medical training when they are the subject of medical waivers or exceptions to prohibited conditions.

Licensees, administrators, staff managers and direct care staff are required to undergo a criminal record clearance prior to their presence in an RCFE. CDSS reports that out of 200,000 background checks that are processed every year, approximately 1,200 individuals are excluded from becoming a licensee or caregiver in a CCL licensed facility.

[17] HSC 1569.15
[18] Title 22 CCR 87408

Staff members who assist residents with activities of daily living must receive at least 10 hours of training within four weeks of being hired on subjects including physical limitations of the elderly, importance and techniques for personal care services, residents' rights, medication procedures and psychosocial needs of the elderly. Facility employees who help residents with the self-administration of medications must undergo training and pass an examination.

State oversight of Licensees

Regulatory oversight

CDSS is charged with regulating and licensing non-medical residential facilities and community services. CCL reports that there are approximately 462 licensing program analysts (LPAs) who are monitoring activities of more than 66,000 licensed community care facilities, including RCFEs, child care homes, adult day care programs and other types of programs. The department notes that its analysts conduct more than 24,000 inspections and investigate more than 13,000 complaints involving licensed care annually.[19] The Department states that, due to barriers in the IT system they are unable to characterize whether or how these complaints have been resolved.

Licensing staff employed by CDSS are required to undergo 36 hours of training per year and to be provided with comprehensive training within six months of employment.

Regulatory Visits

CDSS is required to make unscheduled visits to all licensed RCFEs "as often as necessary," and is required to do so annually in certain instances, such as when a licensee is on probation, the facility compliance plan requires annual visits, or when an accusation against a licensee is pending, among others. CDSS is required to visit all RCFEs no less than once every five years and any individual may request an inspection of an RCFE.

When a complaint is received, the department is required to open a preliminary review and to inspect the facility within 10 days unless doing so would impede a law enforcement investigation. CDSS states that thousands of complaints are received every year. However, advocates state that complaints are frequently ignored or remain unaddressed, and that CCL staff is struggling to meet the statutory requirement to visit facilities no less than once every 5 years.

History of Budget Cuts

At one time, CCL conducted annual visits of all RCFEs and other licensed facilities within its jurisdiction. However, as a result of a series of budget cuts beginning in 2003, CCL began inspecting facilities based on a random sample protocol. Under this scenario, those facilities that warrant close monitoring because of a poor history of compliance are monitored annually, as

[19] Department of Social Services Budget Change Proposal CCLD-2, 2014-15

well as facilities that are federally required to be inspected annually. Typically, this comprises about 10 percent of all facilities. Of the remaining 90 percent, approximately 30 percent are randomly selected for annual inspection. The five-year inspection mandate was intended to catch facilities that are not randomly selected at least that often for inspection.

CCL has repeatedly sought to restore the cuts made to licensing, arguing that the cuts to staff and resulting changed protocols "have put client health and safety at risk. By not consistently inspecting facilities, inspecting a facility only once every five years or inspecting a facility only as the result of a complaint, CCL LPAs have lost rapport with licensees, which in turn has not been conducive to helping clients in those facilities."[20]

Key Indicator Tool

In 2010, after several years of budget cuts that reduced the ability of CCL to make regular inspection visits to RCFEs, child care centers, foster care group homes and other facilities, the department proposed the use of "key indicator tools" (KIT) to speed inspections. Under the KIT, licensing analysts would be able to review an adult residential facility's compliance using a single-page 29-question form, as opposed to the standardized regulatory packet. This would allow analysts to visit more facilities and to pinpoint facilities that were not in compliance and needed further review. When it was proposed, the department estimated that switching to use of the tool would move the visit frequency from once every five years to annually or biennially.[21]

The use of weighted, or key, indicators for child care facilities had been well researched. More than three decades ago, the U.S. Department of Health and Human Services began investigating the use of weighted tools in evaluating safety in childcare centers. Ultimately researchers and the federal HHS developed a 13-item list of the most common indicators of overall compliance with child care regulations. By 1994, the U.S. General Accounting Office estimated that 30 states were using the indicator tool to streamline licensing enforcement systems.

Various states have adapted the tool for use in evaluating other service providers, including mental health and long term care facilities, although the same degree of validation and research into the measurements has not been done. California currently uses the validated childcare tool for those facilities, and has created an additional tool for RCFEs.

CDSS contracted with the Institute for Social Research at California State University, Sacramento, to provide a key indicator tool that is validated for use in this state. This requires a data analysis that identifies well-performing and poorly performing facilities and statistically correlates recurring violations with overall poor care. However, researchers have been unable to

[20] Department of Social Services spring finance letter CCLD-1, 2011-12
[21] ibid

identify citations common to poorly performing facilities within CDSS's data collection system, and therefore cannot readily identify appropriate indicators to use on the abbreviated tool.

When the department requested the use of the Key Indicator Tool be codified in Trailer Bill Language in 2010, concerns about validation of the tool prompted the department and legislature to postpone adopting it into statute. Citing the need to find a way to provide more frequent visits, CDSS proceeded with use of the KIT, and contracted with CSUS to provide a validated tool. The Governor's current budget proposal includes an assumption that use of the tool will be ongoing.

Event of license revocation or eviction

If CDSS determines that it is necessary to temporarily suspend or revoke an RCFE license, the department is required to minimize trauma to the residents. Specifically, CDSS is required to contact local agencies that may have placement responsibilities for the residents. This can include local ombudsmen, Adult Protective Services offices, private placement agencies and others. Additionally, the department is required to use physicians and other medical personnel to provide onsite evaluations and to assist with transfers.

Regulations define a facility as being abandoned by the licensee, one type of license forfeiture, if the department is unable to reach the licensee after making daily phone calls for five consecutive days, and after sending a certified letter with no response for seven days.[22]

Licensees are required to provide a 60-day notice of a potential license revocation to residents within 24 hours of receiving it. In some cases, providers may contract with another entity to manage day-to-day operations of the facility while they attempt to sell the property. Prior to a forfeiture of license, a facility with more than seven residents is required to prepare a proposed closure plan to CDSS for approval. Additionally, prior to transferring a resident, licensees are required to prepare a relocation evaluation of the needs of the resident that includes recommendations about the type of facility that would meet the resident's needs and a list of appropriate facilities within a 60 mile radius of the facility.

Eviction notices to residents are required to be provided 60 days prior to the intended eviction and must include the reason for the eviction, the resident's current service plan, the relocation evaluation, information regarding a resident's right to contact CDSS, and contact information for the long term care ombudsman.

Monetary sanctions

If a licensee fails to comply with the above requirements, California law requires CDSS to take any necessary action to minimize trauma for the residents. Additionally, noncompliant licensees

[22] Title 22 CCR 87112 (f)

are required to reimburse the department for the cost of providing relocation services and are subject to maximum civil penalties of $150 per violation per day.[23] Furthermore, a resident of an RCFE may bring a civil action against the licensee.

Transparency

Existing law requires CDSS to publish and make available lists of all licensed RCFEs and to develop a written notice to be provided by RCFEs to interested parties, informing them that the department licensing analyst inspection reports on all RCFEs are on file and are available for public view in the departments community care licensing district office nearest to each RCFE.[24] RCFEs are required to publish the current license number in all outreach materials and correspondence. These materials, while available online in other states, can only be accessed by the public by physically visiting a regional office and requesting the inspection reports.

CDSS publishes on its website a "myccl" webpage in which the public can search for providers of adult residential care and child care by zip code. Information found on the website includes the facility's license number, its capacity and which CDSS district office houses additional materials. However, the website does not provide information about citations or sanctions against providers. The primary reason for this is a technology barrier, according CDSS.

Currently, LPAs input survey results, including citation information, into an antiquated word processing system, Lotus Notes, that does not interact with any of the department's other data collection tools. As a result, the department is unable to track patterns of poor care within a single facility, much less across facilities with the same owner. CDSS is also unable to upload information to its web site for the public to see citation information on facilities. Efforts have been made to bridge the antiquated field information system to data collection systems, including a grant from the California Health Care Foundation in 2008. However the Lotus system is so old those technology patches have been unsuccessful.

[23] HSC 1569.682 (d)
[24] HSC 1569.76