

July 31, 2014

The Changing Landscape of Assisted Living

Developments in the States

Eric Carlson



The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.



- **The Assisted Living Consumer Alliance (ALCA) is a national collaboration of groups and individuals working together to promote consumer safety, choice, and rights in assisted living.**

Thank you

- To the California HealthCare Foundation, based in Oakland, California.
 - www.chcf.org

The Changing Landscape

- Dramatic changes in last 10-15 years:
 - In past, a relatively bright line between a “typical” nursing facility resident and a “typical” assisted living resident.
 - Now, many persons who formerly would have required nursing facility care, instead are residing in assisted living facilities.

Various Ways that Assisted Living Has Evolved

- e.g., Elimination or loosening of ceilings on type of care that can be provided.
- Establishment of levels of care that increase quality of care standards to match resident care needs.
- Greater participation by health care providers, either on staff or provided through outside agencies.

Assisted Living Evolution (cont.)

- Mandated disclosure to consumers prior to and at time of admission.
- Separation of housing and services.
- Standards specific for particular conditions (most commonly dementia).

California – Slow to Adapt

- California licenses Residential Care Facilities for the Elderly (RCFES).
- Report: Best Practices in Assisted Living (Feb. 2014); <http://www.nsclc.org/wp-content/uploads/2014/02/Final-Draft-Best-Practices-in-Assisted-Living.pdf>
- Compares California to 11 other states:
 - AL, AR, CT, FL, KS, MS, NY, OR, PA, WA, WI

Levels of Care

- Residential Care Facilities for the Elderly (RCFEs) have a single level of care.
- Four of the surveyed states offer two or more levels.
 - e.g., AR licenses Assisted Living Levels I and II.
 - Florida licenses assisted living facilities with option for additional permission for limited nursing services, limited mental health, or extended congregate care.

Nurse Participation

- In CA, certain “allowable” health conditions can be accommodated only if procedure is performed by resident or “appropriately skilled professional.”
- In OR, licensed nurse must have regular on-site duties and otherwise must be available over the phone.
- In AR, Level II facilities must have nurses to provide nursing care and direct care services.

Medication Administration

- In CA, staff can assist with self-administration of medication.
- In KS, medications are administered by medication aides.
- In WA, authority to administer medications is delegated from nurses to nurse aides or home care aides, who receive additional training.

New Assisted Living Reform Project in CA

- Organized by National Senior Citizens Law Center, with assistance from California Advocates for Nursing Home Reform.
- Funding by California HealthCare Foundation.

Premises of Project

- CA's RCFE system is overdue for comprehensive review.
- Stakeholders will be better able to consider alternatives if they understand what other states are doing.
- There are no off-the-rack options; each state must develop its own variations.

Initiating and Advancing the Discussion

- Issue Briefs
- Webinars
- Policy Briefing

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The Changing Landscape of Assisted Living Developments in the States

The Connecticut Assisted Living Experience Resident and Consumer Friendly Features

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July 31, 2014

The Connecticut Assisted Living Experience: Resident and Consumer Friendly Features

- History and Model
- Assisted Living Services Agency (ALSA) versus Managed Residential Communities (MRC)
- Selected Resident and Consumer Friendly features of Connecticut's ALSA/MRC model

History and Model

- Home Health parallel
- 1995 first Assisted Living license issued
- Key Champion: Commissioner Edith Prague, State Department on Aging
- Department of Public Health regulations developed rather than statutes
- 2001: legislation to construct 300 new AL units with funds from Social Service, Housing & Economic Development agencies
- 2006: consumer concerns led to MRC legislation in 2007
- Private pay Assisted Living development and expansion (overcapacity in certain markets 5-10 years and limited new Assisted Living development in recent years)

Assisted Living Services Agency (ALSA) versus Managed Residential Community (MRC)

- Assisted living services agency is licensed by the CT Department of Public Health
- The facility (MRC) is not licensed
- Resident enters into a tenant-landlord agreement with the MRC
- Resident signs a contract agreement with the ALSA
- The ALSA has written policies regarding the delivery of nursing services
- Emphasis on nursing services and designated role of Registered Nurse

Selected Resident and Consumer Friendly AL and MRC Features

- Resident bill of rights
- Required Ombudsman and DPH contact information is posted and provided and at time of admission
- Specialized dementia unit and pain recognition training requirements
- Disclosure requirements-specialized dementia units
- Regulatory surveys every two years
- Individualized service plans and resident care planning participation
- Minimum and annual training requirements for home health aides and CNAs
- Tenant council-required regs that staff help establish, support and respond
- Resident death-maximum payment owed 15 days if apt vacated by then
- Four dedicated state-supported AL's and 150 pilot slots at private facilities
- 2014 CT legislation on new and expanded Alz/dementia training requirements

Assisted Living Regulations

Selected key features

- 2008 DPH convened AL stakeholder workgroup to review and revise regulations-LTCOP participation
- Initial application of financial viability, malpractice and liability insurance required
- Client bill of rights
- Key core services to include 3 meals/day, regular laundry/linen, scheduled transportation, housekeeping, recreation programs, security
- RN head nurse/SALSA-supervisor of assisted living services; designated RN also; 24/7 RN on-call
- Annual 6 hours in-service training requirement for assisted living aides (CNAs or home health aides); 10 hours orientation
- 120 day care plan updates required and done by RN with MD signature required; more frequent with significant change of condition
- Quality assurance committee required to include MD, RN, SW
- Department of Public Health surveys every 2 years and DPH regulations require that residents must be chronic and stable

Managed Residential Communities (MRCs)

Selected key features

2007 MRC legislation

- Required Long Term Care Ombudsman and DPH info provided at admission and required onsite posting
- Operational requirements – written residency agreement; coordinate resident needs; assist w/LTC insurance benefit processing; notification to prospective and current residents when petition for facility bankruptcy filed;
- Key consumer concerns: contract issues including rent/ancillary rate increases; care level increases; termination
- **Resident's Bill of Rights** – (a) A managed residential community shall have a written bill of rights that prescribes the rights afforded to each resident. A designated staff person from the managed residential community shall provide and explain the bill of rights to the resident at the time that such resident enters into a residency agreement at the managed residential community. The bill of rights shall include, but not be limited to, that each resident has the right to:
 - (1) Live in a clean, safe and habitable private residential unit;
 - (2) Be treated with consideration, respect and due recognition of personal dignity, individuality and the need for privacy;
 - (3) Privacy within a private residential unit, subject to rules of the managed residential community reasonably designed to promote the health, safety and welfare of the resident;
 - (4) Retain and use one's own personal property within a private residential unit so as to maintain individuality and personal dignity provided the use of personal property does not infringe on the rights of other residents or threaten the health, safety and welfare of other resident
 - (5) Private communications, including receiving and sending unopened correspondence, telephone access and visiting with persons of one's choice;
 - (6) Freedom to participate in and benefit from community services and activities so as to achieve the highest possible level of independence, autonomy and interaction within the community;
 - (7) Directly engage or contract with licensed health care professionals and providers of one's choice to obtain necessary health care services in one's private residential unit, or such other space in the managed residential community as may be made available to residents for such purposes;

MRC key features

(continued)

- **Resident's Bill of Rights** (continued)

(8) Manage one's own financial affairs;

(9) Exercise civil and religious liberties;

(10) **Present grievances and recommend changes in policies, procedures and services to the manager or staff of the managed residential community, government officials or any other person without restraint, interference, coercion, discrimination or reprisal from the managed residential community, including access to representatives of the department or the Office of the Long-Term Care Ombudsman;**

(11) Upon request, obtain from the managed residential community the name of the service coordinator or any other persons responsible for resident care or the coordination of resident care;

(12) Confidential treatment of all records and communications to the extent required by state and federal law;

(13) Have all reasonable requests responded to promptly and adequately within the capacity of the managed residential community and with due consideration given to the rights of other residents;

(14) Be fully advised of the relationship that the managed residential community has with any assisted living services agency, health care facility or educational institution to the extent that such relationship relates to resident medical care or treatment and to receive an explanation about the relationship;

(15) Receive a copy of any rules or regulations of the managed residential community;

(16) Privacy when receiving medical treatment or other services within the capacity of the managed residential community;

(17) Refuse care and treatment and participate in the planning for the care and services the resident needs or receives, provided the refusal of care and treatment may preclude the resident from being able to continue to reside in the managed residential community; and

(18) All rights and privileges afforded to tenants under title 47a.

(b) A managed residential community shall post in a prominent place in the managed residential community the resident's bill of rights, including those rights set forth in subsection (a) of this section. The posting of the resident's bill of rights shall include contact information for the Department of Public Health and the Office of the State Long-Term Care Ombudsman, including the names, addresses and telephone numbers of persons within such agencies who handle questions, comments or complaints concerning managed residential community.

Managed Residential Community Written Residency Agreement Requirements

Sec. 19a-700. Written residency agreements. Required content. A managed residential community shall enter into a written residency agreement with each resident that clearly sets forth the rights and responsibilities of the resident and the managed residential community, including the duties set forth in section 19a-562. The residency agreement shall be set forth in plain language and printed in not less than fourteen-point type. The residency agreement shall be signed by the managed residential community's authorized agent and by the resident, or the resident's legal representative, prior to the resident taking possession of a private residential unit and shall include, at a minimum:

- (1) An itemization of assisted living services, transportation services, recreation services and any other services and goods, lodging and meals to be provided on behalf of the resident by the managed residential community;
- (2) A full and fair disclosure of all charges, fees, expenses and costs to be borne by the resident;
- (3) A schedule of payments and disclosure of all late fees or potential penalties;
- (4) The grievance procedure with respect to enforcement of the terms of the residency agreement;**
- (5) The managed residential community's covenant to comply with all municipal, state and federal laws and regulations regarding consumer protection and protection from financial exploitation;
- (6) The managed residential community's covenant to afford residents all rights and privileges afforded under title 47a (landlord-tenant);
- (7) The conditions under which the agreement can be terminated by either party;
- (8) Full disclosure of the rights and responsibilities of the resident and the managed residential community in situations involving serious deterioration in the health of the resident, hospitalization of the resident or death of the resident, including a provision that specifies that in the event that a resident of the community dies, the estate or family of such resident shall only be responsible for further payment to the community for a period of time not to exceed fifteen days following the date of death of such resident as long as the private residential unit formerly occupied by the resident has been vacated;** and
- (9) Any adopted rules of the managed residential community reasonably designed to promote the health, safety and welfare of residents.

Managed Residential Community

Alzheimer's Special Care Units

Pain Recognition and Training Requirements

- Sec. 19a-562a. Pain recognition and management training requirements for nursing home facility staff. Staff training requirements for Alzheimer's special care units or programs. **(a) Each nursing home facility that is not a residential care home or an Alzheimer's special care unit or program shall annually provide a minimum of two hours of training in pain recognition and administration of pain management techniques to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents.**
- (b) Each Alzheimer's special care unit or program **shall annually provide Alzheimer's and dementia specific training to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents enrolled in the Alzheimer's special care unit or program. Such requirements shall include, but not be limited to, (1) not less than eight hours of dementia-specific training, which shall be completed not later than six months after the date of employment and not less than eight hours of such training annually thereafter, and**
- **(2) annual training of not less than two hours in pain recognition and administration of pain management techniques for direct care staff.**
- (c) Each Alzheimer's special care unit or program shall annually provide a minimum of one hour of **Alzheimer's and dementia specific training to all unlicensed and unregistered staff, except nurse's aides, who provide services and care to residents enrolled in the Alzheimer's special care unit or program.** For such staff hired on or after October 1, 2007, such training shall be completed not later than six months after the date of employment.

MRC – Alzheimer’s Special Care Units – Disclosure Requirements

Sec. 19a-562. Alzheimer’s special care units or programs. Definitions. Disclosure requirements. (a) As used in this section and section 19a-562a, “Alzheimer’s special care unit or program” means any nursing facility, residential care home, assisted living facility, adult congregate living facility, adult day care center, hospice or adult foster home that locks, secures, segregates or provides a special program or unit for residents with a diagnosis of probable Alzheimer’s disease, dementia or other similar disorder, in order to prevent or limit access by a resident outside the designated or separated area, or that advertises or markets the facility as providing specialized care or services for persons suffering from Alzheimer’s disease or dementia.

(b) On and after January 1, 2007, each Alzheimer’s special care unit or program shall provide written disclosure to any person who will be placed in such a unit or program or to that person’s legal representative or other responsible party. Such disclosure shall be signed by the patient or responsible party and shall explain what additional care and treatment or specialized program will be provided in the Alzheimer’s special care unit or program that is distinct from the care and treatment required by applicable licensing rules and regulations, including, but not limited to:

(1) Philosophy. A written statement of the overall philosophy and mission of the Alzheimer’s special care unit or program that reflects the needs of residents with Alzheimer’s disease, dementia or other similar disorders.

(2) Preadmission, admission and discharge. The process and criteria for placement within or transfer or discharge from the Alzheimer’s special care unit or program.

(3) Assessment, care planning and implementation. The process used for assessing and establishing and implementing the plan of care, including the method by which the plan of care is modified in response to changes in condition.

MRC – Alzheimer’s Special Care Units – Disclosure Requirements (continued)

- (4) Staffing patterns and training ratios. The nature and extent of staff coverage, including staff to patient ratios and staff training and continuing education.
- (5) Physical environment. The physical environment and design features appropriate to support the functioning of cognitively impaired adult residents.
- (6) Residents’ activities. The frequency and types of resident activities and the ratio of residents to recreation staff.
- (7) Family role in care. The involvement of families and family support programs.
- (8) Program costs. The cost of care and any additional fees.
- (c) Each Alzheimer’s special care unit or program shall develop a standard disclosure form for compliance with subsection (b) of this section and shall annually review and verify the accuracy of the information provided by Alzheimer’s special care units or programs. Each Alzheimer’s special care unit or program shall update any significant change to the information reported pursuant to subsection (b) of this section not later than thirty days after such change.

2014 CT Legislation: An Act Concerning Alzheimer's Disease and Dementia Task Force Recommendations on Training

Bill 179 and Public Act 14-194

<http://www.cga.ct.gov/2014/ACT/PA/2014PA-00194-R00SB-00179-PA.htm>

(note: certain prior Alzheimer's and dementia training was required –see 19a-562 and 19a-562a above)

Bill Excerpts:

- each home health agency, residential care home and **assisted living services agency**...and each licensed hospice organization **shall provide training and education on Alzheimer's disease and dementia symptoms and care to all staff providing direct care upon employment and annually thereafter; all residential facilities serving persons with Down syndrome fifty years of age or older have at least one staff member trained in Alzheimer's disease and dementia symptoms and care.**
- (b) Each Alzheimer's special care unit or program shall annually provide Alzheimer's and dementia specific training to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents enrolled in the Alzheimer's special care unit or program. Such requirements shall include, but not be limited to, (1) **not less than eight hours of dementia-specific training, which shall be completed not later than six months after the date of employment or, if the date of employment is on or after the effective date of this section, not later than one hundred twenty days after the date of employment and not less than eight hours of such training annually thereafter, and (2) annual training of not less than two hours in pain recognition and administration of pain management techniques for direct care staff.**

2014 CT Legislation: An Act Concerning Alzheimer's Disease and Dementia Task Force Recommendations on Training

Bill 179 and Public Act 14-194

(continued)

- **(c) Each Alzheimer's special care unit or program shall annually provide a minimum of one hour of Alzheimer's and dementia specific training to all unlicensed and unregistered staff, except nurse's aides, who provide services and care to residents enrolled in the Alzheimer's special care unit or program.** For such staff hired on or after October 1, 2007, such training shall be completed not later than six months after the date of employment and, for such staff hired on or after the effective date of this section, not later than one hundred twenty days after the date of employment.
- **The nursing home administrator** required upfront and ongoing training in Alzheimer's disease and dementia care
- **The Probate Court Administrator shall develop a plan to offer training to probate judges, paid conservators** and other fiduciaries in diseases and disorders affecting the judgment of a person, including, but not limited to, Alzheimer's disease and dementia.
- **The Commissioner of Social Services shall ensure that all employees assigned to the Department of Social Service's protective services for the elderly program** who directly interact with elderly persons receive annual training in Alzheimer's disease and dementia symptoms and care.

Key Resources

- **CT Department of Public Health Assisted Living Regulations** - 19-13-D105
- http://www.ct.gov/dph/lib/dph/agency_regulations/sections/pdfs/title_19_health_and_safety/phc/chapter_iv/19-35_coordination.pdf or www.ct.gov/dph (highlight regulation and licensure then public health code)
- **Managed Residential Communities – State Statutes** 19a-693–19a709
- http://www.cga.ct.gov/2013/pub/chap_368bb.htm
- **Table of Contents**
- [Sec. 19a-693. Definitions.](#)
- [Sec. 19a-694. Managed residential communities. Operational requirements.](#)
- [Sec. 19a-694a. Notification when petition for bankruptcy filed.](#)
- [Sec. 19a-695. Investigation of complaints.](#)
- [Sec. 19a-696. Biennial reviews. Written reports. Remedial orders. Enforcement of remedial orders.](#)
- [Sec. 19a-697. Resident’s bill of rights.](#)
- [Sec. 19a-698. Residency agreements. Twenty-four-hour skilled nursing care.](#)
- [Sec. 19a-699. Individualized service plans. Assessment of resident who requires assisted living services.](#)
- [Sec. 19a-700. Written residency agreements. Required content.](#)
- [Sec. 19a-701. Compliance with applicable laws and regulations.](#)
- [Secs. 19a-702 to 19a-709. Reserved](#)
- http://www.cga.ct.gov/2013/pub/chap_368v.htm
- [Sec. 19a-562. Alzheimer’s special care units or programs. Definitions. Disclosure requirements.](#)
- [Sec. 19a-562a. Pain recognition and management training requirements for nursing home facility staff. Staff training requirements for Alzheimer’s special care units or programs.](#)

Key Resources

(continued)

- **An Act Concerning Alzheimer’s Disease and Dementia Training Task Force Recommendations – 2014 Bill 179/Public Act 14-194;**
www.cga.ct.gov/2014/ACT/PA/2014PA-00194-R00SB-00179-PA.htm
- **CT State Statutes - Landlord and Tenant;** http://www.cga.ct.gov/2013/pub/title_47a.htm
- includes rights and responsibilities of landlord and tenant; advance rental payment and security deposits; summary process; entry and detainer; public enforcement of health and safety standards; and court proceedings on housing matters. MRC residents are covered under landlord-tenant statutes. Assisted living residents also covered under contract provisions related to AL health care services provided or termination.
- **CT Department of Social Services;** <http://www.ct.gov/dss/site/default.asp>
- includes Medicaid and waiver programs, Medicaid assisted living – the four demonstration AL sites and the pilot program; Money Follows the Person, alternate care unit, home and community-based services, assistance programs, rehab services, protective services to the elderly, housing, social work support, energy assistance, etc.

The RCFE Reform Act of 2014

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This is Cal and Reggie



This is me with Cal and Reggie



What is an RCFE?

- Residential Care Facilities for the Elderly
 - social model of care – supervision, moderate assistance with activities of daily living
 - health care is provided, if needed, by outsiders
- Two “models”: assisted living and board-and-care
- Regulated by the CA Dept. of Social Services

Major Growth

- Nursing home population has flattened
- Long-term care is all going to assisted living
- Today, about 7,600 facilities with about 175,000 residents in CA

2013 Environment

- No energy for RCFE legislation
- DSS budget cuts lead to evaporated regulatory presence
 - Inspections
 - Complaint investigations
- The media gets interested . . .

Media Blow-Up


- ProPublica “Life and Death in Assisted Living”
- San Diego Union-Tribune “Deadly Neglect”
- Valley Springs Manor (Castro Valley)

WATCHDOG

Deadly Neglect: A U-T special report

By UT San Diego 4:26 P.M. SEPT. 9, 2013 Updated 5:40 P.M. JAN. 10, 2014


PRINT COMMENTS 2



Hazel Lovell, 95, has lived at Emeritus in Carmel Valley for six years. She is still active, attends many outings and is president of a residents' group. — Peggy Postle

Life and Death in Assisted Living

In collaboration with FRONTLINE



PART 1
“The Emerald City”

DN, ProPublica and JONATHAN JONIS, special to ProPublica, July 26, 2013

...ed help. Lots of it. Her physician had tallied the damage: sease, high blood pressure, osteoporosis, pain from a compression spine. [Read more »](#)

PART 2 **PART 3** **PART 4**

...ating Mom Well” “A Sinking Ship” “Close the Back Door”

New Details Emerge Of Patients In Abandoned In Fast Bay Care Home



Maurice Rowland
FORMER VALLEY SPRINGS MANOR EMPLOYEE

5 KPIX

They wanted a safe, comfortable place to spend their sunset years. Instead, at least 27 San Diego County seniors found something else — death, often in excruciating circumstances, in an assisted living facility. Behind the bright lobbies, flowers and chandeliers in some of

rt: Those Lost and Those Left Behind
...cial to ProPublica and A.C. Thompson, ProPublica, Aug. 1, 2013

g in assisted living, people can pay with their dignity, and sometimes with if state regulatory records and more than 100 lawsuits turned up repeated abuse or gross neglect at facilities operated by Emeritus. Earlier 1 July, the

WATCH THE FILM



Nothing Happens by Accident

CANHR White Paper: Unsafe, Unregulated, and Unaccountable

http://www.canhr.org/reports/Residential_Care_in_California.pdf

**Residential Care in California:
Unsafe, Unregulated & Unaccountable**

A SPECIAL REPORT BY:
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Boom.



The RCFE Reform Act of 2014 – Assembly Bills

- 1. AB 1523 (Atkins) RCFE Liability Insurance***
- 2. AB 1554 (Skinner) Responding to Consumer Complaints**
- 3. AB 1571 (Eggman) Consumer Information System**
- 4. AB 1572 (Eggman) Resident & Family Councils**
- 5. AB 1899 (Brown) Lifetime Ban for Resident Abandonment***
- 6. AB 2044 (Rodriguez) Staffing Requirements***

The RCFE Reform Act of 2014 –Senate Bills

- 7. AB 2171 (Wieckowski) Statutory Bill of Rights**
- 8. AB 2236 (Stone and Mainschein) Increased Penalties for Violations**
- 9. SB 894 (Corbett) RCFE Suspension/Revocation of Licenses**
- 10. SB 895 (Corbett) Inspections/evaluations of RCFEs**
- 11. SB 911 (Block) Training and qualifications of RCFE staff**
- 12. SB 1153 (Leno) Ban on Admissions**
- 13. SB 1382 (Block) Increase in RCFE Fees***

* not sponsored by CANHR

Lessons So Far

- Take advantage of your opportunities
- It's good to have friends
- Tough call: fixer-upper or raze-and-start-over?
- Home care and hospice will have something to say
- The more woe the better but the key is the narrative