STATE OF CONNECTICUT

PERFORMANCE AUDIT

Oversight of Connecticut's Assisted Living Facilities

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN ❖ CLARK J. CHAPIN

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Acronym/ Abbreviation	Definition
ADL	Activities of Daily Living
ALSA	Assisted Living Services Agency
CALA	Connecticut Assisted Living Association
CDC	Centers for Disease Control
CGS	Connecticut General Statutes
CHCPE	Connecticut Home Care Program for Elders
CHFA	Connecticut Housing Finance Authority
CMS	Centers for Medicare and Medicaid Services
CWCSEO	Commission on Women, Children, Seniors, Equity & Opportunity
DCP	Connecticut Department of Consumer Protection
DOB	Connecticut Department of Banking
DOH	Connecticut Department of Housing
DPH	Connecticut Department of Public Health
DSS	Connecticut Department of Social Services
FFY	Federal Fiscal Year
FLIS	Connecticut Department of Public Health Facility Licensing and Investigations Section
HUD	United States Department of Housing and Urban Development
IJ	Immediate Jeopardy
ISP	Individualized Service Plan
LTCOP	State Long-Term Care Ombudsman Program
MRC	Managed Residential Community
NORS	National Ombudsman Reporting System
OPM	Connecticut Office of Policy and Management
PSE	Connecticut Department of Social Services Protective Services for the Elderly Program
RA	Volunteer Residents' Advocate for the State Long-Term Care Ombudsman Program
RCSA	Regulations of Connecticut State Agencies
RN	Registered Nurse
SALSA	Supervisor for the Assisted Living Services Agency
SMQT	Surveyor Minimum Qualifications Test

Performance Audit Highlights

September 23, 2021
Oversight of Connecticut's Assisted Living Facilities

Background

The purpose of this audit was to assess how state agencies provided oversight of Connecticut's assisted living facilities during 2017-2019. We focused on the efficiency and effectiveness of the Department of Public Health (DPH) Facility Licensing and Investigations Section (FLIS), Department of Aging and Disability Services Long-Term Care Ombudsman Program (LTCOP), and Department of Social Services Protective Services for the Elderly Program (PSE). The state has a bifurcated system in which FLIS licenses the assisted living services component through assisted living services agencies, or ALSA, but registers the facility itself referred to as managed residential communities (MRC). We recommend improvements to the current oversight of assisted living facilities and consumer protections for this vulnerable population.

Connecticut has nearly 8,000 assisted living units or apartments within 142 MRC. Except for publicly funded assisted living facilities, nearly all MRC and the ALSA are under the same ownership structure. Approximately 60% of Connecticut assisted living facilities are part of national or regional chains and 18% are independently owned. Connecticut is the only state that does not fully license assisted living facilities.

Key Findings

1. The Department of Public Health (DPH) Facility Licensing and Investigations Section (FLIS) doesn't always adequately communicate with assisted living services agencies (ALSA) and managed residential communities (MRC) regarding registration, inspection and investigation results.
2. Managed residential communities are not required to conduct employee criminal background checks.
3. There are no minimum staffing requirements for memory care units.
4. *Assisted living facility* is not defined in statute.
5. With limited resources, the State Long-Term Care Ombudsman Program (LTCOP) prioritizes nursing home residents and did not visit 63% of assisted living facilities in FFY 2018.
6. Consumers have limited information and guidance when choosing an assisted living facility.
7. Fire safety inspections of assisted living facilities, particularly those with memory care units, may be inadequate and delayed. Some local fire marshals believe they cannot apply the more stringent institutional inspection criteria when conducting fire safety inspections of assisted living facilities, leading to concern about potential significant loss of life.
8. No state agency is monitoring MRC adherence to statutory requirements. The current partial licensure system may not adequately protect residents.

Recommendations

We developed 22 specific recommendations to improve oversight of Connecticut's assisted living facilities and increase consumer protections for this vulnerable population. In general, we recommend:

- FLIS should send MRC letters within 30 days confirming their registration and establish deadlines for communicating ALSA inspection and investigation results to both the ALSA and MRC.
- DPH should require criminal background checks for MRC employees with direct access to residents and establish minimum staffing requirements for aides, therapeutic recreational staff and other staff or specialists serving assisted living residents in memory care units.
- *Assisted living facility* should be defined in statute as a managed residential community that offers its residents nursing services and assistance with activities of daily living through an assisted living services agency.
- LTCOP should develop a minimum frequency standard of non-complaint visits to MRC and consider assigning volunteer residents' advocates to meet that standard.
- A work group should develop a comprehensive assisted living facilities resource on the My Place CT website and LTCOP should develop a checklist or consumer guide with questions to ask when visiting assisted living facilities.
- DPH should require an annual fire marshal safety inspection report for MRC to maintain their registration. The Codes and Standards Committee should clarify whether local fire marshals should use residential or institutional fire code requirements when inspecting assisted living facilities.
- DPH should resume biennial inspections and complaint investigations concerning violations of certain statutory requirements for managed residential communities. A work group should explore the development of an assisted living licensure system that combines MRC and ALSA.

View the full report, including management's responses, by visiting www.cga.ct.gov/apa
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September 23, 2021

INTRODUCTION
AUDITORS' REPORT

OVERSIGHT OF CONNECTICUT'S ASSISTED LIVING FACILITIES
JANUARY 1, 2017 – DECEMBER 31, 2019

Audit Objectives

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes and Generally Accepted Government Auditing Standards, we have conducted a performance audit of Oversight of Connecticut's Assisted Living Facilities. The audit focuses on the efficiency and effectiveness of the current state agency oversight of the two aspects of assisted living: assisted living services agencies; and managed residential communities. The scope of our audit included, but was not necessarily limited to, January 1, 2017 through December 31, 2019. We based this performance audit on the following objectives:

1. Efficiency and effectiveness of the Department of Public Health's oversight of assisted living services agencies (ALSA)

2. Efficiency and effectiveness of state agency oversight of managed residential communities

3. Identification and potential application of best practices in oversight of assisted living facilities

4. Recommendations to improve current oversight of assisted living facilities and consumer protections for this vulnerable population

Methodology

We used multiple sources and methods to conduct this performance audit, including: a review of relevant state statutes, regulations, and state fire safety codes; agency licensure, registration, complaint, and visitation databases; inspection, complaint investigation, and visitation policies and procedures; and assisted living websites and consumer brochures.

To assess how well Connecticut is overseeing assisted living facilities, we interviewed employees, representatives, personnel, and staff from the following entities:

- Department of Public Health Facility Licensing and Investigations Section
- Office of the State Long-Term Care Ombudsman Program
- Department of Social Services Protective Services for the Elderly Program
- Department of Consumer Protection
- Office of Policy and Management
- Department of Housing
- Office of Legislative Research
- Office of State Fire Marshal
- Local Fire Marshals
- Assisted Living Facilities
- Connecticut Assisted Living Association
- LeadingAge Connecticut
- Argentum
- AARP Connecticut
- Alzheimer's Association Connecticut Chapter
- Massachusetts State Long-Term Care Ombudsman Program
- Minnesota Office of Legislative Auditor, Program Evaluation Division

Through this methodology, we obtained an understanding of internal controls that we deem significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We conducted our audit in accordance with the standards applicable to performance audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. These standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence we obtained provides such a basis.

The accompanying background is presented for informational purposes. We obtained this information from interviews, documents, and data provided by key stakeholders, and this information was not subject to the procedures applied in our audit of oversight of Connecticut's assisted living facilities. For the areas audited, we determined/identified the following:

1. The Department of Public Health (DPH) Facility Licensing and Investigations Section (FLIS) doesn't always adequately communicate with assisted living services agencies (ALSA) and managed residential communities (MRC) regarding registration, inspection and investigation results.

2. Managed residential communities are not required to conduct employee criminal background checks.

3. There are no minimum staffing requirements for memory care units.

4. *Assisted living facility* is not defined in statute.

5. With limited resources, the State Long-Term Care Ombudsman Program (LTCOP) prioritizes nursing home residents and did not visit 63% of assisted living facilities in federal fiscal year 2018.

6. Consumers have limited information and guidance when choosing an assisted living facility.

7. Fire safety inspections of assisted living facilities, particularly those with memory care units, may be inadequate and delayed. Some local fire marshals believe they cannot apply the more stringent institutional inspection criteria when conducting fire safety inspections of assisted living facilities, leading to concern about potential significant loss of life.

8. No state agency is monitoring managed residential communities' adherence to statutory requirements. The current partial licensure system may not adequately protect residents.

The State Auditors' Findings and Recommendations in the accompanying report presents any findings arising from our audit of Oversight of Connecticut's Assisted Living Facilities.

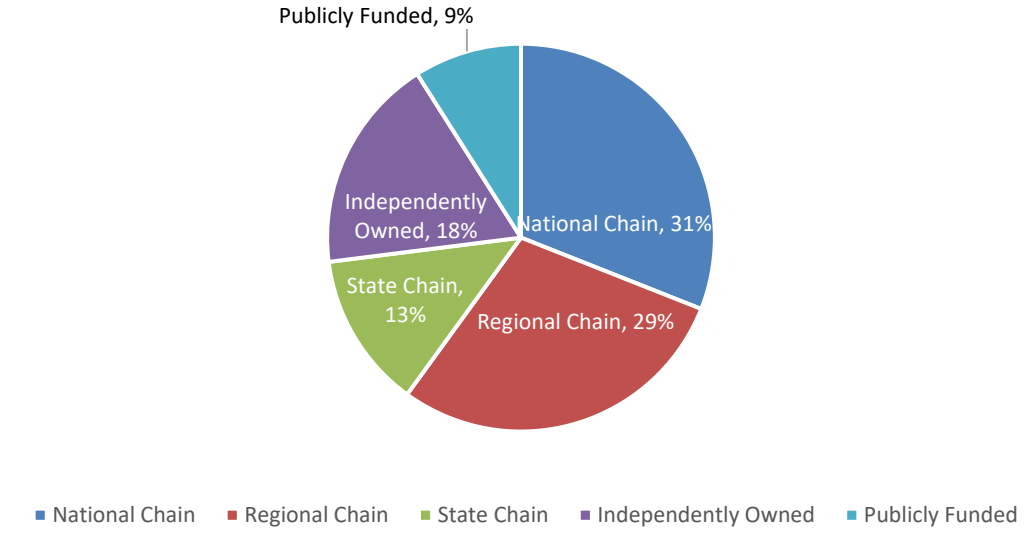
BACKGROUND

Unlike Connecticut's licensed nursing homes, the state's assisted living facilities are considered non-medical residential settings. The state has a bifurcated system in which the Department of Public Health licenses the assisted living services component through assisted living services agencies (ALSA), but not the facilities (referred to as managed residential communities (MRC)). According to a 2019 article by AARP, the United States has approximately 28,900 assisted living facilities with almost one million beds. Over half are part of national chains and the rest are independently owned. Assisted living facilities vary in size from fewer than 10 to over 100 residents, with an average capacity of 33 residents.

In 2020, Connecticut had 142 managed residential communities and 112 assisted living services agencies. The first Connecticut assisted living community opened in 1998 in Hamden and there are estimated to be nearly 8,000 Connecticut assisted living units or apartments, some of which are spousal occupied or shared units. The average estimated cost in 2020 for traditional assisted living in Connecticut was $6,300 per month or $75,600 annually. Memory care services cost an additional 20-30%. This compares to the annual cost for traditional nursing home care of $155,125 (semi-private room) to $167,900 (private room).

The Department of Public Health provided us with a list of active managed residential communities as of April 30, 2021. With the exception of the publicly-funded assisted living facilities, nearly all managed residential communities and assisted living services agencies providing assisted living services are under the same ownership. **Exhibit 1** shows that approximately 60% of Connecticut assisted living facilities are part of national or regional chains and 18% are independently owned.

Exhibit 1. Ownership of Connecticut Assisted Living Facilities



When residents moved into assisted living 20 years ago, they were younger and healthier. As early residents aged in place and more people waited until their late 70s to mid-80s before entering

a managed residential community, there is an increased percentage of residents with chronic conditions, frailty, and a more severe acuity level. The Department of Public Health stated that the average age of assisted living residents is currently between 84 and 86 years old. DPH has concerns about the changing level of acuity of the residents. DPH and a local fire marshal referred to some assisted living memory care units as "miniature nursing homes" due to the level of care required. They identified assisted living memory care unit elopements (i.e., person unattended when leaving the memory care unit) as a challenge and ongoing concern because not all memory care units use the same safeguards that nursing home memory care units use.

Assisted Living Services Agencies (ALSA)

Section 19a-693 of the General Statutes defines an assisted living services agency (ALSA) as an entity, licensed by the Department of Public Health pursuant to chapter 368v that provides, among other things, nursing services and assistance with activities of daily living to a population that is chronic and stable. Activities of daily living are defined in statute as activities or tasks that are essential for a person's healthful and safe existence, including, but not limited to, bathing, dressing, grooming, eating, meal preparation, shopping, housekeeping, transfers, bowel and bladder care, laundry, communication, self-administration of medication and ambulation. ALSA provide nursing services and assistance with activities of daily living (ADL) to individuals aged 55 or older living within managed residential communities. ALSA cannot provide services outside of a registered MRC. ALSA are inspected by the Department of Public Health Facility Licensing and Investigations Section every two years and must adhere to DPH regulations. ALSA can only provide limited health care services. Residents must be chronic and stable as certified by a physician. Some may continue to reside in an MRC, receive assisted living services from an ALSA and supplement these services with private-duty caregivers.

Assisted living services agencies must develop and provide the resident with an individualized service plan within seven days of admission to the facility. This plan must include the resident's service needs, prices, identification of the providers, and the frequency of necessary services. The resident and community manager must reevaluate the plan quarterly.

Department of Public Health regulations specify that assisted living services agencies shall have a clients' bill of rights and responsibilities. The bill of rights must be explained and the ALSA must give a written copy to each client. It includes a description of available services, billing, complaint procedures, and right to refuse recommended services.

Managed Residential Communities (MRC)

Section 19a-693 of the General Statutes defines a managed residential community as a for-profit or not-for-profit facility consisting of private residential units that provides a managed group living environment consisting of housing and services for persons who are primarily fifty-five years of age or older. 'Managed residential community' does not include any state-funded congregate housing facilities. The statute defines private residential units as a private living environment designed for use and occupancy by a resident within a managed residential community that includes a full bathroom and access to facilities and equipment for the preparation

and storage of food. The operator of an MRC may also be licensed as an assisted living services agency. Core activities and services offered include:

- Three regularly-scheduled meals per day
- Regularly scheduled housekeeping, and laundry service
- Maintenance service and chores for the living units
- Transportation for certain needs
- Social and recreational activities
- 24-hour security and emergency call systems in each living unit

There are different levels of care and services in Connecticut's managed residential communities. Some offer both independent and assisted living apartments and others are mainly for individuals needing assisted living services. Some MRC also have secure units for residents with dementia and others serve only residents with dementia. Since the establishment of assisted living facilities in Connecticut, the resident population has become older and more acute. The differences between assisted living and nursing home populations have diminished, particularly for memory care units, age of entry into care, and complexity of needs.

The managed residential community building and basic core services such as meals, housekeeping, laundry, and transportation, are not licensed. However, the building must meet applicable building and fire safety codes. The MRC provider must register with the Department of Public Health Facility Licensing and Investigations Section (FLIS). MRC are not required to conduct employee background checks. However, the administrator and medical personnel (e.g., nurses and aides) must be licensed by DPH, which includes a comprehensive federal background check. Findings of elder abuse of any kind would disqualify a person from working as a nurse or administrator.

As required by statute, every managed residential community must have a written residents' bill of rights. The MRC must post these rights in a prominent place and include contact information for the Department of Public Health and the Long-Term Care Ombudsman Program. Rights include being treated with consideration, respect, and personal dignity, and all rights and privileges afforded to tenants under the tenant-landlord requirements. Residents must receive a copy of the MRC's rules or regulations.

Memory Care Units within Managed Residential Communities

As noted above, some managed residential communities also have secure units for residents with dementia or serve only residents with dementia. Section 19a-562 of the General Statutes defines Alzheimer's special care units or programs, associated definitions and disclosure requirements. This section of the statutes applies to assisted living facilities, nursing homes and other settings. It requires the unit to prevent or limit access to this separate area, and the unit's residents must have a diagnosis of Alzheimer's disease, dementia, or other similar disorder. The units are required to develop and provide a standard written disclosure form to the resident or legal representative, which the resident or responsible party must sign. The disclosure must explain the additional care and treatment the resident will receive that is different from others at the facility including:

1) Philosophy
2) Preadmission, admission, and discharge
3) Assessment, care planning and implementation
4) Staffing patterns and training ratios, and staff training and continuing education
5) Physical environment
6) Resident activities
7) Family role in care
8) Program costs

Disclosure forms must be reviewed annually to verify their accuracy and must be updated with any significant changes within 30 days of the change. Memory care units are statutorily required to provide at least eight hours of dementia-specific training annually to all licensed and registered direct care staff including the unit's nurse's aides. Direct care staff must also have at least two hours of training in pain recognition and administration of pain management techniques each year. All other unlicensed and unregistered unit staff must receive at least one hour of Alzheimer's and dementia training each year. This training is also required for memory care unit staff in nursing homes and assisted living.

Connecticut offers state and federally funded programs to help defray the high cost of assisted living. There are approximately 1,245 assisted living slots or apartments available to Connecticut residents across four programs described in **Appendix A**.

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

Department of Public Health Facility Licensing and Investigations Section (FLIS)

The Facility Licensing and Investigations Section (FLIS) is under the Healthcare Quality & Safety Branch of the Department of Public Health. FLIS is responsible for the initial and biennial renewal of assisted living services agencies' licenses including periodic on-site inspections and complaint handling. There are approximately 112 assisted living services agencies (ALSA) in Connecticut. ALSA provide 24-hour care, an on-site nursing staff, and help with daily activities such as bathing, dressing, grooming, eating, ambulating, transferring and toileting. *Assisted living facility* is not defined in Connecticut statutes, but apart from ALSA, the facilities are referred to as managed residential communities (MRC).

As part of its oversight of assisted living facilities, the Facility Licensing and Investigations Section receives and investigates complaints about assisted living services agencies. The Centers for Medicare and Medicaid Services (CMS) provides states with guidelines for conducting these complaint investigations. FLIS surveyors/investigators are also certified using a Surveyor Minimum Qualifications Test (SMQT) through CMS that requires mastery of complaint investigation guidelines found in Chapter 5 of the CMS State Operations Manual.

Complaints are triaged into priority levels:

- **Immediate Jeopardy (IJ)** - The most serious priority level is assigned when the provider's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.
- **Non-immediate Jeopardy (non-IJ High)** - A priority level 2 complaint is assigned when the provider's noncompliance may have caused harm that negatively impacted the individual's mental, physical and/or psychosocial status, and was of such consequence to the person's well-being that a DPH FLIS rapid response is indicated (e.g., verbal abuse, inappropriate use of physical or chemical restraint resulting in serious injury if it is clear that this is not an ongoing situation).
- **Non-immediate Jeopardy Medium (non-IJ Medium)** - A priority level 3 complaint, is assigned when the complaint alleges harm that is of limited consequence and does not significantly impair the person's mental, physical or psychosocial status to function (e.g., cold food, lost items, problems with odors). This is the most frequently used level.
- **Non-immediate Jeopardy Low (non-IJ-low)** - The rarely used priority level 4 complaint is assigned when the complaint alleges noncompliance with one or more requirements or conditions that may have caused physical, mental and/or psychosocial discomfort, but not injury or damage (e.g., housekeeping complaints, medication errors with no adverse consequences).

According to Department of Public Health officials, no assisted living services agency's license was suspended, revoked, or denied renewal during 2017-2019.

Exhibit 2 shows when investigations must begin for each of the priority levels.

Exhibit 2. Required Timeframes for Investigating Complaints

Priority Level	Onsite investigation must begin within
Priority 1: Immediate Jeopardy (IJ)	2 business days of receipt
Priority 2: non-IJ High	10 business days of prioritization
Priority 3: non-IJ Medium	45 business days of receipt
Priority 4: non-IJ Low	Must investigate during next (annual) onsite survey

Exhibit 3 shows that Priority level 3: non-IJ Medium make up the majority of assisted living services agencies complaints and incidents (self-reported by the assisted living services agency administrator). The actual number and percentage of complaints are shown.

Exhibit 3. Assisted Living Services Agencies Complaints and Incidents

	2017	2018	2019
IJ	0 (0%)	2 (1.4%)	0 (0%)
Non-IJ High	5 (3.1%)	24 (17.4%)	19 (16.4%)
Non-IJ Medium	135 (84.4%)	95 (68.8%)	87 (75.0%)
Non-IJ Low	0 (0%)	1 (0.7%)	4 (3.4%)
Not investigated by FLIS	20 (12.5%)	16 (11.6%)	6 (5.2%)
Total Complaints	**160**	**138**	**116**
IJ	0 (0%)	0 (0%)	2 (4.2%)
Non-IJ High	0 (0%)	3 (4.3%)	3 (6.3%)
Non-IJ Medium	34 (100%)	63 (91.3%)	41 (85.4%)
Non-IJ Low	0 (0%)	0 (0%)	0 (0%)
Not investigated by FLIS	0 (0%)	3 (4.3%)	2 (4.2%)
Total Incidents	**34**	**69**	**48**

Percentages may not total to 100% due to rounding.

Exhibit 4 shows quality of care/treatment as the most frequent type of non-immediate jeopardy medium priority complaint.

Exhibit 4. Non-IJ Medium Priority Complaints for Assisted Living Services Agencies

Allegation Category	2017	2018	2019
Quality of Care/Treatment	117 (73.1%)	59 (42.8%)	42 (36.2%)
Nursing Services	10 (6.3%)	29 (21.0%)	8 (6.9%)
Accidents	2 (1.3%)	1 (0.7%)	11 (9.5%)
Resident Abuse	1 (0.6%)	6 (4.3%)	5 (4.3%)
Resident Rights	2 (1.3%)	4 (2.9%)	2 (1.7%)
Resident Neglect	2 (1.3%)	1 (0.7%)	2 (1.7%)
Physical Environment	2 (1.3%)	1 (0.7%)	2 (1.7%)
Injury of Unknown Origin	0 (0%)	3 (2.2%)	2 (1.7%)
Misappropriation of Property	0 (0%)	2 (1.4%)	1 (0.9%)
Infection Control	1 (0.6%)	3 (2.2%)	2 (1.7%)
Admission, Transfer & Discharge Rights	0 (0%)	1 (0.7%)	2 (1.7%)
Other	23 (14.2%)	28 (20.4%)	37 (32.0%)
Total	**160 (100%)**	**138 (100%)**	**116 (100%)**

Facility Licensing and Investigations Section Findings and Recommendations

Finding 1: The Department of Public Health Facility Licensing and Investigations Section (FLIS) does not always send written confirmation to managed residential communities (MRC) upon receipt and acceptance of registration paperwork, leading to lack of formal documentation and proof of the MRC's registration.

One chain with more than one dozen assisted living facilities in Connecticut told us that the Facility Licensing and Investigations Section does not consistently send letters to managed residential community service coordinators (also referred to as administrators or executive directors) confirming the MRC's registration. For example, one of two recently-opened MRC received a letter confirming its registration. This same entity also said FLIS is inconsistent in sending registration letters when there is a change in MRC ownership.

Section 19-13-D105(c)(2) of the Regulations of Connecticut State Agencies states that once the Facility Licensing and Investigations Section has received a managed residential community's registration forms, it must notify the MRC in writing within 30 days that its forms are complete or that information is incorrect or incomplete.

Recommendation: The Department of Public Health should adhere to Section 19-13-D105(c)(2) of the Regulations of Connecticut State Agencies and send managed residential community service coordinators letters within 30 days confirming their registration including when there is a change of ownership. **(See Recommendation 1.)**

DPH Response "The Department agrees with this comment. FLIS has established a process to ensure compliance with section 19-13-D105(c)(2) of the Regulations of the Connecticut State Agencies. The process includes a standardized letter template regarding confirmation of a MRC's initial registration has been developed by FLIS. The template has been utilized by FLIS' licensure processing team since June 2021. In addition to confirming the initial registration, it is stated in the letter that the MRC is responsible for submitting a fire marshal's certificate of approval on an annual basis to FLIS, in accordance with Chapter 541 – Section 29-305 of the Connecticut General Statutes. Also, the letter reiterates the MRC's responsibility as far as notifying FLIS and completing an application (if required) for certain requested changes. Also, an electronic list of active MRCs is continually maintained in the State of Connecticut's e-License web portal."

Finding 2: There are statutory requirements for the operation of managed residential communities (MRC). However, there is no agency monitoring to determine if these requirements are being met, leading to potentially unsafe conditions for assisted living facility residents. While DPH monitors the care and services provided by assisted living services agencies (ALSA) during survey activities, it does not monitor the operation of residents living in MRC that do not receive ALSA services.

Public Act 07-2 enacted by the June 2007 Special Session of the General Assembly required the Department of Public Health (DPH) to review each managed residential community every two years and whenever it had reason to believe the MRC had violated certain requirements. The act also required DPH to receive and investigate complaints about MRCs. However, Public Act 09-3 enacted by the September 2009 Special Session of the General Assembly eliminated DPH's requirement to review all MRC operations every two years and investigate complaints about MRC violations of the law. The only reference we could find to the reason for this change was in the transcript summarizing Emergency Certified Bill 2051, An Act Implementing the Provisions of the Budget Concerning Public Health and Making Changes to Various Health Statutes: "We conform oversight of our managed residential communities, which people know as assisted living, to the budget and current practice." When asked why this change was made, one key stakeholder told us that after passage in 2007, DPH identified a lack of resources necessary to comply with the requirements. Another key stakeholder thought it was removed because of possible redundancy.

There are statutory requirements for managed residential communities operating in Connecticut including:

- Providing a written residency agreement to each resident;
- Providing residents with a written bill of rights;
- Giving residents access to assisted living services;
- Providing a security program to protect residents from intruders;
- Assisting residents with long-term care policies in submitting necessary claims paperwork;
- Allowing residents to present grievances and recommend changes in policies, procedures and services; and
- Adhering to state and federal laws governing confidential treatment of records and communications.

Since the Department of Public Health's oversight of managed residential communities was eliminated in 2009, no state agency has been responsible for ensuring that MRC adhere to statutory requirements. Minnesota was the only other state to register its MRC equivalent. However, a 2018 Minnesota evaluation concluded that because the state registers rather than licenses its MRCs no state agency confirms the information on the registration application is correct, no surveys/regular compliance inspections occur to ensure that they are complying with applicable registration requirements, and no violations can be cited.

The Department of Public Health is required to inspect the licensed assisted living services agencies every two years. This inspection must take place at the managed residential community. DPH could resume inspecting MRC every two years combining them with the ALSA inspections. DPH personnel and assisted living services coordinators informed us that sometimes Facility Licensing and Investigations Section inspectors of ALSA will see something wrong on the MRC side and try to address it by finding a way to link it to an ALSA deficiency. DPH told us of instances of burst pipes and air conditioning problems that lead to violations for failing to maintain a safe environment for ALSA clients. DPH could also provide oversight by resuming complaint investigations.

Recommendation: The Department of Public Health should resume biennial inspections and complaint investigations concerning violations of certain statutory requirements for managed residential communities. **(See Recommendation 2.)**

DPH Response "On October 6, 2009, legislation repealed in part, investigation of complaints and biennial inspections of managed residential care communities. The Facility Licensing and Investigations Section (FLIS) does not have authority to monitor the requirements of the MRCs. This recommendation would require enabling legislation and additional resources to conduct the inspection activities."

Finding 3: The Department of Public Health requires criminal background checks for certain assisted living services agency (ALSA) personnel but not for managed residential community personnel, potentially putting assisted living residents at risk for maltreatment.

The Department of Public Health Facilities Licensing and Investigations Section (FLIS) requires the same criminal background checks for ALSA personnel as they do for nursing home facilities since both are categorized as long-term care facilities in Section 19a-491c(a) of the General Statutes. All ALSA staff with direct access to residents, as determined by the ALSA, undergo criminal background checks. However, FLIS does not consider managed residential communities long-term care facilities, and therefore does not require criminal background checks for all MRC employees with direct access to residents (e.g., recreation directors and transportation providers). Elder abuse findings of any kind from the criminal background checks would disqualify a person from working as a nurse or administrator.

According to the Connecticut Assisted Living Association, most managed residential communities voluntarily conduct their own criminal background checks. We confirmed this in multiple interviews with service coordinators of assisted living communities. Since many are already conducting these background checks, a requirement should not be burdensome.

Recommendation: The Department of Public Health should require criminal background checks for managed residential community employees with direct access to residents. **(See Recommendation 3.)**

DPH Response "The enabling legislation for the criminal background check program was limited to long term care facilities as defined in section 19a-491c of the Connecticut General Statutes as follows, "Long-term care facility" means any facility, agency or provider that is a nursing home, as defined in section 19a-521, a residential care home, as defined in section 19a-521, a home health agency, as defined in section 19a-490, an assisted living services agency, as defined in section 19a-490, an intermediate care facility for individuals with intellectual disabilities, as defined in 42 USC 1396d(d), except any such facility operated by a Department of Developmental

Services' program subject to background checks pursuant to section 17a-227a, a chronic disease hospital, as defined in section 19a-550, or an agency providing hospice care which is licensed to provide such care by the Department of Public Health or certified to provide such care pursuant to 42 USC 1395x.

This recommendation would require a statutory change"

Finding 4: The Department of Public Health Facility Licensing and Investigations Section (FLIS) Assisted Living Services Agency Licensure Inspection Procedures were last revised on October 6, 1995, making them out-of-date. This could lead to an incomplete review of licensure requirements.

The Facility Licensing and Investigations Section provided us with a copy of its Assisted Living Services Agency (ALSA) Licensure Inspection Procedures that had an original date of July 25, 1995, and revised date of October 6, 1995. In the past 25 years, there have been changes to the regulation of assisted living services agencies. For example, the current ALSA licensure inspection procedures exclude reference to review of the ALSA Individualized Service Plan, a requirement that was added in 2007. Many of the estimated 187 memory care units or facilities in Connecticut are now located in assisted living facilities, but the inspection procedures do not mention memory care units. The inspection procedures also do not ask for evidence of completion of training requirements added since 1995, particularly for dementia training.

Recommendation: The Department of Public Health Facility Licensing and Investigations Section should update its Assisted Living Services Agency Licensure Inspection Procedures. **(See Recommendation 4.)**

DPH Response "DPH has a priority list of regulations that need to be reviewed and revised. ALSAs are on this list and plan to review within the next three (3) years."

Finding 5: The Department of Public Health Facility Licensing and Investigations Section (FLIS) does not always report licensure inspection and complaint investigation results in a timely manner, making it difficult for assisted living services agencies (ALSA) to promptly correct deficiencies.

Unlike nursing home inspections or investigations in which the Facility Licensing and Investigations Section mails the provider a copy of deficiencies within ten working days after the inspection survey, there is no similar requirement for oversight of assisted living services agencies. Section 19a-496(b) of the General Statutes states that upon finding noncompliance with statutes or regulations, the Department of Public Health (DPH) shall issue a written notice of noncompliance to the institution, including assisted living services agencies. Within ten days of receipt of this notification, the assisted living services agency must submit a plan of correction to DPH. No reference is made to the time in which FLIS must notify the noncompliant ALSA.

In interviews with assisted living facilities, we were told of instances in which the supervisor of assisted living services for the ALSA received a letter of violation six months to one year after the FLIS biennial inspection or complaint investigation. This delays the development of a plan of

correction to address the deficiencies. Assisted living administrators would like to quickly know of problems FLIS identifies so they may address them in a timely manner. The assisted living services agencies also do not receive notification when they are fully compliant. Administrators are not immediately sure of the results of inspections or investigations.

Recommendation: The Department of Public Health should establish deadlines for notifying the assisted living services agency of inspection and complaint investigation results and inform the assisted living services agencies when it will communicate those results. **(See Recommendation 5.)**

DPH Response "The Department agrees with this response. The Supervisor of the ALSA unit is required to conduct a quality assurance review of the findings for surveys/complaints before the correspondence is issued to the administrators/executive director. Work is prioritized and triaged so depending on the workload, findings may be issued at different times. A policy and procedure will be developed which will include establishing timeframes of review and dissemination to the provider. Once developed, communication to the provider industry will be completed."

Finding 6: The Department of Public Health Facility Licensing and Investigations Section does not notify the managed residential community (MRC) within which the assisted living services agency (ALSA) operates of ALSA noncompliance or a required corrective action plan report, potentially leading to lack of awareness of ALSA deficiencies in services provided to its residents.

The Department of Public Health Facility Licensing and Investigations Section (FLIS) inspects assisted living services agencies every two years and investigates complaints made against them. Any correspondence associated with these activities is limited to the supervisor of assisted living for the ALSA, since FLIS only has oversight of the ALSA portion of the assisted living facility. If the ALSA is not under the same ownership as the managed residential community, then the MRC may be unaware of any violations of state statutes and/or regulations uncovered during an inspection or complaint investigation. The MRC employs the ALSA and as such, should know when FLIS finds deficiencies in the entity that the MRC employs. Because there are rare occasions in which the MRC and ALSA are separately owned, it would be beneficial for DPH to inform both of inspection and investigation results, including instances in which there are no findings or deficiencies.

Recommendation: The Department of Public Health Facility Licensing and Investigations Section should inform the managed residential communities in which an assisted living services agency operates of results of inspections and complaint investigations. **(See Recommendation 6.)**

DPH Response "On October 6, 2009, legislation repealed in part, investigation of complaints and biennial inspections of managed residential care communities. FLIS does not have authority to monitor the requirements of

the MRCs. This would require a statutory change and additional resources to comply with the inspection activities."

Finding 7: There are minimal staffing requirements for memory care units in assisted living facilities, leading to potentially insufficient resources for this vulnerable population.

Section 19-13-D105(j) of the Regulations of State Agencies identifies the following assisted living services agency staffing requirements:

- Supervising registered nurse on-site at least 20 hours per week for each 10 full-time equivalent (FTE) licensed nurses or assisted living aides, or at least 40 hours per week for each 20 FTE licensed nurses or assisted living aides, referred to as the director of nursing, or SALSA
- One additional licensed nurse at least 10 hours per week for every 10 or less FTE assisted living aides beyond the 20 FTE licensed nurses or assisted living aides
- Designated on-call registered nurse

It is common for facilities to charge higher rates for assisted living residents in memory care units. However, there are no minimum requirements for the number of assisted living aides needed per resident. There are also no minimum requirements for therapeutic recreational staff or other program staff/specialists that may serve this population.

While one key stakeholder stated that assisted living memory care unit residents are higher functioning than residents in nursing home memory care units, others stated that assisted living memory care units are just like memory care units in nursing homes. Department of Public Health (DPH) officials are concerned about inadequate staffing for memory care units. In particular, they are concerned about the lack of on-site nursing staff outside of regular hours. DPH told us that some assisted living memory care units are only run by aides in the evening when there would be an expectation for around-the-clock nursing for memory care units with acute residents.

To illustrate a potential result of insufficient staffing requirements, the Long-Term Care Ombudsman gave us an example of an assisted living memory care unit resident who fell out of bed at night and remained on the floor for many hours because no one was periodically checking on residents through the night.

Recommendation: The Department of Public Health should establish minimum staffing requirements for assisted living memory care units. **(See Recommendation 7.)**

DPH Response "DPH has a priority list of regulations that need to be reviewed and revised. ALSA regulations are on this list and staffing requirements for the memory care units will be considered."

Finding 8: Connecticut assisted living regulations require the supervising registered nurse and designated on-call registered nurse to have experience working for a home health care agency or community health program, making it difficult to fill these positions.

Connecticut assisted living regulations require the supervisor of assisted living services for the assisted living services agencies to be a Connecticut registered nurse (RN) with two to four years of clinical experience, at least one of which must be in a home health care agency or community health program setting that included care of the sick at home. Similarly, the on-call RN designated for times when the supervising nurse is not present, must have at least two years of clinical experience, at least one of which must be in a home health care agency or community health program setting.

Assisted living personnel told us that it is challenging to find registered nurses with this particular experience. We were told there are a limited number of RNs with this experience and the requirement rules out many RNs who would otherwise be deemed qualified for the position. There is a process in place to request a waiver from the Department of Public Health for this requirement. However, we were told that DPH rarely grants the waiver.

Some assisted living personnel have suggested expanding the requirement to allow case management experience in any health care setting, not just a home health care agency or community health care program. Others have suggested that the experience called for in this requirement can be learned or taught, and that registered nurses can fulfill this requirement within 6-12 months of hire through online courses and/or mentoring by another RN with this experience.

Recommendation: The Department of Public Health should amend its assisted living regulations to allow supervising registered nurses and designated on-call registered nurses to substitute case management experience in any health care setting, or mentoring or training initiated within 90 days of hire, in place of the currently required one year of experience working for a home health care agency or community health program. **(See Recommendation 8.)**

DPH Response "The Department agrees with this comment. Over the last few years, the Department has approved waivers to allow candidates to work with nursing home experience to meet the requirement for care of the sick at home. DPH has a priority list of regulations that need to be reviewed and revised. ALSA regulations are on this list and revision to the Supervisor of the ALSA requirements will be considered."

Finding 9: Assisted living facilities must store medication in the residents' rooms, causing a potentially unsafe situation for some residents.

Section 19-13-D105(h)(4)(F) of the Regulations of State Agencies requires all medication be stored in the client's private residential unit. If a resident is receiving medication management services, then narcotics must be kept in a secure locked box in the resident's apartment. At least 1-2 times per day, a licensed nurse must go to each apartment, open the lockbox with a key or combination lock and do a narcotics count.

We were told of instances in which residents broke into their lock boxes using a butter knife or learned the combination code and accessed their medication. In addition to resident safety concerns, this process reduces nursing time with residents. For example, one facility estimated the nurse needed 45-60 minutes for the narcotic count. Department of Public Health personnel told us they were concerned about assisted living staffing patterns, particularly for nurses in memory care units. Having centralized, secure narcotic storage could reduce the time nurses spend on narcotic counts and increase nursing availability for residents.

Recommendation: Section 19-13-D105 of the Regulations of State Agencies should be amended to permit storage of medication in a centralized, secure place for residents requiring medication administration assistance. **(See Recommendation 9.)**

DPH Response "The Department agrees with this comment. The Department has approved waivers to permit centralized medication storage with policies and procedures in place for safety. ALSA regulations are on this list to be reviewed and revised and alternate medication storage will be considered."

Finding 10: Connecticut currently limits medication administration in assisted living facilities to licensed assisted living services agency (ALSA) personnel, contributing to residents' high assisted living costs.

Assisted living facility directors estimated approximately 75% to 91% of assisted living residents receive assistance with medication administration, with a higher rate for residents in memory care units.

The Department of Public Health requires licensed nurses to administer medication at managed residential communities. Section 19-13-D105(h)(4)(C) of the Regulations of Connecticut State Agencies restricts unlicensed assisted living aides to supervising the resident's self-administration of medications including reminding resident to take medication, verifying that medication was taken, or opening bottles or bubble packs if the resident cannot do so.

Section 19-13-D6(m) of the Regulations of Connecticut State Agencies permits unlicensed personnel at residential care homes (often referred to as homes for the aged or rest homes) to administer medication if they have been trained and certified. The Certified Nurse Aide or aide must receive training from a registered pharmacist, physician, physician assistant, registered nurse, or advanced practical registered nurse in the methods of medication administration. The person must also successfully complete a written examination and practicum administered by the Connecticut League for Nursing or other DPH-approved certifying organization.

According to DPH officials, medication administration in assisted living facilities is a gray area. For example, aides are permitted to remind or cue residents on their medication, but it is unclear what constitutes cuing, particularly for memory care unit residents. Assisted living facility directors also told us that the requirement for medication administration by licensed nurses increases the cost of assisted living to residents.

Recommendation: Section 19-13-D105 of the Regulations of State Agencies should be amended to permit unlicensed assisted living services agency personnel to be trained and certified to administer certain medication. **(See Recommendation 10.)**

DPH Response "Currently, medication administration by unlicensed personnel with appropriate training and certification is permitted in residential care homes and in the home care setting. DPH has a priority list of regulations that need to be reviewed and revised. ALSA regulations are on this list and medication administration by unlicensed staff will be considered"

Finding 11: Falls are a common occurrence at assisted living facilities, but many of residents' personal emergency alert necklace pendants or bracelets do not contain fall detection technology.

According to the U.S. Centers for Disease Control and Prevention (CDC), one-fourth of Americans aged 65 and older fall each year, and falls are the leading cause of fatal and nonfatal injuries for this age group. Many assisted living facilities offer medical alert systems that allow residents to press a button on a pendant necklace or bracelet to alert staff in case of an emergency. Some medical alert systems also have fall detection technology that automatically notifies staff of a fall.

We were told of an assisted living resident who fell at approximately 9 p.m. and remained on the floor unattended and in pain for 12 hours. The situation was documented through a camera the resident's family placed in her room. We interviewed several assisted living administrators and none of them currently had fall detection as part of their personal emergency alert systems. Fall detection technology can alert staff and provide residents with faster assistance.

Recommendation: Assisted living facilities should consider upgrading their medical alert systems to offer fall detection technology to residents. **(See Recommendation 11.)**

Finding 12: The term assisted living facility is referenced in statute, but not defined, creating possible confusion.

Although there is currently no definition of assisted living facility in the General Statutes, the term assisted living facility or assisted living facilities is used in the following ten statutory sections:

1. Supervised absentee voting by patients at institutions upon request of registrar, administrator. Supervised absentee voting by applicants from same street address at discretion of registrars (Section 9-159q of the General Statutes)
2. Exemptions (Section 12-412 of the General Statutes)
3. Fall prevention program (Section 17a-303a of the General Statutes)
4. Resident health care rights and protections (Section 17b-523c of the General Statutes)

5. Regulations re standards for hospital discharge planning. Caregiver designation and training (Section 19a-504c of the General Statutes)
6. Nursing home facility discharge. Caregiver instruction and training requirements (Section 19a-535c of the General Statutes)
7. Alzheimer's special care units or programs. Definitions. Disclosure requirements (Section 19a-562 of the General Statutes)
8. Confirmation of identification prior to release of controlled substance (Section 20-612a of the General Statutes)
9. Department of Veterans Affairs. Veterans Residential Services facility. Office of Advocacy and Assistance. Powers and duties. Regulations (Section 27-102*l* of the General Statutes)
10. Pharmacy audits (Section 38a-479iii of the General Statutes)

Some key stakeholders view use of the word "facility" negatively as implying an institutional setting rather than its intended community, home-like setting. However, the term "assisted living facility" is used by many organizations including the Centers for Disease Control (CDC), National Institute on Aging, and Connecticut Care Planning Council. A statutory definition of "assisted living facility" that refers to the combination of managed residential communities and assisted living services agencies would clarify the term.

Recommendation: The General Statutes should be amended to define assisted living facility as a managed residential community that offers its residents nursing services and assistance with activities of daily living through an assisted living services agency. **(See Recommendation 12.)**

Finding 13: The current assisted living services agency (ALSA) regulations have out-of-date references and omissions, making them inaccurate.

Section 19-13-D105 of the Regulations of State Agencies (RCSA) (Assisted living services agency) was last updated June 29, 2001. There are currently two instances in which the regulations are no longer correct and four instances in which changes since 2001 are not included:

Regulation Inaccuracies:

- The definition of Commissioner refers to the Commissioner of the Department of Public Health and Addiction Services, or the commissioner's representative. It should be changed to the Commissioner of the Department of Public Health, or the commissioner's representative. (Section 19-13-D105(a)(7) of the RCSA)

- The definition of Department refers to the Connecticut Department of Public Health and Addiction Services. It should be changed to the Department of Public Health. (Section 19-13-D105(a)(10) of the RCSA)

Regulation Omissions:

- The regulations omit the resident's bill of rights for residents of managed residential communities (Section 19a-697 of the General Statutes), effective October 1, 2007.

- The regulations omit the residency agreement and 24-hour skilled nursing care which prohibits a managed residential community (MRC) from entering into a written residency agreement with anyone who requires 24-hour skilled nursing care unless they establish to the MRC's and assisted living services agency's satisfaction that they have, or have arranged for, such 24-hour care and maintain it as a condition of residency if an ALSA determines that such care is necessary (Section 19a-698 of the General Statutes), effective October 1, 2007.

- The regulations omit reference to the ALSA Individualized Service Plan (ISP) which is completed after consulting with the resident and following a registered nurse's assessment. The ISP is developed and maintained for any managed residential community resident who receives assisted living services. The plan must describe in lay terms the individual's need for such services; the providers or intended providers of needed services; the scope, type, and frequency; itemized costs of such services; and other information the Department of Public Health may require. The ISP and any associated periodic revisions must be confidential and signed by the resident (or the resident's legal representative) and an ALSA representative. It must also be available for inspection by the resident and DPH. This became effective October 1, 2007.

- The regulations omit reference to a written residency agreement, which is required to be entered into between an MRC and resident. The residency agreement clearly sets forth the resident's and the MRC's rights and responsibilities, including rights under PA 06-195, which set requirements for facilities with Alzheimer's special care units or programs. The agreement must be in plain language, at least 14-point type, and signed by the MRC's authorized agent and the resident before the resident takes possession of a private residential unit. It must include, at a minimum:

    1) Itemization of assisted living services, transportation services, recreation services, etc., and itemization of goods, lodging and meals
    2) Full disclosure of all charges, fees, expenses, costs to resident
    3) Payment schedule and disclosure of all late fees or potential penalties
    4) Grievance procedure re enforcement of agreement
    5) MRC to comply with all municipal, state, federal laws and regs regarding consumer protection and protection from financial exploitation
    6) MRC to give residents all rights and privileges under title 47a
    7) Conditions of termination by either party
    8) Full disclosure of rights and responsibilities of resident and MRC when resident has serious health deterioration, hospitalization, death; also must include provision

that specifies when resident dies, the estate or family is only responsible for no more than 15 additional days of payment as long as unit has been vacated

9) MRC rules designed to promote the health, safety and welfare of residents

Recommendation: Section 19-13-D105 of the Regulations of State Agencies needs to be updated to include statutory and other changes since 2001. **(See Recommendation 13.)**

DPH Response "DPH has a priority list of regulations that need to be reviewed and revised. ALSA regulations are on this list and the recommended changes will be considered. The recommendations require a statutory change."

The State Long-Term Care Ombudsman Program (LTCOP)

Mandated by the federal Older Americans Act and Chapter 319h of the General Statutes, the State Long-Term Care Ombudsman Program (LTCOP) protects and promotes the rights and quality of life for residents of managed residential care communities (also known as assisted living facilities). Located within the Connecticut Department of Aging and Disability Services, the current State Long-Term Care Ombudsman, eight regional ombudsmen, and seven certified volunteer residents' advocates provide a voice to residents' concerns and empower residents to have a voice in ensuring their rights. This is accomplished through individual consultation and complaint resolution and work with other state agencies and advocacy organizations. The regional ombudsmen are each assigned to cover a portion of Connecticut. They identify, investigate, and resolve complaints made by or on behalf of residents in nursing homes, residential care homes and assisted living facilities in their assigned territories.

Under supervision of regional ombudsmen, the volunteer residents' advocates are assigned to one nursing home facility and required to spend four hours a week at the home helping to resolve complaints and be the "eyes and ears" for the regional ombudsmen. **Exhibit 5** summarizes the efforts of the State Long-Term Care Ombudsman Program.

Exhibit 5. Efforts of the State Long-Term Care Ombudsman Program Information

Effort	2018	2017	2016	2015
Complaints Received	3423	3090	3044	2694
Cases Opened	1964	1791	1809	1635
Nursing Home Visits for Other than Complaints	38	**	**	**
Facility Visits (Nursing Home, Residential Care Homes and Assisted Living Facilities)	**	290	272/205*	290
Consultations to Individuals	363	400	960	1,096
Consultations to Facilities	340	231	235/248*	201
Training Sessions for Ombudsman Staff and Volunteers	91	91	100	118
Licensure and Certification Survey	49	51	89	93
Community Education Presentations	39	48	68/78*	116
Training to Facility Staff	1	7	12	25
Nursing Home Closures	5	4	6	2
Resident Council Meetings Attended	**	**	204	**

Source: 2015-2018 State Long-Term Care Ombudsman Program Annual Reports
*Different numbers listed in the annual report
** Reporting not listed

Long-Term Care Ombudsman Program Findings and Recommendations

Finding 14: The Long-Term Care Ombudsman Program does not specify the frequency of non-complaint visits to managed residential communities, making expectations unclear and accountability difficult for consumers, providers, and other stakeholders.

Of the 142 assisted living facilities in Connecticut, Long-Term Care Ombudsmen personnel visited 52 (37%) at least once during FFY 2018. In contrast, LTCOP visited 90% of nursing homes at least once during that same time period.

The Long-Term Care Ombudsman Program (LTCOP) visits less than half of managed residential communities annually providing less oversight than nursing homes. Like nursing home residents, assisted living residents are a vulnerable population and oversight is important.

State statute, and state and federal regulations require the Long-Term Care Ombudsman Program to ensure that assisted living residents have “regular and timely access” to the program. LTCOP does not have minimum visitation standards to ensure regular and timely access to assisted living facilities and residents. Federal guidance strongly encourages states to develop minimum standards to provide consumers, providers, and other stakeholders with an expectation of regular visits and program accountability.

While limited staffing is a sizable barrier, development of an expectation of Long-Term Care Ombudsman Program visitation to assisted living facilities would be useful in resource allocation and future planning efforts.

Recommendation: The State Long-Term Care Ombudsman should develop a minimum standard of frequency of non-complaint visits to managed residential

communities and amend section 17a-408 of the General Statutes to reflect that standard. Section 17a-417 of the General Statutes should be amended to require the State Long-Term Care Ombudsman's annual report to include outcomes of meeting the visitation standard and each facility's visitation frequency. **(See Recommendation 14.)**

LTCOP Response "The LTCOP received approval to cover this setting, however the funding was never approved. The program supports and represents this setting within available time and financial ability. A commitment as presented above would require more staff and committed funding."

Finding 15: There are no volunteer residents' advocates assigned to assisted living facilities, leading to a lack of oversight and advocacy for residents.

Under supervision of regional ombudsmen, the volunteer residents' advocates (RA) are assigned to one nursing home. They are required to help resolve complaints, advocate for residents, and to be the "eyes and ears" for the regional ombudsmen. There are challenges in recruiting and retaining volunteer residents' advocates due to time constraints, volunteers aging, lack of appreciation, and family responsibilities. Currently, there are only seven RA assigned to all long-term care facilities.

According to the ombudsman, residents' advocates are not currently assigned to managed residential communities and the current priority is nursing homes. Although the ombudsman gives priority to volunteers in nursing homes, some RA might be better suited or interested in volunteering in managed residential communities, potentially providing expanded coverage and increased retention of LTCOP volunteers.

Recommendation: The State Long-Term Care Ombudsman should consider recruiting and assigning volunteer residents' advocates to assisted living facilities. **(See Recommendation 15.)**

LTCOP Response "The LTCOP has had a significant decrease in the number of volunteers over the past 15 years. Currently there are not enough volunteers to cover the nursing homes. The LTCOP needs a position for a Volunteer Coordinator. If the program had enough volunteers, then the State Ombudsman could begin to assign volunteers to Managed Residential Communities."

Finding 16: There is no comprehensive assisted living resource available on a single, government-sponsored website, leading to a lack of readily accessible, independent consumer information.

We have been told by key stakeholders that consumers are not educated on assisted living issues. Consumers do not know where to access information about assisted living services agencies and managed residential communities and lack a basic understanding of the services and related

terms (i.e., assisted living). It is also difficult for consumers experiencing a health crisis to quickly find assisted living information.

A Place for Mom, founded to help families navigate senior housing options, maintains a website with free resources to help seniors and families find assisted living facilities, dementia care, Alzheimer's memory care, and nursing homes. A Place for Mom created a State Guide to Assisted Living Records and Reports. This guide is a detailed snapshot of each state's accessibility to public information regarding assisted living licensure, monitoring, and deficiency reporting. States are ranked from basic, moderate, high, and exceptional. Connecticut was ranked moderate because it has online directories of licensed communities but does not have a searchable database. The database also lacks information about inspections and regulatory actions. Connecticut ranked lower than New York ("exceptional") and Rhode Island ("high").

The Connecticut Assisted Living Association (CALA) website provides an assisted living locator with a map, contact information and addresses for each of their providers. The LeadingAge Connecticut website has a directory of their non-profit providers with their names, locations, websites, and phone numbers. Many people go to resources such as the MS Society, AARP CT, or the CT Alzheimer's Association for information and they are directed to MyPlaceCT.org for assisted living information. The MyPlaceCT.org website was developed in collaboration with partner state agencies and is administered by the Department of Social Services. My Place CT is intended to provide older adults living at home or in the community with access to information about their options and to support their decision making, but there is limited information on this platform about managed residential communities. There is a CALA consumer guide linked on this page. While it includes a general description of assisted living, it does not provide detailed pricing information, a searchable listing of all facilities, a direct link to assisted living services agency inspection reports, and administrator contact information. My Place CT has the potential to be a public, independently sponsored government source of assisted living information for consumers including a searchable listing of all facilities, pricing, a link to ALSA inspection reports, and administrator contact information.

Recommendation: The General Assembly should establish a workgroup to develop a comprehensive assisted living facilities resource on the My Place CT website. Members of this workgroup should include representatives from the departments of Social Services and Public Health, the Long-Term Care Ombudsman, Connecticut Commission on Women, Children, Seniors, Equity & Opportunity, the Connecticut Assisted Living Association, LeadingAge Connecticut, and 2-1-1 Info-Line. The guide should have a searchable listing of all assisted living facilities, pricing, fees, Department of Public Health assisted living services agency inspection reports, and administrator contact information. **(See Recommendation 16.)**

DSS Response "The Department believes that a comprehensive assisted living facilities resource website would be a positive enhancement to the program. If directed by the General Assembly through statute to participate in a workgroup for this purpose, the Department would welcome the

opportunity to participate but would require additional staff resources and program funding."

DPH Response "This recommendation requires a statutory change; it is up to the General Assembly to do this."

CWCSEO Response "CWCSEO agrees with the recommendation of Finding 16."

Finding 17: There is no checklist or guide for consumers to use when visiting assisted living facilities, leading to less than optimal decision making for older adults and their families.

Consumers may not know what questions to ask or what to look for when selecting an assisted living facility. Often family members are looking for options during times of crisis or emergency. Some key stakeholders told us managed residency agreements lack information and are unclear to the consumer. The State Long-Term Care Ombudsman has created a two-page "Brochure of Assisted Living Facility Resident Rights." By building on this brochure, the ombudsman can provide consumer guidance on questions to ask and what to look for when visiting assisted living facilities. The checklist or guide would also help consumers better understand residency agreements.

Recommendation: The State Long-Term Care Ombudsman should develop a checklist or guide with questions for consumers to ask when visiting assisted living facilities. **(See Recommendation 17.)**

LTCOP Response "The LTCOP will consider, but feel this should be done jointly with DPH."

Department of Social Services Protective Services for the Elderly Program (PSE)

Connecticut's Protective Services for the Elderly Program (PSE), administered by the Department of Social Services (DSS), was established in 1978 pursuant to Sections 17b-450 through 17b-461, inclusive, of the General Statutes. DSS workers investigate reports of known or suspected physical, mental, and emotional abuse, neglect, and abandonment and/or financial abuse and exploitation of adults ages 60 and over who are living in the community, including in assisted living facilities.

A centralized intake unit receives all reports and determines if the report meets the criteria for the Protective Services for the Elderly Program, such as age, state of residence, and reason for call. Additionally, PSE can receive reports of elder maltreatment by fax or mail on standardized forms. In 2019, 66% of all reports were accepted for investigation by the intake unit. Of the accepted reports, approximately 1% related to residents of assisted living facilities. Accepted reports are distributed to one of ten regional supervisors for assignment to a social worker. The social worker meets in person with the elder to identify unmet needs and develop a comprehensive plan to

address their needs. When necessary, staff will intervene immediately to safeguard the individual's health and well-being.

From 2017 to 2019, the program has served an increasing number of elders (**Exhibit 6**). However, the number of elders served in an assisted living setting has remained stable. DSS does not make a distinction between clients living in assisted living or other community residences. A manager at a publicly funded assisted living facility suggested that the facility would access the Protective Services for the Elderly Program more often if the program had more resources. The number of cases referred to PSE from assisted living may be artificially low due to a perceived lack of resources.

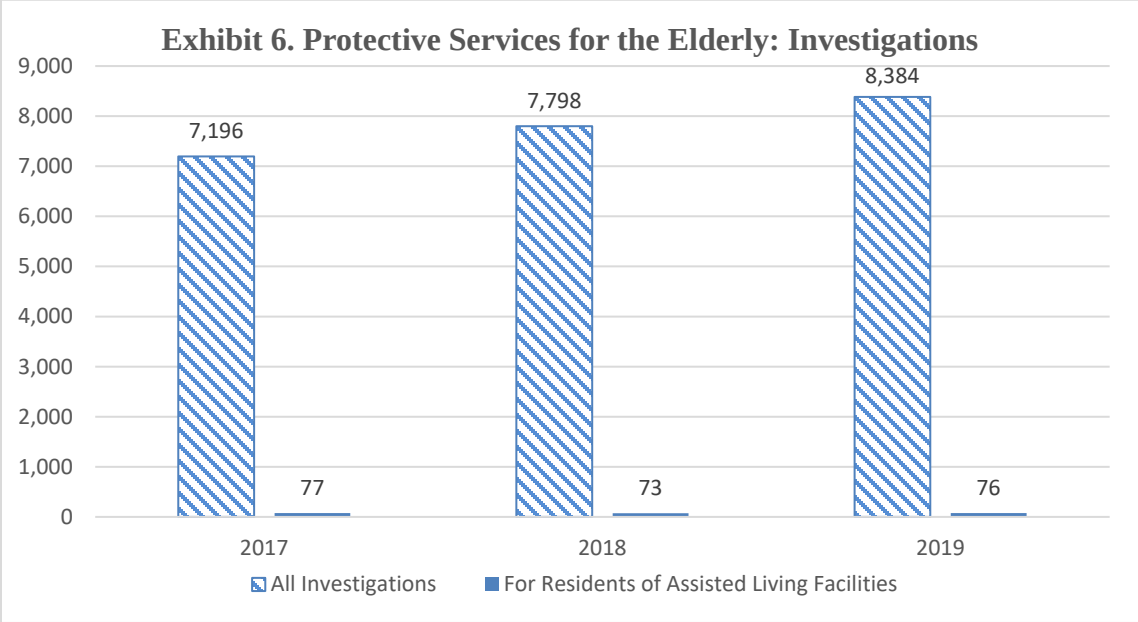


Exhibit 7 shows that, relative to all other elder maltreatment reports, assisted living facility reports were twice as likely to be for physical abuse and significantly less likely to be for self-neglect.

Exhibit 7. Frequency of Allegations Reported to PSE 2017-2019

Allegation*	% of PSE Reports with this Allegation (Excluding Assisted Living)	% of PSE Reports for Assisted Living Residents with this Allegation
Self-Neglect	44.0%	15.9%
Physical Abuse	10.3%	21.2%
Emotional Abuse	19.4%	12.8%
Neglect	31.5%	35.0%
Exploitation	36.4%	38.9%

Sexual Abuse	0.5%	1.3%
Abandonment	0.5%	0.4%
Total Reports	**20,905**	**226**
***More than one allegation may be included in a single PSE report.**		

Protective Services for the Elderly Findings and Recommendations

Finding 18: Assisted living facilities are not required to post Protective Services for the Elderly Program (PSE) contact information, creating a barrier to reports of suspected elder maltreatment at assisted living facilities.

Only 1% of the Protective Services for the Elderly complaints were from assisted living facilities in 2019. Section 19a-697(b) of the General Statutes requires managed residential communities to post the resident's bill of rights in a prominent place. The bill of rights must include contact information for the Long-Term Care Ombudsman and Department of Public Health. It would be beneficial to also provide the consumer with contact information for the Protective Services for the Elderly Program. Maine, for example, provides a posting for Adult Protective Services at its assisted living facilities.

Some assisted living facility administrators have told us they already post Protective Services for the Elderly contact information. Adding this requirement may encourage more reporting of suspected elder maltreatment.

Recommendation: Section 19a-697(b) of the General Statutes should be amended to require managed residential communities to post Department of Social Services Protective Services for Elderly Program's contact information. **(See Recommendation 18.)**

DSS Response "The Department believes that the recommended amendment to Section 19a-697(b) would increase awareness of the Protective Services for the Elderly Program and would be a positive enhancement to the program. The Department will discuss this recommendation and pursue the proposed statutory amendment with the Department of Public Health."

Finding 19: The Department of Social Services Protective Services for the Elderly Program (PSE) does not categorize assisted living allegations, potentially overlooking significant differences between the assisted living and other community-based clients.

The Protective Services for the Elderly Program maintains a database of reports of alleged elder abuse, neglect, exploitation and abandonment (i.e., elder maltreatment). One of the pieces of information PSE collects describes the elder's living situation (e.g., living alone, with spouse, with children).

Residency in an assisted living facility is not currently captured in the PSE database. Adding this information could result in PSE staff training and interventions beneficial to assisted living facility residents.

Recommendation: The Department of Social Services Protective Services for the Elderly Program database should include assisted living residency. **(See Recommendation 19.)**

DSS Response "The Department agrees with this recommendation but notes that it would require a modification to the Social Work case management database. The Department will explore possible future modifications that could align with this recommendation."

Fire Marshals

Finding 20: Local fire marshals are statutorily required to conduct annual inspections of managed residential communities. Due to limited resources and lack of prioritization, these inspections may not be occurring every year in certain communities.

Managed residential communities (MRCs) located in buildings with a residential building code designation are registered by the Department of Public Health (DPH), but DPH does not conduct building inspections. Rather, section 29-305(b) of the General Statutes requires local fire marshals to conduct annual fire safety inspections, in accordance with the Connecticut State Fire Prevention and Safety codes. The inspections cover all aspects of the codes including the proper operation of emergency lights and doors, handrails safety, and ensuring that exits are not blocked.

Local fire marshals report insufficient resources to conduct all statutorily required building inspections. In addition, there are no oversight mechanisms in place to ensure these inspections occur. The lack of resources and oversight may lead to a delay in inspections, which increases the risk to residents. If the Department of Public Health required the facility to show proof of its annual inspections and any corrective action plan, owners of assisted living facilities may prioritize inspections. DPH staff told us that they support requiring managed residential communities to provide proof of annual fire marshal inspections to maintain their registration.

Recommendation: The Department of Public Health should require an annual fire marshal safety inspection report for managed residential communities to maintain their registration. **(See Recommendation 20.)**

DPH Response "This recommendation requires a statutory change."

Finding 21: Some local fire marshals believe they cannot apply the more stringent institutional inspection criteria when conducting fire safety inspections of assisted living facilities, leading to concern about potential significant loss of life.

Connecticut's fire safety inspection requirements are very complex, and involve statutes, regulations, and several code books. Assisted living facilities are not clearly categorized in the fire codes and can be inspected under the residential or institutional use code depending on certain factors. Those factors include the number of residents, level of care, living arrangements, and residents' ability to self-preserve or evacuate without direct intervention, in case of an emergency. The Office of the State Fire Marshal told us that the institutional use code should be applied when most of the individuals in facilities with more than 17 residents are not capable of self-preservation.

Due to the various types of assisted living facilities, it can be challenging to determine which fire inspection criteria are most appropriate for each facility. These complexities led to differences in how local fire marshals interpret and apply the fire code to assisted living facilities. Local fire marshals do not always know which use code to apply. Some local fire marshals believe they can only use the residential code for assisted living facilities when they could be inspected under the more stringent institutional use code.

Inspecting assisted living facilities with memory care units under the residential use code is of particular concern. One assisted living facility suggested that none of their memory care residents are capable of self-preservation, while another facility has only 5 of 89 (6%) residents that can exit without assistance. Local fire marshals expressed concern about the potential of significant loss of life in these facilities in the case of a fire. They are also frustrated that they cannot effectively apply the institutional use fire inspection code. It appears that if the institutional fire inspection code was applied to assisted living facilities, they would have to increase their staffing to ensure the safe evacuation of residents. The fire marshals are also concerned about fire drills as there are different requirements within the different use codes, and this ambiguity may put residents and staff in danger.

The Department of Administrative Services Codes and Standards Committee is responsible for adopting a state building code. The committee has a Codes Amendment Subcommittee that works with staff from the offices of the State Building Inspector and State Fire Marshal to adopt state building and fire safety codes. The subcommittee meets regularly to consider proposals for changes to the code.

Recommendation: The state fire marshal should work with the Codes and Standards Committee to clarify whether local fire marshals should use residential or institutional fire code requirements when inspecting assisted living facilities. **(See Recommendation 21.)**

Licensure of Assisted Living Facilities

Finding 22: The Department of Public Health Facility Licensing and Investigations Section (FLIS) registers rather than licenses managed residential communities. This may provide inadequate oversight and lead to insufficient consumer protections for assisted living residents.

Managed residential communities (MRC) are registered with the Department of Public Health Facility Licensing and Investigations Section (FLIS) and are not licensed. FLIS does not verify the information on the MRC registration application. FLIS does not conduct surveys or regular compliance inspections to ensure that the MRC is complying with applicable registration requirements. Also, because they are not licensed, DPH cannot cite the MRC for violations or require corrective action plans. FLIS can only intervene to investigate a complaint from an MRC resident receiving assisted living services agency (ALSA) services. FLIS cannot investigate the complaint if the MRC resident is not receiving assisted living services agency services.

As noted earlier in this report, residents in assisted living facilities have become older and frailer over time. This is due to initial residents aging in place and recent resifdents waiting until their late 70s to mid-80s before moving into assisted living. We were told in interviews that assisted living residents are increasingly similar to the nursing home population. Regardless of their setting, frail and vulnerable older adults should have a similar protection including facility inspections, background checks, and minimum staffing requirements. The level of oversight for a similar population currently depends on if they reside in assisted living facilities or nursing homes. There currently do not appear to be adequate consumer protections for the assisted living population.

In some interviews with assisted living facility administrators and associations, we were told that the current bifurcated registration/licensure system provides flexibility for managed residential community residents, allowing them to remain in the same apartment while transitioning from independent living to assisted living services. However, it is unnecessary to require that all assisted living facility residents must receive assisted living services or that certain apartments are designated as either independent living or assisted living. The administrators and associations are also concerned that assisted living licensure would lead to a more institutional setting. However, nearly all states license assisted living facilities and those facilities did not appear to turn into nursing home settings. Each type of license has its own unique requirements related to the particular services and setting.

The vast majority of managed residential community and assisted living services agency portions of assisted living facilities are under the same ownership. Many of these owners operate assisted living facilities in other states that license assisted living as a whole without breaking out the assisted living services portion. Until recently, Minnesota and Connecticut were the only states not licensing all of assisted living (i.e., managed residential communities plus assisted living services agencies). However, in May 2019, Minnesota passed legislation to license assisted living facilities, effective August 1, 2021 leaving Connecticut as the only state without this licensure requirement.

Recommendation: The General Assembly should consider establishing a work group to explore the development of an assisted living licensure system that combines managed residential communities and assisted living services agencies. The workgroup should include the chairpersons and ranking members, or their designees, of the joint standing committees of the General Assembly having cognizance of matters relating to aging, public health, and human services, representatives from the Departments of Public Health and Social Services, the Long-Term Care Ombudsman, the Connecticut Assisted Living Association, LeadingAge Connecticut, AARP Connecticut, and the Connecticut Chapter of the Alzheimer's Association.

The workgroup, prior to the start of the next legislative session, should report its findings and recommendations on possible legislation requiring licensure to the joint standing committees of the General Assembly having cognizance of matters relating to aging, public health, and human services. **(See Recommendation 22.)**

DSS Response "The Department believes that the development of an assisted living licensure system has the potential to be a positive enhancement to the Protective Services for the Elderly program. If directed by the General Assembly through statute to participate in a workgroup for this purpose, the Department would welcome the opportunity to participate but would require additional staff resources."

DPH Response "This recommendation requires a statutory change and possible regulations, and it is up to the General Assembly to do this."

RECOMMENDATIONS

This is our first audit of Oversight of Connecticut's Assisted Living Facilities, and there are no prior audit recommendations to address. Our current audit resulted in 22 recommendations.

Department of Public Health Facility Licensing and Investigations Section

1. The Department of Public Health should adhere to Section 19-13-D105(c)(2) of the Regulations of Connecticut State Agencies and send managed residential community service coordinators letters within 30 days confirming their registration including when there is a change of ownership.

2. The Department of Public Health should resume biennial inspections and complaint investigations concerning violations of certain statutory requirements for managed residential communities.

3. The Department of Public Health should require criminal background checks for managed residential community employees with direct access to residents.

4. The Department of Public Health Facility Licensing and Investigations Section should update its Assisted Living Services Agency Licensure Inspection Procedures.

5. The Department of Public Health should establish deadlines for notifying the assisted living services agency of inspection and complaint investigation results and inform the assisted living services agencies when it will communicate those results.

6. The Department of Public Health Facility Licensing and Investigations Section should inform the managed residential communities in which an assisted living services agency operates of results of inspections and complaint investigations.

7. The Department of Public Health should establish minimum staffing requirements for assisted living memory care units.

8. The Department of Public Health should amend its assisted living regulations to allow supervising registered nurses and designated on-call registered nurses to substitute case management experience in any health care setting, or mentoring or training initiated within 90 days of hire, in place of the currently required one year of experience working for a home health care agency or community health program.

9. Section 19-13-D105 of the Regulations of State Agencies should be amended to permit storage of medication in a centralized, secure place for residents requiring medication administration assistance.

10. Section 19-13-D105 of the Regulations of State Agencies should be amended to permit unlicensed assisted living services agency personnel to be trained and certified to administer certain medication.

11. Assisted living facilities should consider upgrading their medical alert systems to offer fall detection technology to residents.

12. The General Statutes should be amended to define assisted living facility as a managed residential community that offers its residents nursing services and assistance with activities of daily living through an assisted living services agency.

13. Section 19-13-D105 of the Regulations of State Agencies needs to be updated to include statutory and other changes since 2001.

The State Long-Term Care Ombudsman Program

14. The State Long-Term Care Ombudsman should develop a minimum standard of frequency of non-complaint visits to managed residential communities and amend section 17a-408 of the General Statutes to reflect that standard. Section 17a-417 of the General Statutes should be amended to require the State Long-Term Care Ombudsman's annual report to include outcomes of meeting the visitation standard and each facility's visitation frequency.

15. The State Long-Term Care Ombudsman should consider recruiting and assigning volunteer residents' advocates to assisted living facilities.

16. The General Assembly should establish a workgroup to develop a comprehensive assisted living facilities resource on the My Place CT website. Members of this workgroup should include representatives from the departments of Social Services and Public Health, the Long-Term Care Ombudsman, Connecticut Commission on Women, Children, Seniors, Equity & Opportunity, the Connecticut Assisted Living Association, LeadingAge Connecticut, and 2-1-1 Info-Line. The guide should have a searchable listing of all assisted living facilities, pricing, fees, Department of Public Health assisted living services agency inspection reports, and administrator contact information.

17. The State Long-Term Care Ombudsman should develop a checklist or guide with questions for consumers to ask when visiting assisted living facilities.

Department of Social Services Protective Services for the Elderly Program

18. Section 19a-697(b) of the General Statutes should be amended to require managed residential communities to post Department of Social Services Protective Services for Elderly Program's contact information.

19. The Department of Social Services Protective Services for the Elderly Program database should include assisted living residency.

Fire Marshal

20. The Department of Public Health should require an annual fire marshal safety inspection report for managed residential communities to maintain their registration.

21. The state fire marshal should work with the Codes and Standards Committee to clarify whether local fire marshals should use residential or institutional fire code requirements when inspecting assisted living facilities.

Licensure of Assisted Living Facilities

22. The General Assembly should consider establishing a work group to explore the development of an assisted living licensure system that combines managed residential communities and assisted living services agencies. The workgroup should include the chairpersons and ranking members, or their designees, of the joint standing committees of the General Assembly having cognizance of matters relating to aging, public health, and human services, representatives from the Departments of Public Health and Social Services, the Long-Term Care Ombudsman, the Connecticut Assisted Living Association, LeadingAge Connecticut, AARP Connecticut, and the Connecticut Chapter of the Alzheimer's Association.

    The workgroup, prior to the start of the next legislative session, should report its findings and recommendations on possible legislation requiring licensure to the joint standing committees of the General Assembly having cognizance of matters relating to aging, public health, and human services.

ACKNOWLEDGMENTS

The Auditors of Public Accounts wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Departments of Public Health and Social Services, and the Department of Aging and Disability Services Long-Term Care Ombudsman Program during the course of our examination.

The Auditors of Public Accounts would also like to acknowledge the auditors who authored this report:

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Miriam Kluger
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We want to especially acknowledge Miriam Kluger, who served as lead auditor on this audit. Miriam retired on August 1, 2021. We wish Miriam the best in her retirement and thank her for many years of service to the State of Connecticut and our office.

Maura Pardo
Administrative Auditor

Approved:

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State Auditor

APPENDIX A

Publicly Funded Assisted Living Models in Connecticut

Demonstration Model. There are four demonstration model assisted living facilities in Connecticut: Herbert T. Clarke in Glastonbury, The Retreat in Hartford, Luther Ridge in Middletown, and Smithfield Gardens in Seymour. Collectively, these four sites offer 226 subsidized assisted living apartments. Although the model is referred to as a demonstration in statute, these projects began by 2001 and are no longer in the demonstration phase.

The demonstration projects are funded with both state and federal dollars. The cost for ALSA services is subsidized through the Connecticut Home Care Program for Elders (CHCPE), which relies on both state and federal dollars. Residents of the demonstration facilities must qualify for the CHCPE program. Although 300 apartments are authorized by statute, there were only capital funds available for 226 apartments. There are no plans to grow the demonstration model.

State Funded Congregate Housing. There are approximately 23 congregate housing facilities in Connecticut for low and moderate-income frail seniors who are age 62 and older who can live independently but require some assistance. These facilities contain separate living units for residents and provide some housekeeping, personal care, transportation, and at least one meal a day in a common dining room. Of these 23 facilities, seven offer assisted living services through a statutory waiver program. The waiver reduces the nursing requirements to make service provision more affordable for the small number of residents that participate in the program. The seven facilities are located across Connecticut and collectively offer 304 living units.

Private Pay Assisted Living Services Pilot Program. There are 125 slots for the private pay assisted living services pilot program. The program is referred to as a pilot; however, it has been in existence since 2003 and is no longer in the pilot phase. The program is a component of the CHCPE program and helps by paying for home care services for elders living in an assisted living community. To participate in the CHCPE program, an individual must be 65 or older, functionally and financially eligible for CHCPE, a resident in an MRC and served by a participating ASLA, and have completed the required application and financial verification.

In this program, the elder or their family continues to pay for room and board and the program covers the cost of ALSA services. The program currently serves 97 elders through a mix of state and Medicaid funding. Program participation requires elders to have less than $39,000 of assets, yet program participants are required to continue paying for room and board. These restrictions make the program a very short-term solution as elders will quickly run out of money to pay for room and board.

Assisted Living in Federal Facilities Program. There are six facilities that provide assisted living services through the assisted living in federal facilities program (The Towers in New Haven, Horace T. Bushnell in Hartford, Immanuel House in Hartford, Juniper Hill Village in Storrs, Wells Country Village in Talcottville, and Kingsway Senior Housing in Norwalk). The United States Department of Housing and Urban Development (HUD) supplied the capital project funds to convert existing apartments into assisted living apartments. This conversion modernized the

apartments, making them larger and handicap accessible. Room and board is federally subsidized and ALSA services are covered through the CHCPE program.

There is no limit on the number of facilities that can apply for the waiver, however funding is not currently available through HUD for additional conversions. HUD inspects the facilities every one to three years depending on the cycle. Facilities in the program are also subject to DPH oversight. There are currently 590 assisted living apartments in the six facilities.