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FIGHTING SENIOR POVERTY THROUGH LAW

Best Practices in Assisted Living: Considering Potential Reforms for California

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TABLE OF CONTENTS

Overview

Based on a review of assisted living laws of California and 11 other states, California's assisted living policy is significantly out of date. An assisted living resident today is likely to have significant care needs, but California's law in general has low standards for quality of care. Unlike many other states, California has not adjusted adequately to the sharp increase in residents' care needs over the past 10 to 15 years. California's assisted living law was enacted in 1985, and has been amended only intermittently since then. It requires significant revision in order to keep pace with the new realities of assisted living.

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Executive Summary

Introduction

Assisted living facilities offer residential care and services for older persons who are unable to live independently. Some residents require relatively limited assistance; others require significantly more assistance, and many require health care services on an ongoing basis. California has over 7,500 facilities with the capacity of housing approximately 175,000 residents.

Assisted living facilities are licensed by individual states under laws developed by those states. In California, assisted living facilities are licensed as Residential Care Facilities for the Elderly, or RCFEs. Standards for these facilities are set by 1985 legislation that has been amended only on a limited basis in the subsequent 29 years. The California Department of Social Services (which regulates the facilities) has made some regulatory amendments, but those have not altered the law's basic framework. Regardless of size, all facilities are governed by the same rules.

A recent budget proposal from the Department of Social Services describes how California's system has failed to keep up with resident's increased needs:

> For decades, Assisted Living and Residential Care Facilities for the Elderly have been distinguished from their counterparts, [nursing homes], by drawing a bright line between the medical versus non-medical needs of the residents. This line has blurred, but the regulatory structure has not kept adequate pace.

As the Department acknowledges, the public now expects that assisted living residents will have access to "health care delivery and management of medical conditions." The Department states, however, that it has not had the "resources for policy and regulatory changes to keep pace with the public's changing expectations."

Many other states, however, have made more significant revisions to their residential care/assisted living laws in recent years, in an effort to better align those laws with the greater needs presented by today's assisted living residents. There is no standard formula. The laws of the individual states demonstrate a variety of strategies to balance the various public policy concerns.

Based on an examination of state assisted living laws from California and 11 other states, this report makes the following recommendations based on best practices noted in those states.

Recommendation

I. Type of Care, and Types of Residents

- Levels of Care: California law should be revised to establish a separate level-of-care classification for facilities that serve residents with greater care needs, or in some other way to better connect regulatory minimums with residents' needs.
- Care Need Ceilings: Care need ceilings should be revised to be less dependent on whether or not a facility chooses to cooperate with an outside agency such as a home health agency. Options should rest with residents rather than with facilities.

II. Care Standards

- Service Planning: California law should include a specific provision requiring a comprehensive service plan, and giving a resident the right to participate in the plan's development and to appeal unfavorable provisions.
- Nurse Participation: Some level of nurse involvement should be considered for incorporation into the rules governing assessment, care planning, and service delivery.
- Medication Administration: California should establish a regulatory framework for medication administration that properly and honestly balances required expertise and supervision with the practical realities of operating a facility.
- Dementia Care Standards: Training standards should be raised to increase the expertise of direct-care staff members.

III. Staff Training and Staffing Levels

- Training for Direct-Care Staff: Minimum training standards should be increased significantly from the current minimum of 10 hours.
- Staffing Standards: California's minimum staffing levels must be increased in order to be meaningful.
- Administrator Standards: California law should be revised to require an administrator generally to be on-site full-time, and to enumerate the qualifications of a designated substitute when an administrator is absent.

IV. Resident Rights

- Right to Make Everyday Decisions: California regulations should incorporate a "person-centered" philosophy that allows facility residents to make decisions and exercise preferences.
- Visitors: Residents should have a right to accept visits at any time.
- Right to Refuse Treatment: Residents should have an explicit right to informed consent.
- Evictions: The authorized justifications for eviction should be narrowed in order to give residents more stability.
- Restraints: Use of physical or chemical restraints should be prohibited.
- Managing Residents' Money: A resident should have timely access to personal funds held by a facility, and earned interest should be the resident's property.

V. Accountability

- Frequency of Inspections: California should require more frequent inspections — the current interval of five years between inspections is excessive. Furthermore, these inspections should not be limited to so-called "key indicators."
- Enforcement System: California law should be revised to authorize per-instance money penalties of a meaningful amount, and to establish intermediate penalties to enable the state to compel compliance without the need to seek a license's suspension or revocation.

- Insurance and Bonding: California law should be revised to require liability coverage of a meaningful amount.
- Website Information: California should develop a website that allows consumers to find facilities by county, city and zip code. At a minimum, such a website should provide copies of inspection reports for the preceding three years, along with a usable summary of those inspection reports for that period.

Conclusion

A significant part of the current problem is California's orientation over the years towards maintaining a bright-line separation between assisted living and health care expertise. Other states have searched for a best-of-both-worlds situation in which a pleasant environment and a satisfying quality of life are teamed with competent health care as necessary.

A defense of the status quo might protest that the introduction of health care expertise would convert assisted living facilities into nursing homes. On the contrary, incorporating health care expertise makes it more likely that assisted living care will be adequate, and reduces the chance that a resident will suffer from neglect, or be forced prematurely to move to a nursing home.

A status quo defense also might argue that additional standards would be prohibitively expensive for small six-bed facilities with relatively independent residents, particularly when those residents rely on Supplemental Security Income (SSI). This type of argument, however, illustrates how a one-size-fits-all model can distort public policy. The state's strategy should be to develop standards that vary to a certain extent with circumstances, rather than applying loose, lowest-common-denominator standards across the board.

As this report demonstrates, there is no one right answer. Each state must weigh the options and develop its own system. For too long, however, California has abdicated this responsibility and failed to address many extremely important issues. As soon as possible, the California Legislature and Department of Social Services should rectify this problem and initiate honest discussion about the pros and cons of various policy options. Such a discussion is the necessary first step in bringing California assisted living policy into the 21st century.

Introduction

Background and Problem

Assisted living facilities offer residential care and services for older persons who are unable to live independently. Some residents require relatively limited assistance with dressing, bathing, or other activities of daily living. Other residents, however, require significantly more assistance, and many require health care services on an ongoing basis. For example, some residents are non-ambulatory or incontinent, and others require oxygen administration or treatment for pressure sores.

Assisted living facilities are licensed by individual states under laws developed by those states. In California, assisted living facilities are licensed as Residential Care Facilities for the Elderly, or RCFEs. Licensing and inspection activities are carried out by the Community Care Licensing Division of the California Department of Social Services.

Terminology varies from state to state; these types of facilities are variously denominated as (for example) assisted living facilities, assisted living residences, or personal care homes. For simplicity, this report in many cases uses the term "assisted living facility" generically, regardless of the state involved.

California has approximately 7,500 facilities housing a total of 80,000 residents. Standards for these facilities are set by 1985 legislation that has been amended only on a limited basis in the subsequent 29 years. The Department of Social Services has made some regulatory amendments but those have not altered the law's basic framework. Regardless of size, all facilities are governed by the same rules.

Particularly in comparison with many other states, the California regulatory system has attempted to maintain a strong separation between Residential Care Facilities for the Elderly and health care. In general, facility staff has minimal health care training. Instead, for residents with certain specified health care needs, the system relies extensively on care provided by "appropriately skilled professionals" who usually are not facility employees. For example, California law recognizes that residents may receive necessary care on an ongoing basis from visiting home health care agencies or hospice agencies. The relevant law sets standards for cooperation between these agencies and facility staff.

A recent Budget Change Proposal (Sept. 11, 2013) from the Department of Social Services describes how California's system has failed to keep up with residents' increased needs:

> For decades, Assisted Living and Residential Care Facilities for the Elderly have been distinguished from their counterparts, [nursing homes], by drawing a bright line between the medical versus non-medical needs of the residents. This line has blurred, but the regulatory structure has not kept adequate pace.

As the Department acknowledges, the public now expects that assisted living residents will have access to "health care delivery and management of medical conditions." The Department states, however, that it has not had the "resources for policy and regulatory changes to keep pace with the public's changing expectations."

Many other states, however, have made more significant revisions to their residential

care/assisted living laws in recent years, in an effort to better align those laws with the greater needs presented by today's assisted living residents. There is no standard formula. The laws of the individual states demonstrate a variety of strategies to balance the various public policy concerns. Participation by home health agencies and hospice agencies is common, as are nursing services and health-related services provided by facility staff.

A focused public discussion on these issues and others is long overdue in California. Unfortunately, the inadequacy of California's system has received very little legislative attention. Instead, the Department of Social Services has attempted to keep its head above water through the occasional revision of RCFE regulations.

Methodology

To encourage and then facilitate the necessary policy discussion on the regulation of assisted living in California, this report presents public policy options for consideration by California lawmakers and other stakeholders. For 19 important issues in assisted living policy, this report examines the relevant assisted living law in California and 11 other states, and concludes with a policy recommendation. For each of the 19 issues, the discussion is supported by tables that offer more specifics on each state's position. Citations to the relevant provisions in each state's law are included at the end of this report.

Aside from California, the states included in this report are Alabama, Arkansas, Connecticut, Florida, Kansas, Mississippi, New York, Oregon, Pennsylvania, Washington, and Wisconsin. They were selected as states that, in general, have amended their assisted living laws in recent years in an effort to keep their standards appropriate to the assisted living population.

Wisconsin licenses three different types of assisted living facilities: Adult Family Homes, Community Based Residential Facilities, and Residential Care Apartment Complexes. This report's research reviewed the law from all three types of facilities and, since this report focuses on best practices, the report for each issue includes the provision that best protects residents' interests as the representative Wisconsin provision. The same procedure is followed in states with multiple levels of care within a licensure category. In Florida, for example, a provision from the "extended congregate care" level is used as representative of Florida's assisted living facilities, when that provision is judged to be the provision of Florida law most protective of residents' interests.

ANALYSIS

I. Type of Care, and Type of Residents

Levels of Care

California Rules

California licenses Residential Care Facilities for the Elderly. This is the state's only licensure category for residential care facilities that serve an older population.

Other States' Rules

Of the 11 surveyed states, four states offer two or more levels of care in the licensure of residential care facilities serving an older population. Arkansas, for example, licenses Assisted Living Level I and Assisted Living Level II. Only Level II facilities can admit and retain residents who require a nursing-home level of care. Due to the greater needs of the Level II resident population, the Level II rules are more demanding.

Florida licenses "assisted living facilities" with an option for a licensee to obtain additional licensure recognition for extended congregate care, limited mental health, or limited nursing services. The latter two categories are largely self-explanatory; the "extended congregate care" category allows a facility to provide residents with additional nursing services and more extensive assistance with activities of daily living.

Similarly, New York licenses assisted living while giving providers the option of obtaining additional certification for "enhanced" assisted living, or assisted living with care of "special needs." Under "enhanced" assisted living, the facility's staff is authorized to provide additional care to meet the needs of residents who (for example) need assistance to walk, are incontinent, or depend upon medical equipment. "Special needs" facilities focus on care of residents with particular conditions; generally these are facilities specializing in dementia care. (Oversight of all forms of assisted living in New York has been greatly limited by a court order that has invalidated certain assisted living rules, on the grounds that those rules exceed the state's authority under the state's assisted living legislation.)

Mississippi licenses two types of facilities: "personal care homes - assisted living" and "personal care homes - residential living." The primary difference between the two is that certain health-related services (medication administration, for example) can be made available in personal care homes - assisted living.

Seven states (including, as discussed above, New York) have licensure categories or designations that focus on residents with dementia. These requirements are discussed in more detail in this report's section on dementia care standards.

Finally, it should be noted that some states offer multiple licensure categories that are distinguished chiefly by factors other than level of care. For example, Oregon licenses both "assisted living facilities" and "residential care facilities," with the difference between the two being the requirement in assisted living that living units be private, not shared. In Wisconsin, a "licensed adult family home" has three

to four residents, a "community based residential facility" has five or more residents, and a "residential care apartment complex" must offer a lockable entrance, a kitchen, and a private living area and bathroom.

Like Wisconsin, many states have licensure categories specifically for very small facilities. In Washington, an "adult family home" has no more than six residents. A limit of five residents applies in Florida (adult family-care home) and Oregon (adult foster home).

Recommendation

California law should be revised to establish a separate level of care classification for facilities that serve residents with greater care needs, or in some other way to better connect regulatory minimums to residents' needs. In California's current system, too frequently standards are based on a lower-common-denominator framework. Consideration of possible revisions has focused inordinately on how additional standards might affect small facilities with relatively independent residents, leading to the too-quick refusal to increase minimum standards. As a result, many California regulations may be appropriate for low-needs residents, but are wholly inadequate to ensure an adequate quality of care for higher-needs residents.

As the above analysis indicates, states employ a variety of strategies in order to ensure that facilities can meet residents' needs. A discussion of this issue is long overdue in California.

Licensure Categorization Related to Level of Care

	One Licensure Category	Two or More Licensure Categories	Separate Licensure Category or Designation for Dementia Care
California	X		
Alabama			X
Arkansas		X	X
Connecticut	X		
Florida		X	X
Kansas	X		
Mississippi		X	X
New York		X	X
Oregon			X
Pennsylvania			X
Washington	X		
Wisconsin			

Care Need Ceilings

California Rules

In California, a facility may not accept or retain a resident who requires 24-hour, skilled nursing care, or who depends on others for all activities of daily living. Bedridden residents may be accepted or retained, subject to certain fire safety rules. A resident must be able to self-administer medications, though facility staff may assist the resident in self-administration. A person may not reside in a facility if his or her primary need for care and supervision results from an ongoing

behavior caused by a mental disorder that would upset the general resident group.

In general, a facility cannot accept or retain a resident who has a Stage 3 or 4 pressure sore, a need for gastrostomy care, naso-gastric tubes, a staph infection, or a tracheotomy, although a facility may request a written exception if it believes that the resident's health-related needs can be met in the facility. A licensed home health agency may provide incidental medical care to residents, but the facility and the agency must have a written agreement outlining their responsibilities to provide certain services to the resident. Notably, participation by a home health agency may not expand the scope of care and supervision the facility is required to provide.

Similarly, a facility may retain a terminally ill resident if the facility obtains a hospice care waiver from the state, and the resident receives services from a hospice agency. A care plan between the facility and the hospice agency must limit the facility's role to those tasks allowed under the state's assisted living rules.

Other States' Requirements

Ten of the surveyed states have care-need ceilings that limit the acceptance and retention of residents. Generally, these ceilings fall into four categories: a high need for skilled nursing care; a resident's inability to self-perform activities of daily living or self-administer medications; serious behavioral or mental health issues; and specified medical conditions or needs.

Nine of the 11 surveyed states prohibit the acceptance or retention of residents who need skilled nursing care or around-the-clock nursing care, though a good number of the states allow for exceptions to the general rule. In New York, a facility possessing an enhanced assisted living certificate may retain a resident requiring around-the-clock nursing care when a home care agency documents that, with additional nursing and medical services, the resident can be safely cared for in the facility. Pennsylvania similarly authorizes a facility to request permission from the state to admit or retain a resident with an otherwise impermissible care need.

Eight of the 11 surveyed states place some kind of restriction on the acceptance or retention of a resident who is limited in his or her ability to perform activities of daily living. Four states limit residency by persons who are persistently bedridden; four similarly limit residency for persons who need significant assistance with transfer; four require that residents be ambulatory; and two states prohibit residency by incontinent persons.

Persons who exhibit behavioral issues, require significant mental health services, or are otherwise a danger to themselves or others may not be accepted or retained under the regulations of eight of the surveyed states. Five of the states limit residency if physical restraints are required. Wisconsin rules provide that a Community Based Residential Facility may accept or retain a resident who is destructive to self or property, or is physically or mentally abusive to others, if the facility has sufficient resources to care for the resident, and is able to protect the resident and others.

Five of the 11 surveyed states limit the acceptance or retention of residents with certain complex medical conditions. For example, facilities commonly are not

permitted to accept or retain residents who have certain infectious or communicable diseases, or Stage 3 or 4 pressure sores. Care ceilings frequently are based on a need for certain nursing services, including tracheotomy suctioning, assistance with tube feeding, and ventilator dependency.

Most of the surveyed states (nine of the 11) permit licensed home health agencies to provide services to facility residents, often so that a resident may remain in a facility even as care needs increase. Nine of the 11 surveyed states also permit a terminally ill resident, who otherwise has care needs exceeding a care ceiling, to remain in a facility if a hospice agency can provide needed services.

In contrast to the other states, Oregon by and large does not impose mandatory ceilings. Instead, the rules provide involuntary move-out criteria that authorize a facility, if it chooses, to seek a resident's eviction. (Eviction is discussed in more detail in a separate section of this report.)

Recommendation

Consistent with other recommendations from this report, care-need ceilings should be revised so they are less dependent on whether or not a facility chooses to cooperate with an outside agency (a home health agency, for example). Consumers would benefit from more consistency as to what conditions can and cannot be accommodated in a particular class of facility, and the choice of seeking an exception should rest with consumers rather than facilities, to the extent practicable.

Care Need Ceilings

	Limited by Need for Skilled or 24-Hour Nursing Care	Limited By Deficits in Activities of Daily Living	Limited if Resident Requires Medication Administration	Limited if Resident Creates Danger	Limited if Resident Requires Physical Restraints	Limited By Specified Medical Conditions	Home Health Agency Provides Care	Hospice Care Provides Care
California	X	X	X	X		X	X	X
Alabama	X		X		X	X	X	X
Arkansas	X	X	X	X			X	X (Level II)
Connecticut								
Florida	X	X	X	X		X	X	X (Extended Congregate Care)
Kansas	X	X		X	X		X	X
Mississippi	X	X		X	X	X	X	X
New York	X	X	X	X		X	X	X
Oregon		X		X				
Pennsylvania	X			X	X	X	X	X
Washington	X	X					X	X
Wisconsin	X	X		X	X		X	X

II. Care Standards

Service Planning

California Rules

In California, a facility must perform a pre-admission appraisal, and obtain and evaluate a recent medical assessment. The pre-admission appraisal at a minimum must include an evaluation of the resident's functional capabilities, mental condition and social factors. The facility may use a state-approved form, at its option.

The facility also must meet with the resident prior to admission, or within two weeks thereafter, to develop a written record of care. The meeting may include the resident's representative, facility staff, and a representative from the resident's home health agency, if any.

The record of care must include the agreed-upon services to be provided as well as the resident's preferences regarding services. A copy must be sent to the resident's physician. The record of care must be updated at least every 12 months, or upon a change in condition.

Other States' Rules

All of the states surveyed, except Mississippi, require a facility to develop a service plan prior to admission or soon thereafter. Nine of the surveyed states require that the plan be revised upon a significant change (e.g., after each hospitalization) or at least yearly; in three states, the service plan must be reviewed more frequently.

Generally, a service plan incorporates information acquired through a pre-admission medical evaluation and an assessment conducted by the facility. In six of the surveyed states, a medical evaluation (usually by the resident's physician) is required prior to admission.

A pre-admission assessment on a state-approved form is required in six of the surveyed states. In Kansas, a nurse, social worker, or facility administrator must conduct a screening, using a screening form specified by the state, prior to a resident's admission. When this screening indicates a need for health care services, the resident must be further assessed by a licensed nurse. Arkansas similarly requires a registered nurse to complete a state-approved assessment when a resident who requires health care services seeks admission to a Level II facility. The state-approved assessment must include, among other factors, evaluation of the resident's physical, mental and emotional health, as well as social needs and preferences.

The resident has the right to participate in the service planning process in all 10 states that require service plans. In most of these states, resident participation is protected in a specific section of the rules dedicated to residents' rights. Family members, friends, legal representatives and other chosen representatives may participate with the resident's consent.

State rules generally require that the service plan address a resident's need for assistance with activities of daily living, as well as the other services the resident receives from the facility. In Arkansas and Connecticut, a service plan must reflect the resident's preferences, needs and choices. Oregon requires a service plan to include resident preferences that support principles of dignity, privacy, choice, individuality and independence.

Recommendation

California law should be revised to include a specific provision for development of a comprehensive service plan for each resident. It should be made clear that the resident, along with the resident's chosen family member or representatives, has the right to participate in devising the plan.

The plan should include the resident's preferences that support principles of dignity, privacy, choice, individuality and independence. The service plan should be approved by the resident, or if the resident disagrees, that disagreement should be recorded in the written plan, and the resident should be provided with a meaningful way to appeal.

Service Planning

	State-Approved Assessment	Medical Evaluation	Service Plan	Resident's Right to Participate	Resident's Right to Family/ Representative Participation	Plan Revised Upon Significant Change	Plan Revised at Least Yearly
California	**X** (form available but not required)	**X**	**X**	**X**	**X**	**X**	**X**
Alabama		**X**	**X**	**X**	**X**	**X**	**X**
Arkansas I			**X**	**X**	**X**	**X**	**X**
Arkansas II	**X**		**X**	**X**	**X**	**X**	**X**
Connecticut			**X**	**X**	**X**		**X**
Florida	**X**	**X**	**X**	**X**	**X**		
Kansas	**X**		**X**	**X**	**X**	**X**	**X**
Mississippi		**X**					
New York		**X**	**X**	**X**	**X**	**X**	**X**
Oregon	**X** (Medicaid-funded residents)		**X**	**X**	**X**	**X**	**X**
Pennsylvania	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Washington	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Wisconsin			**X**	**X**	**X**	**X**	**X**

Nurse Participation

California Rules

California rules specify that certain "allowable health conditions" can be accommodated in a facility only if 1) the facility takes certain precautions, and 2) the necessary procedure is performed either by the resident or by an "appropriately skilled professional"(generally a nurse). Thus, unless the resident is capable of performing the relevant tasks himself or herself, nurse participation generally is required in some manner for injections, oxygen administration, fecal impaction removal, an enema, use of an intermittent positive pressure breathing machine, or care of a colostomy or in-dwelling catheter. Also, nurse assistance or supervision is required for care of a healing wound, such as a pressure sore. Nurse assistance also may be required for insulin administration.

Other States' Rules

Ten of the 11 surveyed states involve nurses in some manner in the provision of required services. The exception is New York, where the relevant rules were invalidated by a lawsuit alleging that the rules exceeded the authority of the authorizing legislation.

Six states' rules explicitly describe how nurses are involved in providing care and services to residents. In nine states' rules, nurses are involved in medication administration, or in the preparation of medication for administration. (Medication administration is discussed in more detail in a separate section of this report.)

Nurses are involved in resident assessment in five of the surveyed states. Participation in care planning is identified as a nurse activity in three of the states. Likewise, coordinating or supervising care also is identified as a nurse activity in three states.

Connecticut is one of the states that give nurses a significant role in assisted living. Connecticut licenses assisted living services agencies, rather than facilities; in part because of this different orientation, the state's rules have a greater focus on nurses and nursing services. Each assisted living services agency must have written policies regarding the delivery of nursing services. Nursing services include hands-on services, medication administration, disease prevention, wellness counseling, and health promotion. A registered nurse also is responsible for a variety of other important tasks including assessments, service coordination, training, and discharge planning.

In Kansas, a nurse must perform an assessment if a screening has indicated a need for health care services; thereafter, the nurse participates in developing a health care service plan. A nurse provides any skilled nursing care that may be required, along with medication management and "immediate direction" (as necessary) to nurse aides and medication aides. A nurse also may provide wellness and health monitoring.

In Arkansas, a Level II facility must employ or contract with licensed nurses to provide nursing care and direct care services, including medication administration. In addition, a Level II facility must employ or contract with at least one registered nurse. The registered nurse is responsible for the preparation, coordination and implementation of a resident's direct care services plan, and also reviews and oversees

all direct-care staff. The registered nurse need not be physically present at the facility, but must be available by phone or pager.

Nurses also have a significant role in Oregon's assisted living system. Under Oregon rules, a licensed nurse must be regularly scheduled for on-site duties, and otherwise must be available for phone consultation. Nursing services must be provided as needed: a facility must provide residents with an adequate number of nursing hours, based on the needs of the resident population. A registered nurse performs resident assessments, while a licensed nurse is responsible for participating on the service planning team, and providing individual and group education activities.

Recommendation

Given the significant health care needs of many California assisted living residents, some level of nurse involvement should be considered for incorporation into the rules governing assessment, care planning, and service delivery (including medication administration). The greater involvement of nurses would be particularly appropriate in facilities licensed for a relatively higher level of care, consistent with this report's recommendation on levels of care. In California, as is the case across the country, many assisted living residents have significant health care needs.

As other states have demonstrated, nursing services can play an important role in the assisted living model. That role deserves careful consideration by California legislators, regulators, and stakeholders.

Nurse Participation

	Providing Services	Administering or Setting Up Medication	Participating in Assessments	Participating in Care Planning	Coordinating or Supervising Care
California	X				
Alabama		X			
Arkansas	X	X		X	X
Connecticut	X	X	X	X	X
Florida	X	X			
Kansas	X	X	X		X
Mississippi	X	X			
New York					
Oregon	X		X	X	
Pennsylvania		X	X		
Washington		X			
Wisconsin		X	X		

Medication Administration

Introduction to the Issue

Medication administration presents a challenge for state officials and assisted living facility operators. Historically, under state nurse practice acts, medication administration has been limited to physicians, nurses, and comparable health care professionals. Unlike nursing homes, however, assisted living facilities do not have around-the-clock nurse coverage. Most assisted living facilities, particularly the smaller facilities, have not employed nurses at all, although the use of nurses in assisted living is becoming more common. (Nurse participation in assisted living is discussed in the section immediately above.)

How, then, do assisted living residents receive necessary medications? If a resident is mentally competent, he or she can self-administer medication. Facility direct-care staff is allowed to assist the resident with self-administration, for example, by opening a medication bottle for a resident with arthritis.

If a resident is not mentally competent to self-administer medication, a state may require administration by a nurse pursuant to the state's nurse practice act. As a lower-cost alternative, some states have created exceptions to the nurse practice act that authorize administration by specially trained staff members. These exceptions apply only in assisted living facilities or comparable settings.

One such exception sets certain requirements (training, supervision, etc.) for facility staff members who then have limited authority to administer medication at the facility. Sometimes such staff members are termed "medication aides."

A similar alternative in a state's law allows a nurse to delegate to a facility staff member the authority to administer medication and/or to carry out certain other nursing procedures. In the delegation model, the nurse generally assumes some limited obligation to train and supervise a staff member who, like a medication aide, has circumscribed authority to administer medication at the assisted living facility.

One other common practice deserves mention, although it is noncompliant with state law and based to a certain extent on state inspectors looking the other way. In many instances, unlicensed facility staff members administer medication under the pretense of merely assisting with self-administration. It is likely that this practice is more prevalent in states that do not authorize medication aides or delegation of nursing tasks.

California Rules

California rules do not list medication administration as a required service; instead, the rules require that facility staff assist residents with self-administration of medication. With a physician's order, assistance with self-administration can be provided even if the resident is taking medication on a PRN (as-needed) basis. If a facility has a capacity of 16 or more residents, one or more staff members must be designated as having primary responsibility for assistance with self-administration of medication.

Other States' Rules

Not surprisingly, all of the 11 surveyed states provide for assistance with self-administration of medication. In addition, eight of the 11 states explicitly reference administration by a nurse, and four of the states authorize administration by a trained facility staff member. These categories overlap to a certain extent: three states (Kansas, Washington, and Oregon) explicitly address medication administration by nurses and by trained staff members.

In Kansas, training as a medication aide is available only to certified nurse aides or to qualified intellectual disability professionals. Each medication aide course must be based on a state-certified curriculum, and consist of at least 75 hours, including at least 25 hours of clinical instruction. The training must be sponsored by either a state post-secondary school, a state-operated institution for persons with an intellectual disability, or (with state approval) a professional health care association. Following the training, the applicant also must take and pass a state-approved test.

Washington follows a delegation model that allows a registered nurse to delegate medication administration or another nursing task to a staff member who is certified as a nurse aide or home care aide, and has completed both the basic caregiving training and the core delegation training. Prior to delegation, the nurse identifies and facilitates any necessary additional training. Delegation is only allowed for residents with stable and predictable conditions. The nurse must reevaluate the resident and the services at least once every 90 days, with the nurse having discretion to determine the exact frequency of these reevaluations.

Oregon also follows a delegation model. A registered nurse may delegate a nursing task (including medication administration) to an unlicensed staff member, specific to one resident, if the resident's condition is stable and the nurse has provided adequate training to the staff member. The nurse also must give the staff member written instructions, and then evaluate the resident's condition and the staff member's competence within at least 60 days after the delegation, Subsequent intervals between evaluations are based on factors including the resident's condition and the nurse's overall experience with the staff member.

Recommendation

California's current law does not adequately address the fact that many facility residents are unable to self-administer medication. California should establish a regulatory framework for medication administration in facilities that properly and honestly balances required expertise and supervision with the setting's practical realities.

As is true for many of the issues examined in this report, discussion of this issue is long overdue. Almost certainly, many current residents are having medication administered by a facility staff member with limited training, under the claim that the staff member is merely assisting with self-administration. The current state of affairs needs to be honestly addressed.

Forms of Medication Administration Explicitly Addressed in Facility Rules

	Staff Assisting with Resident Self-Administration	Administration by Nurse	Administration by Trained Facility Staff Member
California	X		
Alabama	X	X	
Arkansas	X	X	
Connecticut	X	X	
Florida	X		
Kansas	X	X	X
Mississippi	X	X	
New York	X		
Oregon	X	X	X
Pennsylvania	X		X
Washington	X	X	X
Wisconsin	X	X	

Dementia Care Standards

California Rules

If a facility accepts and retains residents with dementia, direct-care staff must receive training in dementia care that covers (among other things) "hydration, skin care, communication, therapeutic activities, behavioral challenges, the environment, and assisting with activities of daily living." The training also must cover medication commonly used to treat dementia symptoms, and the recognition of conditions that may exacerbate dementia behaviors, including conditions such as dehydration, urinary tract infections, and problems with swallowing.

Staffing levels must be adequate to meet residents' assessed needs. In addition, if any resident with dementia is determined to require night supervision, the state's overnight minimum staffing levels for smaller facilities (15 or fewer residents) are raised to require

that at least one staff member be awake.

Additional requirements apply to facilities that publicly claim an expertise in dementia care. Within the first four weeks of employment, direct-care staff must receive six hours of training on dementia care. Going forward, each staff member annually must receive at least eight hours of training in dementia care. The training must be developed by, or in consultation with, a person or organization with expertise in dementia care.

Other States' Rules

Six of the 11 surveyed states have created a separate licensure designation for dementia-care facilities. Eight of the surveyed states require dementia-specific training, and three of the states specify increased staffing levels for care of residents with dementia.

In Alabama, a "specialty care assisted living facility" is specially licensed and staffed to enable it to care for residents who have a level of cognitive impairment that otherwise would disqualify them from assisted living. Prior to providing any resident care, all staff members must complete a brain series training developed by the state (or an equivalent training approved by the state), and also must be trained in 19 topics specified in rules. These topics include understanding the aging mind, cognitive symptoms of dementia, psychiatric symptoms of dementia, and end-of-life issues for residents with dementia.

Alabama in addition requires the involvement of a registered nurse in both resident care and facility operation. A nurse must perform a comprehensive assessment of a resident upon admission, after a significant change in condition, or when a problem is identified during a monthly assessment (also performed by a nurse). In facility operations, a nurse must consult with the facility administrator on all issues of resident health and well-being, identify problem areas in resident care, and propose interventions to address any such problem areas.

Alabama also has established specific staffing minimums that vary with the size of the facility and the shift (day, evening, or overnight). A facility with 15 residents, for example, must have two staff members on duty at all times. For a facility with 25 residents, however, the minimum number of staff members is four, three and three, for the day, evening, and overnight shifts, respectively. For 50 residents, the minimum increases to seven, five and four staff members; for 75 residents, the minimum is ten, seven, and five.

Mississippi likewise has established standards for Alzheimer's Disease/Dementia Care Units. At least two staff members must be on duty at all times and at least one of these must be a nurse. Furthermore, facilities must provide at least three hours of nursing care per resident per 24-hour period, with "nursing care" including time worked by nurses or nurse aides. This requirement translates to a staff-to-resident ratio of one to eight, on average; most facilities presumably satisfy minimums by having relatively higher staffing levels during the day, with somewhat lower levels during overnight shifts.

Five of the surveyed states, like California, have standards that apply to facilities that wish to claim an expertise publicly in dementia care. In Arkansas, the designation of Alzheimer's Special Care Unit is available both for Level I and Level II assisted living

facilities that promote themselves as providing dementia care. This designation includes a requirement that direct-care staff receive at least 30 hours of training in 11 specified topics. This training must include, for example, at least two hours on the stages of Alzheimer's Disease, four hours on behavior management, two hours on medication management, and three hours on assessments and the creation of individual support plans.

Similarly, New York offers a license as a Special Needs Assisted Living Residence for those facilities that advertise or market themselves as serving residents with dementia. A facility must develop a "special needs plan" that describes how residents' needs will be met; this plan must include, among other things, staffing levels and staff training.

Recommendation

For dementia care, California training standards should be raised to increase the expertise of direct-care staff members. Nurses or other relevant professionals should be more involved in coordinating and providing care, and in training and supervising direct-care staff.

Dementia Care Training

	Separate Licensure Designation	Demetia-Specific Training Specified	Increased Staffing Levels	Additional Standards If Facility Claims Specialization
California		X		X
Alabama	X	X	X	
Arkansas	X	X		X
Connecticut				X
Florida		X		X
Kansas		X		
Mississippi	X	X	X	
New York	X			
Oregon	X	X		X
Pennsylvania	X	X	X	X
Washington		X		
Wisconsin				

III. Staff Training and Staffing Levels

Training for Direct-Care Staff

California Rules

In California, all direct-care staff must receive at least 10 hours of initial training within the first four weeks of employment. First aid is among the required topics. The other required topics are described in broad terms; among them are the "[i]mportance and techniques of personal care services, including but not limited to, bathing, grooming, dressing, feeding, toileting, and universal precautions." At least three hours must be devoted to this broad and important topic. At least two hours must be directed towards the facility's medication policies and procedures.

Continuing education must consist of at least four hours annually. Not surprisingly, given the relatively limited number of hours, the rules do not mandate that continuing education include any one particular topic.

All training must be conducted by a person knowledgeable in the relevant subject. This person must either 1) be a licensed health care provider, 2) have a four-year college degree and two years of experience in caring for older persons, or 3) have two years of experience as a facility administrator, with a record of operating facilities in substantial compliance with relevant law. With the trainer's approval, training can include use of instructional tapes, interactive CD-ROMs, or similar materials.

Other States' Rules

In nine of the 11 surveyed states, state rules require that initial training cover specified subjects. In eight of those states, first aid and/or CPR are among the required subjects. The list of these required subjects tends to be somewhat extensive, particularly when a specialization or elevated level of care is involved. In Pennsylvania, for example, the initial training of direct-care staff must cover at least 19 specified subjects, including assistance with activities of daily living, the "normal aging-cognitive, psychological and functional abilities of individuals who are older," and "[c]are of residents with mental illness, neurological impairment, mental retardation and other mental disabilities." In Alabama and Arkansas, the basic list of required subjects is significantly more limited, but the list expands greatly for licensure for facilities with an expertise in dementia care. (Dementia care standards are discussed in a separate section of this report.)

Three states – Connecticut, Kansas, and Washington - set standards for persons conducting the training. The Connecticut standards are relatively rigorous: the state licenses "assisted living services agencies" rather than "facilities," and these agencies employ nurse's aides, home health aides, and homemaker-home health aides. Training in Connecticut for these job categories generally is supervised by a registered nurse with at least two years of relevant experience, with all trainers being licensed, registered, and/or certified in their field. In Kansas, training must be supervised by a registered nurse and can be performed by any qualified person. Washington at a minimum requires that a trainer have a high school diploma and at least one year of caregiving experience in a residential care facility. Also, a trainer must either have 100 hours of experience in teaching related topics or 40 hours of teaching experience under a mentorship.

Washington in addition has developed a curriculum, and reviews and approves training programs developed by others. State-developed material is available in English, Chinese, Korean, Russian, Spanish and Vietnamese.

Florida, Connecticut and Kansas require passing an examination as a prerequisite for providing direct-care services. In Florida, the examination is included in core training requirements that apply to management and direct-care staff. The Connecticut examination is part of the requirement to work as a nurse's aide, home health aide, or homemaker-home health aide. In Kansas, the examination is developed by the state to be administered to all direct-care employees who do not administer medication.

Of the 11 surveyed states, six set a minimum number of hours for initial direct-care training. This minimum is 25 hours or greater in four states–Connecticut and Washington (75 hours), Kansas (40 hours), and Florida (26 hours). (In some states, higher hourly requirements are required of facilities specializing in dementia care; those requirements are addressed in this report's section on dementia care.)

Finally, for continuing education, specific hourly requirements are employed by six states: Wisconsin (15 hours), Oregon (12 hours), Washington (10 hours), Arkansas and Connecticut (six hours), and Florida (variable, depending on type of residents). Again, heightened requirements often apply to facilities specializing in dementia care, as discussed in the separate section of this report.

Recommendation

California's minimum training standards should be increased significantly. Ten hours is clearly insufficient, given resident care needs, and is markedly lower than standards employed in other surveyed states.

Direct Care Training

	CPR and/or First Aid Required	Curriculum Developed By State	Certain Topics Required By Law	Exam Required	Trainer Standards Set By Law
California	X		X		X
Alabama	X		X		
Arkansas			X		
Connecticut	X		X		X
Florida	X		X		
Kansas	X		X		X
Mississippi					
New York					
Oregon	X		X		
Pennsylvania	X		X		
Washington	X	X	X		X
Wisconsin	X		X		

Hourly Minimums for Direct Care Training

	Initial Training			Hourly Standards for Continuing Education
	Minimum of 1-12 Hours	Minimum of 13-24 Hours	Minimum of 25+ Hours	
California	X			X
Alabama				
Arkansas				X
Connecticut			X	X
Florida			X	X
Kansas			X	
Mississippi				
New York				
Oregon				X
Pennsylvania		X		
Washington			X	X
Wisconsin	X			X

These tables do not include standards applicable to a dementia-specialization facility; those are discussed in relation to dementia care in a separate section of this report.

Staffing Standards

California Rules

California rules require that staffing always "be sufficient in numbers, and competent to provide the services necessary to meet resident needs." In addition, California rules set specific minimum ratios for the overnight shift (10 p.m. to 6 a.m.). During that time, a facility with 15 or fewer residents must have at least one staff member on duty. If a facility has 16 to 100 residents, at least one staff member must be on duty and another must be on call and no more than 10 minutes away. If a facility has 101 to 200 residents, one staff member must be on duty, another must be at the facility on call (but possibly sleeping), and a third must be on call and within 10 minutes away.

Other States' Rules

Of the 11 surveyed states, nine have rules that explicitly require facility staffing to be adequate to meet residents' needs. Five of the surveyed states also have minimum staffing ratios; in four of these states, the ratio requirement is in addition to the requirement that staffing be adequate to meet residents' needs.

For Arkansas' Level I facilities, state rules set a minimum number of direct-care staff members for the day shift, the evening shift, and the overnight shift, as summarized in the following chart:

Staffing Standards Arkansas Assisted Living Facilities, Level I

# of Residents	Day	Evening	Overnight
1-16	**1**	**1**	**1**
17-32	**2**	**2**	**1**
33-49	**2**	**2**	**2**
50-66	**3**	**2**	**2**
67-83	**4**	**2**	**2**
84 and above	**5**	**3**	**2**

In Arkansas' Level II facilities (for residents who need greater assistance), minimum staffing ratios are based on two shifts: the day shift (7:00 a.m. to 8:00 p.m.) and the night shift (8:00 p.m. to 7:00 a.m.). During the day shift, the facility must employ at least one staff member for each 15 residents; during the night shift, the requirement is reduced to one staff member for each 25 residents. At all times, a Level II facility must have at least two staff members on duty on the premises, and at least one of those staff members must be a certified nurse aide.

Florida's standards are based on minimum staff hours per week. For up to five residents, the minimum is 168 hours weekly (equivalent to one person working around-the-clock). The minimum increases to 212 hours weekly for six to fifteen residents, and 253 hours for 16 to 25 residents. In addition, in facilities with 17 or more residents, at least one staff member must be on duty and awake at all times.

Florida's minimum requirements increase up to (for example) 416 hours for facilities with 56 to 65 residents, and 539 hours for facilities with 86 to 95 residents. Beyond the 95-resident level, the minimum increases by 42 hours weekly

for every 20 additional residents.

The minimum ratios for Mississippi's facilities are comparable to those of Florida's Level II facilities. The Mississippi rules distinguish between a day shift (7:00 a.m. to 7:00 p.m.) and a night shift (7:00 p.m. top 7:00 a.m.), requiring a 1 to 15 ratio during the day and a 1 to 25 ratio during the night.

In New York, each resident must receive at least 3.75 hours of personal services each week, with such hours of service generally provided during the day and evening shifts. In addition, each resident also must be assigned at least one hour of housekeeping services weekly. Accompanying standards govern the supervision that must be provided -- at least one staff supervisor for up to 40 residents, with two, three and four supervisors required for up to 80, 150, and 200 residents, respectively.

The standards in Pennsylvania are based on a resident's mobility, or lack thereof. A "mobile resident" must be provided with at least one hour per day of services; for a resident with mobility needs, this daily minimum is increased to two hours. At least three-quarters of the required hours must be made available during waking hours.

Recommendation

California's current staffing levels are extremely minimal, and should be increased in order to be meaningful. Ideally, staffing minimums would vary to a certain extent based on residents' needs.

Staffing Levels

	Staffing Sufficient to Meet Resident's Needs	Minimum Staffing Ratios
California	X	X
Alabama	X	
Arkansas	X	X
Connecticut		
Florida	X	X
Kansas	X	
Mississippi		X
New York	X	X
Oregon	X	
Pennsylvania	X	X
Washington	X	
Wisconsin	X	

Administrator Standards

California Rules

In California, a facility must have a certified administrator on the premises "a sufficient number of hours to permit adequate attention to management and administration of the facility." When the administrator is absent, a designated substitute with adequate qualifications must provide coverage.

An administrator must be at least 21 years of age, have a high school diploma or the equivalent, and be of good character. In larger facilities, an administrator must also have college and relevant work experience. An administrator must pass a criminal background check before the state can issue a certification.

In order to be certified, an applicant must successfully complete a 40-hour Initial Certification Training Program (including instruction in a specified curriculum) and must pass a standardized test. The training program, the test, and the vendors who provide training must be state-approved. There are limited exceptions from these requirements — for example, applicants with a valid nursing home administrator license must complete only 12 hours of instruction.

Areas of instruction include: facility laws including residents' rights, management and supervision, psychosocial and physical needs of the elderly, the use and misuse of drugs commonly used by the elderly, admission and assessment procedures, and the care of residents with Alzheimer's Disease and other dementias. Certified administrators are required to be recertified every two years, and must take at least 20 hours of continuing education each year.

Other States' Rules

In five of the 11 surveyed states, the rules explicitly require that an administrator be on-premises a specified number of hours per week, generally full-time or 40 hours per week. Seven of the 11 states require that a staff person be designated when the administrator is not present, and four of those states specify that the replacement be qualified. Pennsylvania's strong rules require that the designee have 3,000 hours of direct operational responsibility for approved senior or group housings, pass a state-approved competency-based administrator training test, and meet the qualification and training requirements for direct-care staff. In Arkansas's Level II facilities, the state must be notified if an administrator will be absent for seven or more consecutive days. Ten of the 11 surveyed states set a minimum age requirement for administrators. Eight states require that an administrator be at least 21 years old. Nine of the surveyed states require criminal background checks, and two states specify that an administrator may not be someone listed on the state's nurse's aide or adult abuse registry.

All of the surveyed states set minimum educational requirements for administrators. In seven surveyed states, either some college experience in a health or human services-related field is required, or the applicant must be a high school graduate and/or possess significant health or human services-related experience. In Connecticut, the educational emphasis is placed on a social work background. Three states require only that an administrator have a high school diploma or the equivalent.

In ten of the surveyed states, an administrator must receive some level of pre-certification training and, in six surveyed states, an applicant must pass a written examination, unless excused by the state agency. Kansas and Pennsylvania in particular provide for state-approved training programs and competency examination requirements. In Kansas, an administrator of a facility with 60 or more residents must have a four-year college degree, complete a 480-hour Administrator-in-Training Practicum (with some credit given for experience), and pass both a state and national exam. In Pennsylvania, an applicant must successfully complete a 100-hour standardized administrator training course and competency-based training test. Two states use internships or mentoring programs to meet training requirements.

Seven of the surveyed states require continuing education after certification or licensure, on either an annual or biennial basis. Generally, completion of the continuing education hours is required for renewal of certification. The number of required hours ranges from 12 to 24 hours annually. Three states have two-year continuing education cycles, including Kansas, which requires up to 50 hours, and New York, which requires 60 hours of continuing education during the cycle.

Recommendation

California law should be revised to require an administrator generally to be on-site full-time, and to enumerate the qualifications of a designated substitute when an administrator is absent. The state should consider increasing the number of hours of training required for initial certification, particularly for larger facilities.

Administrator Qualifications

	Required On-Site for Specified Number of Hours	Designated Back-Up When Not Present	Minimum Qualifications (age, education, character, etc.)	Criminal Background Check or Abuse Registry	Certification or Initial Training	State Mandated Curriculum or Written Exam	Continuing Education
California	X	X	X	X	X	X	X
Alabama		X	X	X	X	X	X
Arkansas	X	X	X	X	X	X	
Connecticut			X				
Florida			X	X	X	X	X
Kansas			X	X	X	X	X
Mississippi	X	X	X	X	X		
New York	X	X	X		X		X
Oregon	X	X	X	X	X	X	X
Pennsylvania	X	X	X	X	X	X	X
Washington			X	X	X	X	
Wisconsin		X	X	X	X	X	X

Administrator Training

	Initial Training		Continuing Education	
	Initial Training Minimum of 20-30 Hours	Initial Training Minimum of 30+ Hours	Continuing Education Minimum of 1-20 Hours/Year	Continuing Education Minimum of 20+ Hours/Year
California		X	X	
Alabama	X		X	
Arkansas				
Connecticut				
Florida	X		X	
Kansas		X		X
Mississippi				
New York				X
Oregon		X	X	
Pennsylvania		X		X
Washington	X			
Wisconsin			X	

IV. Resident Rights

Right to Make Everyday Decisions

California Rules

Facility rules provide a resident with explicit rights to wear his or her own clothes, keep and use personal possessions, and spend his or her own money. Between-meal food must be available, unless limited by physician-ordered dietary restrictions.

Other States' Rules

In Oregon, a resident has the right to "exercise individual rights that do not infringe upon the rights of others." Washington similarly requires that a facility "[r]easonably accommodate residents consistent with applicable state and/or federal law."

Six of the surveyed states specify that a resident has a right to wear his or her own clothes; five of these states also set forth a right to retain and use personal possessions. Three states explicitly grant a resident the right to prepare and store food.

Recommendation

Quality of life is crucial for assisted living residents. Accordingly, higher-quality care providers commonly strive for "person-centered" care that allows residents to make decisions and exercise preferences. These principles should

be incorporated into California law. To a certain extent, model language includes the provisions from Oregon and Washington quoted above. Another model is federal nursing home law, which provides residents with the right "to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered." The corresponding regulation expands upon this right by specifying a resident's right to "[c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care."

Another useful model comes from recent federal rules (released January 2014) that govern Medicaid-certified assisted living facilities, along with other Medicaid-funded providers of home and community-based services. The new rules, among other things, require that a facility optimize "individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact." Other provisions of the rules similarly provide strong support for a resident's day-to-day quality of life.

Resident Decision-Making Rights

	Right to Wear Own Clothes	Right to Prepare and Store Food	Right to Retain and Use Personal Possessions	Right to Make Choices that Don't Infringe on Others' Rights
California	X		X	
Alabama	X		X	
Arkansas	X	X	X	
Connecticut				
Florida				
Kansas		X		
Mississippi	X			
New York				
Oregon				X
Pennsylvania	X	X	X	
Washington	X		X	X
Wisconsin	X		X	

Visitors

California Rules

In California, a resident has a right to receive visitors privately at "reasonable hours," without any prior notice to the facility. These visitation rights may be limited if a visit would infringe upon other residents' rights.

Other States' Rules

In seven of the 11 surveyed states, a resident has a right to a visit from any person of the resident's choosing. In four of these states, the visit can take place at any time. In three of the states, the resident must have an opportunity to visit in private. Some of these rights explicitly are subject to limitation if other residents' rights otherwise would be infringed.

In Kansas, a resident must have "immediate access" to any visitor of the resident's choosing, although "reasonable restrictions" can be placed upon friendly visitors who are not family members. Kansas and Wisconsin each prohibit any restrictions on visits from public officials. Mississippi and Wisconsin require a facility to provide space for visitation.

Recommendation

California law should be revised to allow visitation at any time.

Visitors

	Right to Visit from Any Person of Resident's Choosing	Right to Receive Visitor at Any Time	Privacy During Visits
California			X
Alabama	X	X	
Arkansas	X	X	X
Connecticut			
Florida			
Kansas	X		
Mississippi			
New York			
Oregon	X		
Pennsylvania	X	X	X
Washington	X		
Wisconsin	X	X	X

Right to Refuse Treatment

California Rules

California identifies a right to refuse treatment or services: the rules' listing of personal rights includes the resident's right to "receive or reject medical care, or other services."

Other States' Rules

Nine of the 11 surveyed states recognize a resident's right to refuse treatment or services. In Alabama and Wisconsin, this right has an explicit exception in cases when there may be danger to others. Wisconsin also includes an exception for when a court order requires treatment. In Pennsylvania, Washington, and Wisconsin, providers must be notified of a resident's refusal to take a prescribed medication.

In a limited number of states, the rules explicitly require that a resident be provided with information about the risks of refusing care. In Arkansas and Kansas, the right to refuse medication is conditioned on notice of, and acceptance of, the risk of not taking the medication. Similarly, Florida allows a resident to refuse therapeutic diets when he or she is aware of the risk of doing so, and accepts that risk.

Even without explicit rules, notification procedures are likely required in most or all states under generally applicable principles of informed consent. In any setting, under these principles, medication administration or any other medical intervention can take place only if the patient first has been notified of the benefits and risks, and then has chosen to proceed with the recommended action.

Recommendation

The existing rules should be amended to explicitly set forth a right to informed consent.

Right to Refuse Treatment

	Right to Refuse Treatment or Services	Exception to Right When Danger to Others	Exceptions When Court Order Requires Treatment
California	X		
Alabama	X	X	
Arkansas	X		
Connecticut	X		
Florida	X		
Kansas	X		
Mississippi			
New York			
Oregon	X		
Pennsylvania	X		
Washington	X		
Wisconsin	X	X	X

Evictions

California Rules

A resident can be evicted only for one of five reasons: 1) nonpayment, 2) the resident has a need that cannot be met in the facility, 3) the resident has violated facility policies, 4) the resident has violated state or local law, or 5) the facility is changing to a difference type of use. A resident has a right to challenge an eviction in court, following the same procedures that apply in landlord/tenant matters.

Other States' Rules

Of the 11 surveyed states, seven allow eviction if the resident has failed to pay. The same seven states also allow eviction in cases in which the resident's presence endangers the health or safety of others.

A different group of seven states allows eviction due to the resident needing services not provided in the facility. In some cases, the relevant regulation refers to the facility's inability to meet the resident's need; in other cases, the regulation refers to the resident needing a level of care exceeding the scope of the facility's license. From a consumer protection perspective, the latter formulation is preferable: the scope of licensure is a set standard, whereas a facility's ability to meet a resident's need may depend upon the extent to which the management chooses to address the need. Washington addresses this issue by requiring that, before any eviction, the facility must "[f]irst attempt through reasonable accomodations to avoid the transfer or discharge."

In most states, the rules do not articulate a process by which a resident can challenge a proposed eviction. As in California, New York explicitly recognizes the right to a court hearing. (The practice in Washington, based on a discussion with a Washington attorney, also is to require a court hearing, pursuant to a generally accepted interpretation of the state's case law.) Oregon establishes a right to an administrative hearing, and Arkansas and Wisconsin make reference to filing a complaint with the state licensing agency.

Recommendation

California should amend its rules to tighten up the authorized justifications for eviction. Appropriate justifications for eviction are nonpayment, the resident's presence endangering the health or safety of others, and the facility losing its licensure. Any justification based on the resident's care needs should refer to the care needs exceeding the scope of the facility's licensure, and should obligate the facility to take all necessary steps in its authority to attempt to meet those needs in compliance with the Americans with Disabilities Act.

Justifications for Eviction

	Notice By Facility Alone	Facility Unable to Meet Needs	Need for Services Beyond Scope of License	Violation of Admission Agreement or Facility Policies	Danger to Safety or Health of Others	Nonpayment
California		X		X		X
Alabama	X					
Arkansas	X		X	X	X	X
Connecticut						
Florida	X					
Kansas		X			X	X
Mississippi						
New York			X		X	X
Oregon		X			X	X
Pennsylvania		X	X		X	X
Washington		X			X	X
Wisconsin		X	X		X	X

Process for Adjudicating Evictions

	Complaint to Facility	Complaint to State	Administrative Hearing	Court Hearing
California				X
Alabama				
Arkansas		X		
Connecticut				
Florida				
Kansas				
Mississippi				
New York				X
Oregon			X	
Pennsylvania				
Washington				
Wisconsin		X		

Restraints

California Rules

California limits the use of support or safety devices that have restraining qualities, but does not explicitly limit the use of physical or chemical restraints. A "chemical restraint" is a medication used to keep a resident more easily managed.

Other States' Rules

Five of the surveyed states prohibit the use of physical restraints. In addition, Alabama, Oregon and Wisconsin limit physical restraint use to emergencies.

Six states prohibit the use of chemical restraints in assisted living. In addition, Florida and Oregon strictly limit the use of chemical restraints, with Oregon prohibiting their use "to discipline a resident, or for the convenience of the facility."

Recommendation

California law should be revised to bar the use of physical or chemical restraints in assisted living.

Restraints

	Prohibits Use of Physical Restraints	Prohibits Use of Chemical Restraints	Limits Use of Physical Restraints	Limits Use of Chemical Restraints
California				
Alabama		X	X	
Arkansas				
Connecticut				
Florida				X
Kansas	X	X		
Mississippi	X	X		
New York	X			
Oregon			X	X
Pennsylvania	X	X		
Washington	X	X		
Wisconsin		X	X	

Managing Residents' Money

California Rules

When a facility holds and handles a resident's money, California requires individual accounting, receipts for expenditures, and a bond. The state also forbids commingling of resident and facility money.

Other States' Rules

Like California, nine of the 11 surveyed states require individual accounting for resident money. Seven of the 11 states explicitly forbid commingling of facility and resident money; six of those states also require facilities to provide regular statements of residents' accounts.

In addition, four of these six states have explicit rules allowing residents timely and regular access to their funds. For example, Arkansas requires that a resident at a minimum have access to a personal allowance account from nine a.m. to five p.m., Monday through Friday.

New York, Washington, and Wisconsin each specify that interest on accounts is a resident's property.

Recommendation

California law should be revised to specify that a resident must have timely access to personal funds held by a facility, and that any earned interest is the resident's property.

Managing Residents' Funds

	Individual Records of Resident Accounts	No Commingling of Resident and Facility Funds	Regular Statements	Resident Has Timely Access to Funds	Bond Required	Interest on Funds Is Resident's Property
California	X	X	X		X	
Alabama	X					
Arkansas	X	X	X	X		
Connecticut						
Florida	X	X	X			
Kansas						
Mississippi	X					
New York	X	X	X	X		X
Oregon	X	X	X	X		
Pennsylvania	X	X	X	X		
Washington	X	X			X	X
Wisconsin	X	X	X			X

V. Accountability

Frequency of Inspections

California Rules

In general, the state must inspect each facility at least once every five years and, under a random sampling methodology, conduct annual inspections of 30 percent of facilities. In recent years, these inspections have not been comprehensive, but instead have considered only 32 "key indicators," in order to make the inspections shorter and thus less expensive for the state.

Annual inspections are required under the following circumstances: the facility is on probation; the facility's compliance plan requires an annual evaluation; an enforcement accusation is pending against the facility; or annual inspection is required as a condition of the facility's receipt of Medicaid funding. These inspections are comprehensive, rather than being limited to the key indicators.

Other States' Rules

Of the surveyed states, six states require inspection at least once every two years. In Pennsylvania, inspections must occur at least annually. Kansas requires at least one unannounced inspection every 15 months, but also requires that the statewide average interval between inspections not exceed 12 months. Washington's rules are similar — an inspection at least every 18 months, with an annual average of no more than 15 months.

New York requires one unannounced inspection no less than annually, but for facilities receiving the state's highest rating, the law extends that period to at least once every 18 months. Kansas and New York law also allow for agency discretion to require more frequent inspections. Another three of the surveyed states evidently give the licensing agency discretion with respect to the frequency of inspections.

Recommendation

California should require more frequent inspections — five years is an excessive period of time between inspections. Furthermore, these inspections should not be limited to so-called key indicators; the state has no proof that such a truncated survey is adequate.

Inspection Frequency

	Inspection At Least Every Two Years	Inspection At Agency Discretion
California		X
Alabama		X
Arkansas		X
Connecticut		
Florida	X	
Kansas	X	X
Mississippi		
New York	X	X
Oregon	X	
Pennsylvania	X	
Washington	X	
Wisconsin		X

Enforcement System

California Rules

California authorizes a maximum penalty of $150 per day per violation. As a result, violations that occur on one day, regardless of severity, result in a fine not to exceed $150. A certain augmentation is authorized for repeat violations. In addition, of course, the state has authority to terminate or revoke a license in response to particularly egregious actions or inaction.

Other States' Rules

Five of the surveyed states authorize per diem money penalties. In New York, the maximum is $1,000 per day, with no set limit on the total amount. Washington's penalties range as high as $3,000 per day per violation "for interference, coercion, discrimination and/or reprisal by an assisted living facility."

Five of the surveyed states authorize money penalties on a per-instance basis. In Alabama and Florida, the maximum for a per-instance penalty is $10,000. The Arkansas maximum is $2,500 for the most serious category of violation, with an overall monthly limit of $5,000.

Eight of the 11 surveyed states explicitly authorize non-monetary remedies. Arkansas, for example, requires a plan of correction for a violation, and has additional authority to deny new admissions, revoke licenses for a third violation, appoint a temporary administrator, transfer residents, require additional training, or monitor facilities. Wisconsin has authority to deny payment for services provided during a period of noncompliance, in addition to other remedies.

Four of the surveyed states explicitly authorize criminal charges for specified violations of facility rules.

Recommendation

Currently, California's money penalties are set at a relatively low level and, in most situations, the suspension or termination of a license is too extreme a penalty. California law should be revised to authorize per-instance money penalties of a meaningful amount, and to establish intermediate penalties to enable the state to compel compliance without the need to seek suspension or revocation of a license.

Enforcement Penalties

	Per Diem Money Penalties	Per Incident Money Penalties	Non-Monetary Penalties	Criminal Penalties Specific to Residential Care
California	X			
Alabama		X		
Arkansas		X	X	
Connecticut				
Florida		X	X	
Kansas	X		X	X
Mississippi			X	X
New York	X			
Oregon		X	X	X
Pennsylvania	X		X	
Washington	X	X	X	
Wisconsin	X		X	X

Insurance and Bonding

California Rules

Facilities must provide financial documentation at start-up, including a financial plan of operation. Also, facilities must provide proof of a minimum of three months of cash reserves, sufficient funds to complete any proposed construction, and bonds to protect resident funds. Liability insurance is not required although, if the facility has insurance, it must provide the state with information regarding that insurance.

Other States' Rules

In five of the surveyed 11 states, facilities must demonstrate financial stability as a prerequisite to regulatory approval.

Oregon requires that all applicants submit proof of fiscal responsibility and not have any history of negative incidents involving Medicaid overpayments, employee or worker's compensation funds, or certain other expenses. In addition, Oregon requires new facilities to provide monthly breakdowns of revenues and expenditures for the first year of operation, with explanations for any shortfalls and proposed plans for avoiding cash flow problems.

Four of the surveyed states join California in requiring facilities to have operating reserves on hand. Liability insurance is also a somewhat common requirement, with Connecticut, Florida, and Washington

requiring coverage. Washington sets a minimum coverage amount of one million dollars per occurrence and two million dollars in aggregate.

Other states require other types of insurance in some circumstances, with Wisconsin requiring homeowner's or renter's insurance for home-based facilities, and Connecticut and Washington requiring malpractice insurance when licensed professionals work in facilities. Again, Washington's coverage requirements specify minimum coverage of one million dollars per incident and two million dollars in the aggregate.

Florida and Kansas explicitly require that facilities use standard accounting practices.

Recommendation

California law should be revised to require liability coverage of a meaningful amount.

Insurance and Bonding

	Liability or Malpractice Insurance	Operating Reserves	Initial Documentation of Financial Stability	No History of Negative Financial Incidents
California		X	X	
Alabama				
Arkansas				
Connecticut	X		X	
Florida	X	X		
Kansas		X	X	
Mississippi				
New York			X	
Oregon		X	X	X
Pennsylvania				
Washington	X			X
Wisconsin		X	X	

Website Information

California's Website

California does not offer online access to facility-specific information. Under a tab for "Facility Facts," California's website instructs interested persons to contact the appropriate regional office to request review of any licensee's facility file. There are 16 such offices in the state.

A regional office needs several days advance notice in order to prepare a paper file for review. The file is the same file used by state employees; the advance notice is needed for the state to remove any information considered private, prior to review by the consumer or other interested person.

Other States' Websites

Six of the 11 surveyed states provide on-line information regarding a facility's compliance (or non-compliance) with state rules. In four of these states, the website is structured to allow potential residents to look for facilities within a particular geographic area.

Florida, for example, has a Facility Locator website that allows searches under several categories, including county, zip code, non-profit status, and (for persons seeking information on a particular facility) the facility name or street address. Each facility's profile lists (among other things) the owner, the administrator, the date on which the owner began operating the facility, the facility capacity, and whether or not the facility offers extended congregate care (a higher level of care). Also, the site contains a link that leads to copies of the facilities' inspection reports for the preceding five years.

Similarly, Washington's Assisted Living Facility Locator allows a person to search on-line by county, city, zip code, or number of residents. Also, the search can be modified to search only for those facilities that have not received enforcement letters from the state. Pennsylvania's website for personal care homes is similar, allowing searches by county or zip code, and including copies of inspection reports in each facility's on-line profile.

Wisconsin's website provides information on many different types of care providers – the several types of assisted living facilities licensed in Wisconsin, plus nursing homes, hospitals, health clinics, hospice agencies, and other provider types. Also, for assisted living only, a search can focus on facilities specializing in a certain population, such as "advanced aged" persons, or persons who are terminally ill. Geographically, searches can be limited by county, city or zip code. A facility profile page includes a space for a facility's inspection history although, for many facilities, the profile states that no survey information is available.

In several states, inspection-related information is presented in a way that would be of little use to consumers. For example, New York organizes inspection reports by the quarter and year in which they were made, listing violations (if any) only by the category of violation. Alabama similarly lists only the date and category of violation.

Recommendation

California should develop a website that allows consumers to find facilities by county, city and zip code. At a minimum, such a

website should provide copies of inspection reports for the preceding three years, along with a usable summary of those inspection reports for that period. The website should promptly notify consumers whenever a facility's quality of care is potentially compromised, including whenever the state has initiated enforcement proceedings against the facility.

Website Features

	Website Enables Search for Facility By Geographic Area	On-Line Access to Inspection Report Information	State Refers Consumers to State Office for Inspection Report Information
California			X
Alabama		X	
Arkansas			
Connecticut			
Florida	X	X	
Kansas			
Mississippi			
New York		X	
Oregon			X
Pennsylvania	X	X	
Washington	X	X	
Wisconsin	X	X	

Conclusion

Overall, California's assisted living system is significantly out of date. Over the past 10 to 15 years, residents' care needs have increased significantly, but quality-of-care rules have not kept up. In general, California follows a one-size-fits-all model with standards that, if they ever are adequate, are adequate only for residents with low care needs. For example, California still requires only 10 hours of initial training for direct-care staff. Also, a facility with 100 residents can satisfy minimum overnight staffing levels with only one person on duty.

A significant part of the problem is California's orientation over the years towards maintaining a bright-line separation between assisted living and health care expertise. Other states have searched for a best-of-both-worlds situation in which a pleasant environment and a satisfying quality of life are teamed with competent health care as necessary. In California, however, the system relies excessively on health care from visiting nurses or home health aides. Facility standards require virtually no health care expertise from facility staff, and the Department of Social Services similarly is lacking in health care knowledge. This intentional disregard of health care concerns is a disservice to vulnerable facility residents.

A defense of the status quo might protest that the introduction of health care expertise would convert assisted living facilities into nursing homes. In fact, the experience of other states shows the opposite. Requiring some nurse involvement in assessment or service planning, for example, supports the assisted living model in other states. Incorporating health care expertise makes it more likely that assisted living care will be adequate, and reduces the chance that a resident will suffer from neglect, or be forced prematurely to move to a nursing home.

A status quo defense also might argue that additional standards would be prohibitively expensive for small six-bed facilities with relatively independent residents, particularly when those residents rely on Supplemental Security Income (SSI). This type of argument, however, illustrates how a one-size-fits-all model can distort public policy. The inadequacy of California's regulatory standards is due in part to an excessive focus on small facilities and on residents with limited care needs. The public policy strategy should be to develop standards that vary to a certain extent with circumstances, rather than applying loose, lowest-common-denominator standards across the board.

As this report demonstrates, there is no one right answer. Each state must weigh the options and develop its own system. For too long, however, California has abdicated this responsibility and failed to address many extremely important issues. As soon as possible, the California Legislature and Department of Social Services should rectify this problem and initiate honest discussion about the pros and cons of various policy options. Such a discussion is the necessary first step in bringing California assisted living policy into the 21st century.

Citations

I. Type of Care, and Type of Residents

Levels of Care

- *Alabama:* Ala. Admin. Code r. 420-5-4-.02, 420-5-20-.02.
- *Arkansas:* Code Ark. R. §§ 016.06.001.100, 016.06.002.100.
- *California:* Cal. Code Regs. tit. 22, § 87100.
- *Connecticut:* Conn. Agencies Regs. § 19-13-D105(a).
- *Florida:* Fla. State. Ann. § 429.65; Fla. Admin. Code Ann. r. 58A-5.014, 58A-5.029 – 031, 58A-5.0191.
- *Kansas:* Kan. Stat. Ann. § 39-923; Kan. Admin. Regs. §§ 26-39-100, 65-3501.
- *Mississippi:* Code Miss. R. 15 016 048 §§ 5.1 – 5.2, 15 016 050 § 1.2.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, §§ 1001.2, 1001.5; N.Y. Coal. for Quality Assisted Living, Inc. v. Daines, No. 6328-08, slip op. 51942(U) (N.Y. Sup. Ct. Sept. 11, 2009); Empire State Ass'n of Assisted Living v. Daines, 887 N.Y.S. 2d 452 (N.Y. Sup. Ct. 2009). Oregon: Or. Rev. Stat. § 443.705; Or. Admin. R. 411-054-0005, 411-057-0110.
- *Pennsylvania:* 55 Pa. Code §§ 2800.4, 2800.11.
- *Washington:* Wash. Admin. Code §§ 388-76-10000, 388-78A-2020.
- *Wisconsin:* Wis. Admin. Code §§ DHS 82.02, 83.04, 88.02, 89.11.

Care Need Ceilings

- *Alabama:* Ala. Admin. Code r. 420-5-4-.05, 420-5-4-.06.
- *Arkansas:* Ark. Code Ann. § 20-10-1704; Code Ark. R. §§ 016.06.001.601.1, 016.06.001.601.4, 016.06.001.703.2, 016.06.001.704, 016.06.002.601.1, 016.06.002.601.4.
- *California:* Cal. Code Regs. tit. 22, §§ 87455, 87606, 87609, 87615, 87632.
- *Connecticut:* n/a.
- *Florida:* Fla. Stat. Ann. § 429.26; Fla. Admin. Code Ann. r. 58A-5.0181.
- *Kansas:* Kan. Admin. Regs. §§ 26-41-200, 26-41-204.
- *Mississippi:* Code Miss. R. 15 016 047 § 12.1, 15 016 048 § 12.1.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, §§ 1001.2, 1001.7; N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.4, 488.4.
- *Oregon:* Or. Admin. R. 411-054-0045, 411-054-0080.
- *Pennsylvania:* 55 Pa. Code §§ 2800.22, 2800.29, 2800.220, 2800.228 – .229.
- *Washington:* Wash. Admin. Code §§ 388-78A-2050, 388-78A-2202, 388-78A-2340.
- *Wisconsin:* Wis. Admin. Code §§ DHS 82.07, 83.27, 83.38, 88.07, 89.29.

II. Care Standards

Service Planning

- *Alabama:* Ala. Admin. Code r. 420-5-4-.05.

- *Arkansas:* Code Ark. R. §§ 016.06.001.300, 016.06.001.603.1, 016.06.001.703.1, 016.06.001.702, 016.06.001.703.3, 016.06.001.703.4, 016.06.002.300, 016.06.002.603.1, 016.06.002.701.1, 016.06.002.702.2.
- *California:* Cal. Code Regs. tit. 22, §§ 87457 – 87458, 87467.
- *Connecticut:* Conn. Agencies Regs. §§ 19-13-D105(k), 19-13-D105(m).
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.030, 58A-5.0181.
- *Kansas:* Kan. Admin. Regs. §§ 26-39-103, 26-41-201 – 202.
- *Mississippi:* Code Miss. R. 15 016 047 § 12.2, 15 016 048 §12.2.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, § 1001.7.
- *Oregon:* Or. Admin. R. 411-054-0027, 411-054-0034, 411-054-0036.
- *Pennsylvania:* 55 Pa. Code §§ 2800.224 – .225, 2800.227.
- *Washington:* Wash. Admin. Code §§ 388-78A-2070, 388-78A-2130.
- *Wisconsin:* Wis. Admin. Code §§ DHS 82.06, 83.32, 83.35, 88.06, 89.26.

Nurse Participation

- *Alabama:* Ala. Admin. Code r. 420-5-4-.06.
- *Arkansas:* Code Ark. R. §§ 016.06.002.504.2.2, 016.06.002.504.2.3, 016.06.002.703.1.2.
- *California:* Cal. Code Regs. tit. 22, §§ 87101, 87611, 87618 – 87619, 87621 – 87623, 87625 – 87626, 87628 – 87629, 87631, 87633.
- *Connecticut:* Conn. Agencies Regs. §§ 19-13-D105(h), 19-13-D105(i).
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.0131, 58A-5.0182, 58A-5.031.
- *Kansas:* Kan. Admin. Regs. §§ 26-41-201, 26-41-204 – 205.
- *Mississippi:* Code Miss. R. 15 016 047 § 11.4, 15 016 048 § 15.1.
- *New York:* N.Y. Coal. for Quality Assisted Living, Inc. v. Daines, No. 6328-08, slip op. 51942(U) (N.Y. Sup. Ct. Sept. 11, 2009); Empire State Ass'n of Assisted Living v. Daines, 887 N.Y.S. 2d 452 (N.Y. Sup. Ct. 2009).
- *Oregon:* Or. Admin. R. 411-054-0045.
- *Pennsylvania:* 55 Pa. Code §§ 2800.182, 2800.224 – .225.
- *Washington:* Wash. Admin. Code § 388-78A-2280.
- *Wisconsin:* Wis. Admin. Code §§ DHS 83.37, 89.23.

Medication Administration

- *Alabama:* Ala. Admin. Code r. 420-5-4-.06.
- *Arkansas:* Code Ark. R. §§ 016.06.001.702.1, 016.06.002.703.1.
- *California:* Cal. Code Regs. tit. 22, §§ 87101, 87465.
- *Connecticut:* Conn. Agencies Regs. § 19-13-D105(h).
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.0185.
- *Kansas:* Kan. Admin. Regs. §§ 26-39-103, 26-41-205, 26-50-30.

- *Mississippi:* Code Miss. R. 15 016 047 § 11.4, 15 016 048, § 15.1.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.7, 488.7.
- *Oregon:* Or. Admin. R. 411-054-0055, 411-054-0300, 851-047-0000, 851-047-0010 – 0040.
- *Pennsylvania:* 55 Pa. Code §§ 2800.181 – .182.
- *Washington:* Wash. Rev. Code §§ 69-41-010, 69-41.085, Wash. Admin. Code §§ 388-78A-2210 – 2250, 388-78A-2270 – 2290, 246-840-930, 246-840-970.
- *Wisconsin:* Wis. Admin. Code §§ DHS 82.07, 83.37, 88.07, 89.23, 89.34.

Dementia Care Standards

- *Alabama:* Ala. Admin. Code r. 420-5-4-.06, 420-5-20-.04, 420-5-20-.06, 420-5-20-.12.
- *Arkansas:* Code Ark. R. §§ 016.06.001.803 – .807, 016.06.002.803 – .807.
- *California:* Cal. Code Regs. tit. 22, §§ 87705 – 87707.
- *Connecticut:* Conn. Agencies Regs. §§ 19a-562, 19a-562a.
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.026, 58A-5.0191.
- *Kansas:* Kan. Admin. Regs. § 26-41-103.
- *Mississippi:* Code Miss. R. 15 016 050.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, §§ 1001.2, 1001.5.
- *Oregon:* Or. Admin. R. 411-057-0100, 411-057-0110 – 0160.
- *Pennsylvania:* 55 Pa. Code §§ 2800.69, 2800.121, 2800.164, 2800.231 – .239.
- *Washington:* Wash. Admin. Code §§ 388-78A-2370 – 2380, 388-78A-2510.
- *Wisconsin:* n/a.

III. Staff Training and Staffing Levels

Training for Direct-Care Staff

- *Alabama:* Ala. Admin. Code r. 420-5-4-.04, 420-5-20-.04.
- *Arkansas:* Code Ark. R. §§ 016.06.001.504.4, 016.06.002.504.4.
- *California:* Cal. Code Regs. tit. 22, §§ 87411, 87707.
- *Connecticut:* Conn. Agencies Regs. §§ 19-13-D8t(l), 19-13-D69(d)(2), 19-13-D83, 19-13-D105(a)(4), 19-13-D105(f), 19-13-D105(g), 19-13-D105(j).
- *Florida:* Fla. Stat. § 429.52; Fla. Admin. Code r. 58A-5.0191.
- *Kansas:* Kan. Stat. Ann. § 39-936; Kan. Admin. Regs. §§ 26-50-20, 26-50-22, 26-50-30.
- *Mississippi:* n/a.
- *New York:* n/a.
- *Oregon:* Or. Admin. R. 411-054-0070.
- *Pennsylvania:* 55 Pa. Code §§ 2800.63, 2800.65, 2800.67.
- *Washington:* Wash. Rev. Code § 74.39A.074; Wash. Admin. Code

§§ 388-78A-2450, 388-78A-2474, 388-78A-2510, 388-78A-2600, 388-112-0045, 388-112-0205, 388-112-0320, 388-112-0380; Training Requirements & Classes – DSHS Curriculum Available, http://www.altsa.dshs.wa.gov/Professional/training/newcurriculum.htm.

- *Wisconsin:* Wis. Admin. Code §§ 83.19- 83.22, 83.25, 88.04, 89.23;

Staffing Standards

- *Alabama:* Ala. Admin. Code r. 420-5-4-.04, 420-5-20-.04.
- *Arkansas:* Code Ark. R. §§ 016.06.001.504.3, 016.06.001.805, 016.06.002.504.2.4, 016.06.002.504.3, 016.06.002.805.
- *California:* Cal. Code Regs. tit. 22, §§ 87411, 87415.
- *Connecticut:* n/a.
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.019, 58A-5.030.
- *Kansas:* Kan. Admin. Regs. § 26-41-102.
- *Mississippi:* Code Miss. R. 15 016 047, § 11.4, 15 016 048, § 11.4.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.9, 488.9.
- *Oregon:* Or. Admin. R. 411-054-0045, 411-054-0070.
- *Pennsylvania:* 55 Pa. Code §§ 2800.56 – .57, 2800.60.
- *Washington:* Wash. Admin. Code § 388-78A-2450.
- *Wisconsin:* Wis. Admin. Code §§ DHS 83.36, 89.23.

Administrator Standards

- *Alabama:* Ala. Admin. Code r. 135-X-1-.01- 135-X-6-.01, 420-5-4-.04.
- *Arkansas:* Code Ark. R. §§ 016.06.001.300, 016.06.001.504.2, 016.06.002.504.2.
- *California:* Cal. Code Regs. tit. 22, §§ 87405 – 87407, 87785.
- *Connecticut:* Conn. Agencies Regs. § 19-13-D105(c).
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.019, 58A-5.0191.
- *Kansas:* Kan. Stat. Ann. §§ 39-923, 65-3502; Admin. Regs. §§ 26-41-101, 28-38-18 – 19.
- *Mississippi:* Code Miss. R. 15 016 047 §§11.1 – 11.2, 15 016 048 §§ 11.1 – 11.2.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.9, 488.9.
- *Oregon:* Or. Admin. R. 411-054-0065.
- *Pennsylvania:* 55 Pa. Code §§ 2800.53, 2800.56, 2800.64.
- *Washington:* Wash. Admin. Code §§ 388-78A-2520 – 2527, 388-78A-2530, 388-78A-2462.
- *Wisconsin:* Wis. Admin. Code §§ DHS 82.04, 83.15, 83.25, 88.04.

IV. Resident Rights

Right to Make Everyday Decisions

- *Alabama:* Ala. Admin. Code r. 420-5-4-.05, 420-5-20-.05.
- *Arkansas:* Code Ark. R.

§§ 016.06.001.603, 016.06.001.700, 016.06.002.603, 016.06.002.700.

- *California:* Cal. Code Regs. tit. 22, § 87468.
- *Connecticut:* n/a.
- *Florida:* n/a.
- *Kansas:* Kan. Admin. Regs. § 26-41-206.
- *Mississippi:* Code Miss. R. 15 016 047 § 11.11, 15 016 048 § 11.11.
- *New York:* n/a.
- *Oregon:* Or. Admin. R. 411-054-0027.
- *Pennsylvania:* 55 Pa. Code §§ 2800.42, 2800.101.
- *Washington:* Wash. Rev. Code § 70.129.140; Wash. Admin. Code § 388-78A-2660.
- *Wisconsin:* Wis. Stat. Ann. § 51.61; Wis. Admin. Code DHS § 89.34.
- *Federal Nursing Home Law:* 42 U.S.C. §§ 1395i-3(c)(1), 1396r(c)(1); 42 C.F.R. § 483.15.
- *Federal Home and Community-Based Services Rules:* 42 C.F.R. § 441.530.

Visitors

- *Alabama:* Ala. Admin. Code r. 420-5-4-.05, 420-5-20-.05.
- *Arkansas:* Code Ark. R. §§ 016.06.001.603, 016.06.001.505, 016.06.002.603, 016.06.002.505.
- *California:* Cal. Code Regs. tit. 22, § 87468.
- *Connecticut:* n/a.
- *Florida:* n/a.
- *Kansas:* Kan. Admin. Regs. § 26-39-103.
- *Mississippi:* n/a.
- *New York:* n/a.
- *Oregon:* Or. Admin. R. 411-054-0027.
- *Pennsylvania:* 55 Pa. Code § 2800.42.
- *Washington:* Wash. Rev. Code § 70.129.090.
- *Wisconsin:* Wis. Stat. Ann. § 50.09; Wis. Admin. Code DHS § 89.34.

Right to Refuse Treatment

- *Alabama:* Ala. Admin. Code r. 420-5-4-.05, 420-5-20-.05.
- *Arkansas:* Code Ark. R. §§ 016.06.001.603.1, 016.06.002.603.1.
- *California:* Cal. Code Regs. tit. 22, § 87468.
- *Connecticut:* Conn. Agencies Regs. § 19-13-D105(m).
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.020.
- *Kansas:* Kan. Admin. Regs. § 26-39-103.
- *Mississippi:* n/a.
- *New York:* n/a.
- *Oregon:* Or. Admin. R. 411-054-0027.
- *Pennsylvania:* 55 Pa. Code § 2800.142.
- *Washington:* Wash. Admin. Code § 388-78A-2230.
- *Wisconsin:* Wis. Stat. Ann. § 51.61; Wis. Admin. Code §§ DHS 82.07, 83.32, 88.07, 88.10, 89.34.

Evictions

- *Alabama:* Ala. Admin. Code r. 420-5-4-

.05(3)(g)(11).

- *Arkansas:* Code Ark. R. §§ 016.06.001.602, 016.06.002.602.
- *California:* Cal. Code Regs. tit. 22, § 87224.
- *Connecticut:* n/a.
- *Florida:* Fla. Stat. Ann. § 429.28(k).
- *Kansas:* Kan. Stat. Ann. § 39-936; Kan. Admin. Regs. § 26-39-102.
- *Mississippi:* Code Miss. R. 15 016 047 §§ 11.10, 12.1, 15 016 048 §§ 11.10, 12.1.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.5, 488.5.
- *Oregon:* Or. Admin. R. 411-057-0027, 411-057-0080.
- *Pennsylvania:* 55 Pa. Code §§ 2800.228(h).
- *Washington:* Wash. Rev. Code § 70.129.110.
- *Wisconsin:* Wis. Admin. Code §§ DHS 50.09, 82.08, 83.31, 88.08, 89.29.

Restraints

- *Alabama:* Ala. Admin. Code r. 420-5-4-.05, 420-5-4-.06.
- *Arkansas:* n/a.
- *California:* Cal. Code Regs. tit. 22, § 87608.
- *Connecticut:* n/a.
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.0182, 58A-5.0185.
- *Kansas:* Kan. Admin. Regs. § 26-41-200.
- *Mississippi:* Code Miss. R. 15 016 047 § 11.11, 15 016 048 § 11.11.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.7, 488.7.
- *Oregon:* Or. Admin. R. 411-054-0055, 411-054-0060.
- *Pennsylvania:* 55 Pa. Code § 2800.202.
- *Washington:* Wash. Admin. Code § 388-78A-2660.
- *Wisconsin:* Wis. Stat. Ann. § 51.61; Wis. Admin. Code § DHS 82.10, 83.32, 88.10.

Managing Residents' Money

- *Alabama:* Ala. Admin. Code r. 420-5-4-.05, 420-5-20-.05.
- *Arkansas:* Code Ark. R. §§ 016.06.001.505.1.1, 016.06.002-505.1.1.
- *California:* Cal. Code Regs. tit. 22, § 87217.
- *Connecticut:* n/a.
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.021.
- *Kansas:* n/a.
- *Mississippi:* Code Miss. R 15 016 47 §11.8, 15 016 48 §11.8.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, § 1001.9, N.Y. Comp. Codes R. & Regs. tit. 18, §§ 487.6, 488.6.
- *Oregon:* Or. Admin. R. 411-054-0027, 411-054-0085.
- *Pennsylvania:* 55 Pa. Code § 2800.20.
- *Washington:* Wash. Rev. Code § 70.129.040; Wash. Admin. Code §§ 388-78A-2595, 388-78A-2730.
- *Wisconsin:* Wis. Stat. Ann.

§§ 50.09, 51.61; Wis. Admin. Code § DHS 83.34.

V. Accountability

Frequency of Inspections

- *Alabama:* Ala. Code § 22-21-29; Ala. Admin. Code r. 420-5-4-.01.
- *Arkansas:* Code Ark. R. §§ 016.06.001.1001, 016.06.002.1001.
- *California:* Cal. Code Regs. tit. 22, § 87755.
- *Connecticut:* n/a.
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.033, 58A-5.0161.
- *Kansas:* Kan. Stat. Ann. §§ 39-933, 39-935.
- *Mississippi:* Code Miss. R. 15 016 047 § 4.1, 15 016 048 § 4.1.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, § 1001.15; N.Y. Comp. Codes R. & Regs. tit. 18, § 461-a.
- *Oregon:* Or. Admin. R. 411-054-0105.
- *Pennsylvania:* 55 Pa. Code § 2800.3.
- *Washington:* Wash. Rev. Code § 18.20.110; Wash. Admin. Code §§ 388-78A-2594, 388-78A-3140.
- *Wisconsin:* Wis. Admin. Code §§ DHS 89.43, 89.55.

Enforcement System

- *Alabama:* Ala. Code §§ 22-21-33- 34.
- *Arkansas:* Ark. Code Ann. § 20-10-206; Code Ark. R. § 016.06.002.1003.
- *California:* Cal. Code Regs. tit. 22, § 87761.
- *Connecticut:* n/a.
- *Florida:* Fla. Stat. Ann. § 429.19; Fla. Admin. Code Ann. r. 58A-5.033.
- *Kansas:* Kan. Stat. Ann. §§ 39-943, 39-946, 39-953a, 39-954.
- *Mississippi:* Code Miss. R. 15 016 047 § 11.13.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, § 1001.15.
- *Oregon:* Or. Admin. R. 411-054-0110 – 0120, 411-054-0133, 411-054-0135.
- *Pennsylvania:* 55 Pa. Code §§ 2800.262, 2800.269.
- *Washington:* Wash. Admin. Code § 388-78A-3152, 388-78A-3160.
- *Wisconsin:* Wis. Admin. Code §§ DHS 88.03, 89.56.

Insurance and Bonding

- *Alabama:* n/a.
- *Arkansas:* n/a.
- *California:* Cal. Code Regs. tit. 22, § 87155.
- *Connecticut:* Conn. Agencies Regs. § 19-13-D105(b).
- *Florida:* Fla. Admin. Code Ann. r. 58A-5.021.
- *Kansas:* Kan. Admin. Regs. § 26-39-101.
- *Mississippi:* n/a.
- *New York:* N.Y. Comp. Codes R. & Regs. tit. 10, § 1001.5.
- *Oregon:* Or. Admin. R. 411-054-0013, 411-054-0016.
- *Pennsylvania:* n/a.
- *Washington:* Wash. Admin. Code §§ 388-78A-2732, 388-78A-2734, 388-

78A-2740, 388-78A-3170.

- *Wisconsin:* Wis. Admin. Code §§ DHS 83.05, 83.07.

Website Information

- *Alabama:* "Health Provider Standards: Statement of Deficiencies," Alabama Department of Public Health, http://adphnotes.state.al.us/hcfweb.nsf.
- *Arkansas:* n/a.
- *California:* "Facility File Review, California Department of Social Services," http://www.ccld.ca.gov/PG835.htm.
- *Connecticut:* n/a.
- *Florida:* "Facility/Provider Locator," Florida Health Finder, http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx?cc=11.
- *Kansas:* n/a.
- *Mississippi:* n/a.
- *New York:* "Adult Home Quarterly Survey Reports," New York State Department of Health, http://www.health.ny.gov/facilities/adult_care/reports.htm.
- *Oregon:* "Search for Services and Licensed Facilities," Aging and Disability Resource Center of Oregon, https://adrcoforegon.org/orprovider/consumer/globalLuceneSearchForServiceLoad.do?t=Search.
- *Pennsylvania:* "Personal Care Homes Directory," Pennsylvania Department of Public Welfare, http://www.dpw.state.pa.us/searchforprovider/pchdirectory/index.htm.
- *Washington:* "Assisted Living Facility Locator," Washington State Department of Social and Health Services, https://fortress.wa.gov/dshs/adsaapps/lookup/BHAdvLookup.aspx.
- *Wisconsin:* "Division of Quality Assurance Provider Search," Wisconsin Department of Health Services, https://www.forwardhealth.wi.gov/WIPortal/DQA%20Provider%20Search/tabid/318/Default.aspx.

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