United States General Accounting Office

GAO

Report to Congressional Requesters

April 1999

ASSISTED LIVING

Quality-of-Care and Consumer Protection Issues in Four States

GAO/HEHS-99-27

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-278340

April 26, 1999

The Honorable Charles Grassley
Chairman, Special Committee on Aging
United States Senate

The Honorable John Breaux
Ranking Minority Member, Special Committee on Aging
United States Senate

The Honorable Ron Wyden
United States Senate

Assisted living facilities are becoming an increasingly popular setting for providing long-term care through a combination of housing, personal support services, and health care. Consumer demand is expected to grow significantly as the projected number of elderly Americans needing long-term care doubles to nearly 14 million over the next 20 years. The provider and investment communities have responded to this growing demand by increasing the supply of assisted living facilities throughout the country in recent years, and Fortune magazine identified assisted living as one of the top three potential growth industries for 1997.[1] Unlike nursing homes, most assisted living is paid for privately by individuals and their families. However, many states are exploring whether assisted living can be a cost-effective alternative to nursing home care for some residents, and they are expanding the use of Medicaid and other federal and state sources of funds to help pay for care.[2] In addition, many states are examining their role in regulating this industry, and, according to the National Conference of State Legislatures, 32 states plan to consider legislation related to assisted living during 1999.

While interest in assisted living has grown among consumers, the investment community, and state governments, concerns about quality of care and consumer protection in assisted living have been raised in recent media accounts and other reports. As we discussed in an earlier report, little is known about whether consumers are able to make informed choices about their care or about the nature and extent of problems that

[1]Precise numbers of facilities and residents are difficult to obtain because there is no generally accepted definition of assisted living and no systematic means of counting these facilities. Estimates of the current number of assisted living beds range from 800,000 to 1.5 million.

[2]Medicaid is the joint federal and state health financing program for low-income families and aged, blind, and disabled people. Those who receive long-term care under Medicaid include the elderly, persons with physical disabilities, and persons with developmental disabilities.

may be occurring in assisted living.[3] To help the Congress better understand these issues, you asked us to (1) describe the residents' needs and the services provided in assisted living facilities, (2) determine the extent to which facilities provide consumers with information sufficient to help them choose a facility that is appropriate for their needs, (3) describe state approaches to the oversight of assisted living, and (4) determine the type and frequency of quality-of-care and consumer protection problems they identify.

To address these issues, we studied four states that have a range of experiences with assisted living—California, Florida, Ohio, and Oregon. Specifically, we (1) analyzed responses to a mail survey from 622 assisted living facilities concerning the services they provide and the needs of the residents they serve; (2) evaluated written marketing materials and contracts of 60 facilities for completeness, clarity, and consistency with selected state statutes and regulations; (3) interviewed state officials in the four states and reviewed relevant state statutes, regulations, guidance, and policy manuals; and (4) analyzed information on the quality-of-care and consumer protection problems identified by the state licensing and ombudsmen agencies in each state, for calendar years 1996 and 1997, for a random sample of 753 facilities and the adult protective services agency in Florida and Oregon.[4] We also visited 20 assisted living facilities in the four states and interviewed facility administrators, staff, and more than 90 residents or family members. In this report, we do not evaluate the effectiveness of the state agencies' oversight of assisted living facilities. See appendix I for a more detailed discussion of our methodology. We conducted our study from June 1997 through March 1999 in accordance with generally accepted government auditing standards.

Results in Brief

Assisted living facilities provide a growing number of elderly Americans with an alternative to other types of long-term care, such as nursing homes, and many facilities serve a vulnerable population with significant care needs. To make informed choices among various facility options, consumers need clear and complete information on facility services, costs, and policies. However, in many cases, assisted living facilities in the four states we studied are not routinely providing prospective residents with information sufficient for them to select the setting most appropriate for

[3]See Long-Term Care: Consumer Protection and Quality-of-Care Issues in Assisted Living (GAO/HEHS-97-93, May 15, 1997).

[4]We sent our mail survey to 955 randomly selected facilities of 2,652 potential providers of assisted living in the four states. We received responses from 721 facilities, or 75 percent of those we surveyed, 622 of which identified themselves as providers of assisted living services.

their needs. Consumers also need assurance that facilities provide high-quality care and protect consumers' interests. All four states license assisted living facilities and provide oversight through periodic inspections and complaint investigations. Licensing, ombudsmen, and adult protective services (APS) agencies identified some assisted living facilities with quality-of-care and consumer protection problems during 1996 and 1997, such as inadequate care, insufficient staffing, medication errors, abuse, and improper discharge.

Within the parameters of state regulations, assisted living facilities in the four states serve a wide range of resident needs in a variety of residential settings. The 622 facilities that responded to our survey include small homes providing meals, housekeeping, and limited assistance for as few as 2 residents as well as large, multilevel communities that provide or arrange for a variety of specialized health and related care for as many as 600 residents; the average size is 63 beds. The average monthly rate residents pay in the facilities we surveyed ranges from less than $1,000 to more than $4,000, and although the majority of facilities serve only a private pay market, 40 percent reported receiving Medicaid or other public funds to care for one or more residents, primarily in Florida and Oregon. As for the residents' needs, a majority of the facilities reported that more than half their residents need staff assistance with bathing and medications, and 94 percent reported serving some residents who are cognitively impaired. Facilities vary widely in the level of care they choose to provide and in the extent to which they allow residents to remain in a facility as their needs increase. For example, about half of the facilities would admit or retain a resident who has an ongoing need for nursing care while half would discharge a resident who developed that need.

Given the wide variation in what is labeled assisted living, consumers shopping for an appropriate facility must rely primarily on providers for information. However, we found that the providers do not always give consumers information sufficient to determine whether a particular assisted living facility can meet their needs, for how long, and under what circumstances. Marketing material, contracts, and other written material provided by facilities are often incomplete and are sometimes vague or misleading. Only about half of the facilities reported that they provide prospective residents with such key written information as the amount of assistance residents can expect to receive with medications, the circumstances under which the cost of services might change, or when residents might be required to leave if their health changes. In addition, only about one-third provide a description of the qualifications of facility

staff or information on the services that are not available. Moreover, while contracts are an important source of written information about a facility and its services, only 25 percent of the facilities routinely provide these documents to prospective residents before they decide to apply for admission.

All four states have licensing requirements that must be met by facilities that provide assisted living services. Each of these states inspects or surveys assisted living facilities to ensure that they comply with regulations, yet they vary in the frequency and content of inspections. For example, California requires inspections annually, Ohio at least every 15 months, and Oregon every 2 years. Florida's requirements vary depending on the level of assisted living provided—from every 2 years for facilities providing standard assisted living services to twice a year for those providing more extensive nursing care, referred to as extended congregate care (ECC) facilities. The state licensing agencies also respond to complaints they receive related to potential violations of state regulations. In addition to the state licensing agency, other state agencies have a role in the oversight of assisted living facilities. In all four states, the state long-term care ombudsman agency may investigate and resolve complaints involving residents of long-term care facilities including those providing assisted living. In Florida and Oregon, APS agencies also investigate complaints or allegations involving residents of assisted living facilities.

Given the absence of any uniform standards for assisted living facilities across the states and the variation in their oversight approaches, the results of state licensing and monitoring activities on quality-of-care and consumer protection issues also vary, including the frequency of identified problems. However, using available state licensing surveys and reports from other oversight agencies in these four states, we determined that more than one-fourth of the facilities we reviewed were cited by state licensing, ombudsman, or other agencies for five or more quality-of-care or consumer protection related deficiencies or violations during 1996 and 1997. Eleven percent of these facilities were cited by the state agencies with 10 or more quality-of-care or consumer protection related deficiencies or violations during this same time period. Most of the problems identified were related to quality of care rather than consumer protection. While data were not available to assess the seriousness of each identified problem, many problems seemed serious enough to warrant concern. Frequently identified problems included facilities (1) providing inadequate or insufficient care to residents, such as inadequate medical attention after an accident; (2) having insufficient, unqualified, and

untrained staff; (3) not providing residents the appropriate medications or storing medication improperly; and (4) not following admission and discharge policies required by state regulation. According to state officials, factors that contributed to these problems included insufficient numbers of staff, inadequate staff training, high caregiver staff turnover, and low caregiver staff pay rates.

Background

Assisted living is usually viewed as a residential care setting for persons who can no longer live independently. It is designed to respond to the needs of individuals who require help with activities of daily living (ADL) but who may not need the level of skilled nursing care provided in a nursing home. However, there is no uniform assisted living model, and considerable variation exists in what is labeled an assisted living facility. Assisted living facilities are similar to board and care homes in that both may monitor a resident's care needs and condition and may assist with some ADLs and other needs such as medication administration. According to assisted living advocates, however, what may not be evident in board and care is that assisted living emphasizes residents' autonomy, their maximum independence, respect for individual resident preferences, and the ability to meet residents' scheduled and unscheduled needs for assistance. Moreover, assisted living facilities may sometimes admit or retain residents who meet the level-of-care criteria for admission to a nursing home.

Most residents pay for assisted living out of pocket or through other private funding. However, in some states, public funds are available to pay for assisted living care for some low-income residents who may be at risk of institutionalization. For example, some states are attempting to control rising Medicaid costs by using assisted living as an alternative to more expensive nursing home care. While all states pay for nursing home care under Medicaid, according to the National Academy for State Health Policy, 32 states use Medicaid to reimburse for services in assisted living or board and care facilities for more than 40,000 Medicaid beneficiaries.[5] This represents an increase from 22 states that did so as recently as 1996, and several states are currently considering legislation to allow the use of Medicaid funds for assisted living.

To help pay for assisted living services for Medicaid-eligible residents, states typically use Medicaid waivers, specifically the Home and

[5]For further information, see State Assisted Living Policy: 1998 (Portland, Me.: National Academy for State Health Policy, June 1998), prepared under contract to the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

Community Based Services Waiver.[6] Medicaid waivers allow the states to reimburse assisted living facilities for services such as personal care and homemaker services that may not be covered by the states' regular Medicaid programs. However, these payments do not cover room and board. In assisted living, the room and board portion may be paid by a combination of individual resident payments, residents' Supplemental Security Income (SSI), and optional state payments. Through these waivers, the states may choose to provide specific services only to defined groups, such as elderly persons at risk of institutionalization, instead of to all beneficiaries who meet Medicaid's eligibility criteria, which would be required under Medicaid without a waiver. In contrast, a few states pay for services in assisted living facilities through the personal care option under the Medicaid state plan. State plan services are an entitlement, and all beneficiaries who meet Medicaid's eligibility criteria can receive government-funded medical assistance.

The states have the primary responsibility for licensing and overseeing care furnished to assisted living residents, and few federal standards or guidelines govern assisted living.[7] Some states have set very general criteria for the type of resident who can be served and the maximum level of care that can be provided, while other states have set more specific limits in these areas, such as not serving residents who require 24-hour skilled nursing care. In general, state regulations tend to focus on three main areas—requirements for the living unit, admission and retention criteria, and the types and levels of services that may be provided. However, the states vary widely on what they require.

Facility Services and Resident Needs Vary Widely

There is no typical assisted living facility or resident, and within the limits of state regulation, facilities have considerable flexibility to decide what residents they will serve and the types of services they will provide. The assisted living facilities responding to our survey range from small, free-standing, independently owned homes with a few residents to large, multilevel, corporately owned communities caring for several hundred residents. They also serve a wide range of resident needs, with some providing only meals, housekeeping, and limited personal assistance while others provide or arrange for a range of specialized health and related services. The facilities also vary in the extent to which they will admit

[6]Sec. 1915(c) of the Social Security Act.

[7]For further information on federal programs' responsibility related to assisted living, see Long-Term Care: Consumer Protection and Quality-of-Care Issues in Assisted Living (GAO/HEHS-97-93, May 15, 1997).

residents with certain needs and whether they will retain residents as their needs change, referred to as aging in place.

A Wide Range of Facilities Provide Assisted Living

The assisted living facilities in the four states include providers of a variety of types, sizes, and costs. The vast majority of the 622 facilities that responded to our survey, 93 percent, primarily serve the frail elderly.[8] About two-thirds of the facilities in the four states are run as for-profit organizations, ranging from a high of 86 percent in Oregon to a low of 45 percent in Ohio. In California, Ohio, and Oregon, most assisted living facilities are part of a corporation that owns or operates multiple facilities, while in Florida most are independently owned and operated. The facilities vary widely in size and structure as well. The facilities in our survey range from as small as 2 beds to as large as 600 beds. On average, the facilities have 63 beds. Although some facilities are freestanding, about 57 percent are part of a multilevel facility or community that offers other levels of care, such as nursing home care or independent apartments without services. Some providers also offer different types of specialized care within assisted living. For example, about 20 percent of the assisted living facilities reported that they have a special assisted living unit for residents with dementia; the units' average size is 23 beds.

The average monthly rate residents pay for basic and additional services in these four states varies widely, ranging from less than $1,000 per month for general assisted living in some facilities to more than $4,000 per month for special dementia care in others. Among the facilities responding to our survey, about one-third have an average rate for general assisted living of less than $1,500 per month, about one-third between $1,500 and $2,000, and one-third more than $2,000. Although the market for assisted living is primarily among seniors who can afford substantial private payments for their care, many facilities serve some low-income residents who receive government assistance. About 40 percent of the facilities overall reported that they receive Medicaid or other forms of public assistance or subsidy to provide care to one or more residents. The use of public funds to subsidize assisted living care varies among the states. In Florida and Oregon, two states that pay for assisted living care under a Medicaid waiver, 43 and 86 percent of facilities, respectively, reported receiving public funds to pay for care for some of their residents. In contrast, 27 percent of the facilities in Ohio and 28 percent in California receive some public subsidy.

[8]The remaining 7 percent of the survey respondents primarily serve persons with developmental disabilities, mental illness, or other special needs.

Assisted Living Facilities Provide or Arrange for a Variety of Services

A wide variety of services are available to residents in assisted living. Some services may be provided by a facility with its own staff or by staff under contract to the facility. In other cases, the facility may arrange with an outside provider to deliver services, with the residents paying the provider directly, or residents may arrange and pay for services without the facility being involved at all. As shown in table 1, the assisted living facilities in our survey usually provide or arrange for housekeeping, laundry, meals, transportation to medical appointments, special diets, and assistance with medications. Many facilities also provide or arrange for skilled nursing services, skilled therapy services, and hospice care for their residents. More specialized services, such as intravenous (IV) therapy and tube feeding, are least likely to be available.

Table 1: Services Available to Residents in Assisted Living Facilities

Service	Provided or arranged for by facility	Resident must make independent arrangements[a]	Service not available
Housekeeping	98	0	0
Meals	98	0	0
Laundry	97	1	0
Special diets	93	0	5
Supervision of self-medication	93	1	4
Storage and administration of oral medication	92	1	5
Transportation	87	2	6
Storage and administration of injectable medication	78	4	15
Skilled therapy	66	15	13
Hospice	60	17	17
Skilled nursing	41	9	44
IV therapy	20	5	75
Tube feeding	15	3	81

Note: Numbers are percentages of facilities in our survey. They may not add to 100 percent because some facilities did not respond to all items on the survey.

[a]Some facilities allow residents to receive the service but require that they make independent arrangements for the service with an outside provider such as a home health agency.

Facilities Serve a Wide Range of Resident Needs

Assisted living is generally considered to be a residential setting designed to respond to the needs of persons who require some oversight or help with activities of daily living but who may not need the level of skilled care provided in a nursing home. We found considerable variation among facilities and among the four states in the needs of residents they serve. Facilities we visited serve some residents who are completely independent, have some residents with severe cognitive impairment, or have some who are bedridden and require significant amounts of skilled nursing care.

Residents of assisted living facilities typically need the most assistance from facility staff with medications and bathing. As shown in table 2, more than half of all facilities reported that more than 50 percent of their residents need assistance with these activities. Assistance with dressing and toileting or incontinence care were the next most frequently cited ADLs. Assistance was reported to be needed least with feeding, transferring, and ambulation.[9] The highest level of need for staff assistance with ADLs was reported among facilities in Oregon and those in Florida licensed as extended congregate care facilities.[10]

Table 2: Percentage of Facilities in Which More Than Half of Residents Need Staff Assistance With Activities of Daily Living

					Florida[a]		
ADL need	**Total**	**California**	**Ohio**	**Oregon**	**AL**	**LNS**	**ECC**
Medication dispensing	53	68	56	78	29	53	37
Bathing	52	49	52	58	41	50	62
Dressing	34	34	32	33	29	24	42
Toileting	20	18	15	29	21	11	27
Ambulation	11	11	8	15	13	9	8
Transferring	6	3	4	6	9	0	10
Feeding	2	2	1	1	3	3	4

[a]Florida assisted living licensing categories include standard assisted living (AL), limited nursing services (LNS), and extended congregate care (ECC).

[9]These findings are consistent with national studies of assisted living resident needs. The Assisted Living Federation of America's (ALFA) 1996 survey found similar percentages of residents needing assistance with bathing (64 percent), dressing (46 percent), toileting (33 percent), transferring (15 percent), eating (10 percent), and medication dispensing (70 percent).

[10]Florida has four assisted living licensing categories: standard assisted living (AL), limited nursing services (LNS), extended congregate care (ECC), and limited mental health (LMH). We did not include LMH in our analysis.

In addition to needing assistance with activities of daily living, residents of assisted living facilities often have some degree of cognitive impairment.[11] They may suffer from significant short-term memory problems, be disoriented all or most of the time, have difficulty making decisions, or be diagnosed with Alzheimer's disease or some other form of dementia. Their service needs may include behavior monitoring and management, orientation, and reminders or cueing to perform daily tasks. Most facilities in the four states have some residents who are cognitively impaired; however, they range widely in terms of the percentage of their residents with cognitive impairment. More than half of the facilities reported that at least 25 percent of their residents have cognitive impairment, and one-quarter of the facilities reported that more than 50 percent of their residents are cognitively impaired. This ranges from a low of 20 percent of facilities in Oregon to a high of 38 percent among extended congregate care facilities in Florida.

Most Assisted Living Facilities Monitor Residents' Condition

Almost all the assisted living facilities we surveyed reported that they provide some form of oversight to monitor and supervise their residents. Their oversight responsibilities include monitoring changes in residents' health and physical or cognitive functioning, as well as notifying a resident's physician, family, or other responsible person when the resident's condition changes. About 90 percent of the facilities also reported that their oversight includes regular health or wellness checks by a nurse or other licensed health professional and supervision of residents by staff on a 24-hour basis.[12] The only significant variation among the states in terms of oversight is on the issue of 24-hour supervision. While all facilities in Oregon reported that they provide 24-hour supervision by awake staff, only about two-thirds of facilities licensed as standard assisted living in Florida do so.[13] (See table 3.)

[11]ALFA's 1996 survey found 48 percent of residents in assisted living with cognitive impairments.

[12]State regulations generally require the presence of staff on-site 24 hours a day in assisted living. In some small facilities, however, they do not require that staff be awake at all hours.

[13]The Florida standard assisted living category includes a large number of very small facilities. Forty percent are licensed for 12 or fewer residents, 20 percent for 6 or fewer.

Table 3: Percentage of Facilities Providing Oversight to Residents of Assisted Living Facilities

					Florida[a]		
Type of oversight	**All**	**California**	**Ohio**	**Oregon**	**AL**	**LNS**	**ECC**
24-hour supervision of residents by awake staff	90	94	96	100	69	100	90
Monitoring changes in residents' condition or functioning	100	100	99	100	100	100	100
Notification of physician or family when changes in condition are noted	100	100	99	100	100	100	100
Regular health or wellness checks provided by a health professional	91	91	91	90	89	97	91

[a]Florida assisted living licensing categories include standard assisted living (AL), limited nursing services (LNS), and extended congregate care (ECC).

Support for Aging in Place

Assisted living is often promoted as supporting the concept of "aging in place" that allows residents to remain in a facility as their health condition declines or their needs change. The ability of residents to age in place is reflected in a facility's admission and discharge criteria or its rules governing who it will permit to move in and when they may be required to leave. Facilities responding to our survey vary in terms of resident needs they will accept on admission, and they also vary in terms of the degree to which they will retain residents who develop certain needs or conditions after being admitted.

As shown in table 4, more than 75 percent of the facilities reported they admit residents who have mild to moderate memory or judgment problems, are incontinent but can manage on their own or with some assistance, have a short-term need for nursing care, or need oxygen supplementation. Less than 10 percent of the facilities admit residents who are bedridden, require ongoing tube feeding, need a ventilator to assist with breathing, or require IV therapy. Although some facilities might not admit residents with a particular need or condition, they do not necessarily discharge them if they develop that need. In Oregon, for example, most facilities indicated that they will not admit someone who is bedridden, but half would typically retain that individual if he or she becomes bedridden while a resident.

Table 4: Percentage of Facilities That Support Aging in Place as Reflected in Their Admission and Discharge Criteria

	Facility would typically		
Resident condition	Admit	Not admit but retain	Discharge
Has mild to moderate memory or judgment problems	98	2	1
Lacks bladder control but can manage own incontinence supplies	95	4	2
Lacks bowel control but can manage own incontinence supplies	82	8	10
Requires oxygen supplementation	80	7	14
Has a short-term need for nursing care or monitoring by a licensed nurse	76	12	12
Lacks bladder control but needs assistance to manage incontinence	75	9	15
Requires a wheelchair to get around	73	18	10
Requires assistance to transfer from bed to chair or wheelchair	59	16	25
Lacks bowel control but needs assistance to manage incontinence	59	13	28
Requires colostomy or ileostomy care	49	12	40
Requires the use of an indwelling urinary catheter	47	13	40
Wanders	39	9	52
Has severe memory or judgment problems	37	15	48
Has an ongoing need for nursing care or monitoring by a licensed nurse	34	10	56
Requires intravenous medication or therapy	9	0	91
Requires a ventilator to assist with breathing	7	5	88
Requires tube feeding on an ongoing basis	6	7	88
Is confined to bed for 22 or more hours a day	4	19	77

Note: Percentages may not add to 100 because of rounding.

There is also considerable variation across the states in admission and discharge criteria, some of which results from regulatory limits on allowable conditions or services in assisted living facilities, the facilities' choice of whom to serve, and the particular services they choose to provide or make available. Facilities in Oregon are more likely to admit or retain residents with a higher level of need than facilities in the other states. For example, 95 percent of the Oregon facilities admit people requiring assistance to transfer from bed to chair or wheelchair while only 35 percent of the California facilities admit people with this need.

Consumers May Lack Enough Information to Select a Facility That Meets Their Needs

Given the variation in what is labeled assisted living, consumers must rely primarily on information supplied to them by the providers. In order to compare facilities and choose one that best meets their needs, prospective residents should receive information about facility services, costs, and policies in writing. However, we found that written material often does not contain key consumer information or is not routinely provided to prospective residents to use as an aid in decisionmaking. Moreover, in some cases the written material that is provided to consumers is unclear or inconsistent. As a result, consumers may not be receiving information sufficient to determine whether a particular assisted living facility can meet their needs, for how long, and under what circumstances.

Consumers Rely on Information Provided by Facilities

Nursing homes are subject to extensive federal regulations that prescribe detailed standards for their operations and services. In contrast, assisted living facilities are regulated by the states and usually have considerable flexibility to determine what services they will provide and what level of resident need they will serve. As a result, facilities vary widely, and consumers must rely primarily on information providers supply to identify a facility that meets their needs and preferences.

Prospective residents may obtain information to aid in their decisionmaking in a variety of ways, including facility tours, personal interviews, personal recommendations, and written materials. Most residents we interviewed had had the assistance of a family member, usually an adult child, in identifying possible facilities, and they had often relied on the advice of family, friends, or health professionals in making their decisions. Residents often mentioned the facility tour along with interviews with management, staff, and other residents as important means of obtaining information to make their decisions. Providers indicated that written marketing material and sample resident contracts are also useful sources of consumer information.

Much Information Considered Key by Consumer and Industry Groups Is Not Routinely Provided in Writing

To help consumers compare facilities and select the most appropriate setting for their needs, key information should be provided in writing and in advance of their application for admission. However, we found that written material often does not contain key information, and facilities do not routinely provide prospective residents with important documents such as a copy of the contract, sometimes called a resident agreement, to use as an aid in decisionmaking. According to consumer advocates and provider associations, consumers need to know about the services that

will be provided, their costs, and the respective obligations of both the resident and the provider.[14] Specifically, this information should include

- the cost of the basic service package and what is included such as room, board, supervision, amenities, and personal care;
- the availability of additional services such as skilled nursing care or therapy services, who will provide them, and their cost;
- the circumstances under which costs may change, such as when care needs increase;
- how the facility monitors resident health care needs, including requirements for regular health examinations, and how the facility coordinates with a resident's physician;
- the qualifications of staff who provide personal care, medications, and health services;
- discharge criteria, such as when a resident may be required to leave the facility because health or need for supervision changes, and what procedures will be followed for resident notification and relocation; and
- grievance procedures, including the resident's right to challenge decisions about care.

The majority of the facilities responding to our survey said that they generally provide prospective residents with written information about many of their services and costs in advance of a resident's choosing to apply for admission. However, as shown in table 5, less than half indicated that they provide written information in advance on discharge criteria and staff training and qualifications or a description of services not covered or available from the facility. Only about half indicated that they provide information on the circumstances under which the cost of services might change, their policy on medications, or their practice for assessing or monitoring residents' needs.

[14]Advocacy and provider associations we consulted to help identify key consumer information included AARP, the American Association of Homes and Services for the Aging, the American Bar Association Commission on Legal Problems of the Elderly, the American Health Care Association, the Assisted Living Federation of America, the Consumer Consortium on Assisted Living, the Consumers Union, and the United Seniors Health Cooperative.

Table 5: Percentage of Facilities Reporting That They Provide Key Written Information to Prospective Residents

Information[a]	Facilities[b]
Description of services included in the basic rate	78
Cost of the basic service package	73
Statement of residents' rights and responsibilities	73
Description of services available beyond the basic rate	70
Description of complaint or grievance procedure	65
Cost of additional services	63
Policy on medication assistance or administration	56
Facility practice for assessing or monitoring resident needs	53
Circumstances under which costs may change	49
Discharge criteria related to change in health status	47
Description of services not covered or not available	39
Description of staff training and qualifications	31

[a]Key information includes that identified by consumer advocates and provider associations as important for consumers to have in order to choose a facility appropriate for their needs.

[b]Survey respondents indicating that they provide information in writing and, in the case of the contract, in advance of a resident's choosing to apply for admission.

The contract or resident agreement is an important source of written information and, in some cases, may be the only place where certain key points such as discharge criteria or circumstances when costs may change are addressed. However, most providers indicated that they do not routinely make a copy of the contract available to prospective residents to aid in their decisionmaking. Only one out of four of the facilities we surveyed indicated that they routinely provide a copy of the contract to consumers before they make their decision to apply for admission. About 65 percent of the respondents said they would provide a copy if requested, and 10 percent said they do not provide contracts to prospective residents.

We also reviewed the contents of a sample of contracts, marketing materials, and other written information from 60 of the facilities that responded to the survey.[15] These written materials almost always include information about the services available from a facility and, in the contract, some discussion of discharge criteria. However, the written materials we reviewed rarely mention staffing, medication policies, or grievance procedures. Only one in three contain information about services not covered or not available, the facility practice for monitoring

[15]We reviewed written material provided by 60 of the facilities that responded to the survey as providers of assisted living—10 each from California, Ohio, and Oregon and 10 from each of the three licensing categories in Florida.

resident needs, or the circumstances under which the cost of services might change.

Written Information May Be Unclear or Misleading

In addition to lacking important content, the facility contracts, marketing material, and other written information that we reviewed are sometimes vague or misleading. To the extent that contracts and other written material contain information on key points, we examined them to determine whether the information is clear and understandable and whether marketing materials and contracts are consistent with each other and with relevant requirements of state regulations. Contracts range from a one-page standard form lease to a detailed 55-page document that includes multiple attachments. Some are written in very fine print, while others are prepared in large easy-to-read type. Some contracts are complex documents written in specialized legal language while others are not. Marketing and other written material provided by facilities also varies widely from a one-page list of basic services and monthly rent to multiple documents of more than 100 pages.

While most facilities use written materials that are specific and relatively clear in the points they cover, we found written materials from 20 of the 60 facilities, or 33 percent, that contain language that is unclear or potentially misleading, usually concerning the circumstances under which a resident can be required to leave a facility. Contracts and other written materials are often unclear or inconsistent with each other or with requirements of state regulation regarding how long residents can remain as their needs change, resident notification requirements, or other procedural requirements for discharge. Some examples follow.

- The marketing material used by one Florida facility is potentially misleading in specifying that a resident "can be assured if health changes occur, we can meet your needs. And you won't have to deal with the hassles of moving again." However, the contract specifies a range of health-related criteria for immediate discharge, including "changes in [the resident's] physical or mental condition, supplies, services or procedures . . . that [the facility] by certification, licensure, design, or staffing cannot provide."
- In another Florida facility, the marketing material states that the facility is committed to helping individuals to live at the facility "for the rest of their lives by . . . adapting services and care plans to meet the needs of each person." The facility contract, however, states that the facility may terminate the agreement immediately "if the Resident requires services

which are outside the scope of those services which the facility is licensed to provide" or if the facility "determines that the discharge of the Resident is appropriate for the Resident's welfare or for the welfare of other Residents." Florida law states that "any resident who is determined by the medical review team to be inappropriately residing in a facility shall be given 30 days' written notice to relocate unless the resident's continued residence in the facility presents an imminent danger to the health, safety, or welfare of the resident."

- The contract of a California facility lacks specific information about discharge requirements, stating only that the facility "reserves the right by action of its Board of Directors to dismiss Resident for what is, in the judgement of the Board, good and sufficient cause." Moreover, the contract makes no mention of state regulations that specify criteria for discharge or eviction.
- The contract of an Oregon facility is inconsistent with requirements of state regulation regarding notification of residents before their discharge. Oregon regulations specify that residents may not be asked to leave without 14 days' written notice and may be asked to leave only in specified circumstances, such as when the facility cannot meet the residents' needs with available support services or required services are not available. In contrast, the contract states that "the resident shall be required to immediately vacate the Premises . . . [if] the Resident requires medical or nursing care of a higher level or degree than may be available at [the facility]."

The States Use a Range of Approaches to Oversee Assisted Living Facilities

Each of the four states we studied has licensing requirements that must be met by most facilities that provide assisted living services.[16] Some states have created a specific licensing category called "assisted living" while others license and regulate assisted living under existing residential care standards. All states inspect or survey assisted living facilities to ensure that they comply with regulations for quality of care and consumer protection, yet unlike annual nursing home inspections, they vary in the frequency and content of inspections and the range of enforcement mechanisms available to ensure compliance. The state licensing agencies also respond to complaints they receive related to potential violations of state regulations. In addition to the state licensing agency, other state

[16]California and Ohio may have some facilities that advertise themselves as "assisted living facilities" but do not provide a level of care that is required by state law to be licensed. For example, a facility may call itself an assisted living facility but provide only an apartment and one meal per day but no direct care or no supervision of personal care or medical needs and, therefore, it does not meet the criteria that require it to be licensed by the state. In Florida and Oregon, any facility that holds itself out as an assisted living facility must be licensed by the state.

agencies have a role in the oversight of assisted living facilities. In the four states we studied, the state ombudsman agency may investigate and resolve complaints involving residents of long-term care facilities, including those providing assisted living.[17] In two of the four states we studied, Florida and Oregon, APS agencies also investigate complaints or allegations related to abuse, neglect, or exploitation involving residents.

State Requirements for Assisted Living Facility Licensing Vary

Most facilities that provide assisted living services must meet licensing requirements in the four states we studied. Regulations that address quality of care and consumer protection generally cover such areas as admission and discharge criteria, the type and level of services that can be provided, staffing levels and training, as well as resident rights and consumer access to information.[18] However, the four states vary in how they define these requirements and the level of detail with which they describe them.

Florida and Oregon have created a specific licensing category and requirements for assisted living facilities, while California and Ohio generally license them under existing residential care facility regulations.[19] In addition, Florida has four subcategories of assisted living licensure, depending on the types and levels of care that can be provided. These include facilities that provide standard assisted living services, limited nursing services, and extended congregate care for residents needing more care than can be provided in an LNS facility.[20]

Three of the four states we studied have established specific criteria that define who can be admitted to an assisted living facility, and all four states have criteria that specify when a resident must be discharged. In addition, all four states have rules governing the process for resident admission and discharge. For example, regulations in California and Florida generally require that a person needing 24-hour skilled nursing care or supervision cannot be admitted to a facility and must be discharged if he or she

[17]In California and Oregon, the ombudsman investigates and resolves complaints only in licensed long-term care facilities. In contrast, ombudsmen in Florida and Ohio may respond to complaints in both licensed and unlicensed facilities.

[18]The regulations also cover minimum space for the resident's living unit and building and safety standards that we have not covered in this report.

[19]According to state officials, the Oregon regulations that apply to assisted living were recently revised effective April 1, 1999. Not all assisted living facilities in Ohio are licensed as residential care. Some are unlicensed, and some may be licensed as adult care facilities or homes for the aged.

[20]Florida has another assisted living licensing category called limited mental health that we did not include in our study. Facilities with this licensing type serve three or more mental health residents.

develops such a need. In contrast, Oregon regulations allow facilities the most flexibility in deciding who they will serve. For example, Oregon regulations allow residents to remain in a facility as their health condition declines or their needs change, provided the facility can continue to meet their needs.

With respect to resident admission, all states require facilities to conduct an initial assessment of a resident's health, functional ability, and needs for assistance. Except for Florida, the states we studied require all facilities to develop a plan of care to address the identified needs.[21] In California, the initial assessment must include a physical examination of the resident, tests for contagious and infectious diseases, documentation of prior medical services and history and current medical status, a record of current prescribed medications, identification of the resident's physical limitations to determine his or her capability to participate in the facility's programs, and a determination of the person's ambulatory status.

Concerning resident discharge, all states generally require that facilities provide residents with sufficient advance notice of discharge or eviction, ranging from 14 to 30 days, except in certain emergency situations where continued residence would jeopardize the health or safety of the resident or others in the facility. In addition, all state regulations specify certain rights and procedures for residents to appeal or contest a facility's decision to discharge them.

State regulations have similar requirements for the types and the levels of services that assisted living facilities must provide residents. In addition to basic accommodations that include room, board, and housekeeping, all the states require assisted living facilities to provide residents with certain basic services, including (1) assistance with ADLs, (2) ongoing health monitoring, and (3) either the provision or the arrangement of medical services, including transportation to and from those services as needed.

State regulations for assisted living differ with respect to the level of skilled nursing or medical care that facilities can provide to residents and the circumstances under which it can be provided. For example, California regulations contain a list of services that facility staff are generally not allowed to provide, including catheter care, colostomy care, and injections. According to state officials, the care for such conditions in California assisted living facilities is normally provided through a contract

[21]Florida requires the development of a plan of care for residents in an ECC and residents under the Medicaid waiver.

between a resident and a home health agency. With a few exceptions, Ohio regulations limit skilled nursing care to residents who need it only on a part-time, intermittent basis and restrict it to no more than 120 days per year.[22] Oregon, in contrast, has no explicit restrictions on the types or levels of care that facility staff can provide, except that certain nursing tasks must be either assigned or delegated to a caregiver by a registered nurse.

Although all states require facilities to provide some degree of supervision with medications, they differ in the degree to which facility staff can be directly involved in administering medications to residents. For example, in Oregon, unlicensed, nonprofessional staff can administer medications to residents if they have appropriate authorization, training, and general supervision. However, in Florida and Ohio, only staff specifically licensed or certified to administer medications may do so. In California, facility staff may not administer medications to residents but may only assist residents to take medication themselves. The rules governing medications can limit a resident's ability to continue residing in a facility if he or she is unable to manage his or her own medications and licensed or certified staff are not available.

Requirements for staff levels, qualifications, and training also vary among the states. Florida's regulations require facilities to maintain a minimum number of full-time staff, based on the total number of residents, while regulations in California and Ohio require that the number of staff be sufficient to meet the needs of residents. In contrast, Oregon provides no specific guidance on how many staff are needed to provide for the residents' needs. The regulations in all four states specify minimum qualifications for the education and training of facility administrators, and they generally require that caregivers receive training for the personal care services they are to provide. Only Florida's regulations specify the amount and content of training that caregiver staff must receive.

State regulations also generally contain consumer protection provisions governing resident contracts, criminal background checks for staff, and residents' rights, including resident participation in decisionmaking. All four states require that facilities enter into contracts with residents. Although the contracts typically include provisions related to residents' rights, services to be provided, charges, and refund policies, state requirements differ in the level of detail they require in the agreements.

[22]Exceptions include (1) supervision of special diets, (2) applications of dressings, and (3) medication administration, which facilities can provide on an ongoing basis if they have the appropriate skilled staff.

California, Florida, and Oregon have explicit requirements in regulations for criminal background checks of facility administrators, and all four states require such checks for direct care staff.

State Inspections of Assisted Living Facilities Vary

All four states are responsible for conducting periodic inspections or surveys of facilities to ensure that they comply with licensing requirements, yet they vary in the frequency and content of those inspections and in the range of enforcement mechanisms that can be used to correct problems. In each of the four states, licensing agencies conduct periodic inspections or surveys to ensure compliance with regulations. The licensing agency in California is required to inspect facilities annually, and the licensing agency in Ohio is required to inspect facilities every 15 months. Florida and Oregon survey facilities at least once every 2 years.[23] Facilities in Florida licensed as limited nursing services are to be inspected at least once a year for compliance with LNS regulations, and facilities licensed to provide extended congregate care are to be inspected at least twice a year for compliance with ECC regulations. One of these visits may be made in conjunction with the state's biennial standard assisted living survey. Licensing authorities in all four states also conduct investigations in response to complaints they receive regarding the services and care provided to facility residents.

The content of periodic state surveys is driven primarily by the requirements in state regulations. To assist licensing staff in interpreting the regulations, Florida and Ohio have developed detailed guidelines, similar to those used for nursing home inspections, that cover most aspects of regulated facility practice. In contrast, licensing staff in California and Oregon use a checklist that covers a subset of the regulations and focuses on a few selected elements.[24]

The licensing survey process generally includes meeting with the facility's administrator, touring the facility, reviewing facility and resident records, and interviewing residents and staff. A complaint survey can include interviews with the resident, staff, and other relevant persons and a review of facility records. When deficiencies are found, facilities are given the opportunity to correct them. The four states we visited use a variety of

[23]While Oregon has historically conducted biennial inspections to coincide with the expiration of the 2-year license, the licensing agency officials said they have increased the frequency of inspections of all assisted living facilities to at least once a year.

[24]According to state officials, Oregon's checklist is intended to focus on selected elements related to resident care.

means to ensure that facilities correct deficiencies. These include requiring a written plan of correction, reinspection of facilities to verify compliance, civil monetary penalties, restrictions on admissions, criminal sanctions, or license revocation, although not all states use all these. For example, in Florida, a facility with severe or repeated deficiencies with respect to medications or dietary services may be required to add a consultant pharmacist or dietitian to its staff until problems are resolved.

Ombudsmen and Adult Protective Services Also Provide Oversight of Assisted Living Facilities

In addition to the state licensing agency, other state agencies play a role in the oversight of assisted living facilities. In the four states we examined, the state ombudsman agency has a role in overseeing the quality of care and consumer protection of residents. The ombudsmen are intended to serve as advocates to protect the health, safety, welfare, and rights of elderly residents of long-term care facilities and to promote their quality of life. One of their primary responsibilities is to investigate and resolve complaints of residents in long-term care facilities, such as nursing homes, board and care homes, and assisted living facilities.[25]

Typically, ombudsmen receive complaints from residents, family, friends, and facility staff or they initiate a complaint based on their own observation. The complaints name the facility and describe the problem and the resident involved. The ombudsman assigned to that facility generally interviews the resident within a certain period of time to gather additional information about the complaint, to assure the resident that his or her identity will remain confidential unless he or she indicates otherwise, and to request permission to investigate the complaint.[26] The ombudsmen may also need to gather additional information by interviewing physicians and other health practitioners, facility staff, other residents, or family members and reviewing resident records. If the resident gives permission, then the ombudsmen can try to resolve the complaint with the appropriate facility staff. Depending on the state and the nature of the complaint, ombudsmen may refer the complaint to another agency, such as the state licensing agency or adult protective services.

[25]Ombudsmen also (1) visit facilities to educate the administrator, staff, and residents about the ombudsman program; (2) distribute program materials; and (3) offer educational and training programs. For example, Oregon ombudsmen have participated in an assisted living association's monthly training sessions of facility administrators and staff.

[26]If the resident is unable to provide written or verbal consent because of functional or cognitive limitations, then the ombudsmen follow certain guidelines on who can give consent, especially in cases involving access to medical files.

Ombudsmen in Florida are also required to inspect each facility annually to evaluate the residents' quality of care and quality of life. The inspections provide ombudsmen an opportunity to (1) talk to residents, (2) inspect the facility and residents' rooms, (3) identify the level of resident privacy, and (4) check certain safety requirements. Upon completion of the inspection, the ombudsmen discuss any problems with the facility administrator and negotiate a resolution. Any unresolved problems are referred to the licensing agency.

In some states, APS has oversight responsibility for assisted living residents. In two of the four states we studied, Florida and Oregon, APS agencies have authority to investigate complaints or allegations related to abuse, neglect, or exploitation involving residents.[27] In general, the APS agencies are responsible for (1) investigating a complaint or allegation, (2) determining the immediate risk to the person and providing necessary emergency services, (3) evaluating the need for and referrals for ongoing protective services, and (4) providing ongoing protective supervision. The investigations typically include interviewing the victim, alleged perpetrator, and witnesses separately to obtain their accounts of what occurred and obtaining relevant documents and other physical evidence to determine whether abuse, neglect, or exploitation has occurred.

Florida's and Oregon's Medicaid-funded residents receive additional oversight from case managers. Both of these states' Medicaid programs require case management for residents who receive assisted living services under the Medicaid waiver. Case managers meet periodically with residents, their facility administrator, or facility staff and discuss the residents' needs, changes in what services they require, and any other additional issues related to the care plan. In Oregon, the Medicaid Fraud Control Unit within the Office of the Attorney General has investigated cases involving residents of assisted living facilities that receive Medicaid funding.[28] The Oregon Attorney General's office has also been active in educational and training sessions to ensure that residents of assisted living facilities are provided good-quality care.

[27]In California and Ohio, the APS agencies' authority is limited to investigating problems involving persons not residing in "institutions" or "facilities." However, in these two states, complaints related to abuse, neglect, and exploitation of residents in assisted living facilities may be investigated by the licensing agency or the ombudsman agency.

[28]The Florida Medicaid Fraud Control Unit has the authority to investigate cases involving assisted living facility residents in Medicaid-funded facilities. However, as of late February 1999, no investigations of assisted living facilities had taken place.

States Identify Quality-of-Care and Consumer Protection Problems in Assisted Living Facilities

Given that states vary in their licensing requirements for assisted living facilities and in their approaches to oversight, the type and frequency of quality-of-care and consumer protection problems identified by the states may not fully portray the care and services actually provided. However, using available state licensing surveys and reports from ombudsmen and APS agencies, we determined that 27 percent of the facilities in the four states were cited for 5 or more quality-of-care or consumer protection related problems, and 11 percent for 10 or more problems, during 1996 and 1997.[29] The most commonly cited problems were related to quality of care and included inadequate care and staffing and medication issues. According to state officials, factors that contributed to these problems included insufficient numbers of staff, inadequate staff training, high caregiver staff turnover, and low caregiver staff pay rates. Thirty-eight percent of the facilities in the four states were not cited for any quality-of-care or consumer protection related problems during this period.

Some Facilities Have Been Cited for Deficient Care Practices and Inadequate Consumer Protection

Twenty-seven percent (200 of 753) of the assisted living facilities for which we requested state agency data were cited for 5 or more quality-of-care or consumer protection related problems by state oversight officials during 1996 and 1997, while 11 percent (86 of 753) of these facilities had 10 or more problems during this same time period. As shown in table 6, most of the problems identified by the oversight agencies were related to quality of care. While data were not available to assess the seriousness of each identified problem, many problems seemed serious enough to warrant concern.

Table 6: Percentage of Facilities With Quality-of-Care and Consumer Protection Related Problems Identified by Licensing, Ombudsman, and APS Agencies in the Four States

	Facilities with verified problems		
Number of problems	Quality of care or consumer protection	Quality of care	Consumer protection
5 or more	27%	22%	3%
10 or more	11	9	0

Note: Number of facilities = 753.

[29]Our analysis includes quality-of-care or consumer protection related problems (1) cited during each facility's most recent licensing survey or (2) verified by state licensing, ombudsman, or APS agencies for the period 1996 and 1997. The quality-of-care problems related to resident care, services, medications, staffing and training, and outcomes of care. The consumer protection problems related to contracts, consumer disclosure and financial issues, tenant-landlord issues, resident access to information, and resident participation in decisionmaking.

The number and type of problems identified in assisted living facilities often depend on a number of factors that may be unique to each state. For example, facilities in states with more licensing standards, more frequent inspections, or more agencies involved in oversight may be likely to have more problems identified.[30] (Appendix III contains frequencies of the four states' licensing deficiencies and verified ombudsman complaints and Florida's and Oregon's verified APS allegations.)

The most common problems, as shown in table 7, that licensing and ombudsman agencies cited in the four states concerned inadequate care, staffing, and medication. Other frequently cited problems involved resident care plans and assessments; admission, discharge, and level-of-care issues; billing charges; and abuse. These problems included instances in which a facility was found to be providing inadequate care to residents as well as instances in which a facility did not demonstrate the capacity to provide sufficient care. For example, staffing problems included cases in which a resident suffered harm as a result of an insufficient number of staff in the facility, as well as cases in which facilities had no documentation to substantiate that required caregiver training had been provided.

[30]Appendix I discusses the methodology we used to analyze the state data, and appendix III describes the limitations of the data.

Table 7: Types of Quality-of-Care and Consumer Protection Issues Most Frequently Identified by Licensing and Ombudsman Agencies in the Four States, 1996-97

	California		Florida		Ohio		Oregon	
Rank	**Licensing deficiencies**	**Ombudsman complaints**	**Licensing deficiencies**	**Ombudsman complaints**	**Licensing deficiencies**	**Ombudsman complaints**	**Licensing deficiencies**	**Ombudsman complaints**
1	Inadequate care	Inadequate care	Staffing or training	Inadequate care	Care plans or assessments	Admission, discharge, or level of care[a]	Care plans or assessments	Inadequate care
2	Medication	Admission, discharge, or level of care[a]	Medication	Billing or charges[b]	Inadequate care		Medication	Staffing or training
3	Admission, discharge, or level of care[a]	Abuse	Care plans or assessments	Abuse	Medication		Inadequate care	Billing or charges[b]
4	Staffing or training	Billing or charges[b]	Admission, discharge, or level of care[a]	Staffing or training	Staffing or training		Staffing or training	Medication
5	Care plans or assessments	Staffing or training	Contracts[b]		Access to information[b]		Abuse	Care plans or assessments

Note: Includes only types of problems cited at least five times across all facilities we sampled in each state during the 2-year period. Blank cells indicate that no additional type of deficiency or complaint was cited more than four times. All problems are related to quality of care unless noted otherwise.

[a]Problem may be related to either quality of care or consumer protection.

[b]Problem is related to consumer protection.

Deficiencies and complaints related to inadequate care in the four states most frequently dealt with such problems as residents not receiving adequate access to physicians and other medical care or treatment for symptoms, such as pressure sores. For example, in one California facility, staff neglected to call "911" after a resident fell and injured her head. Instead, they gave the resident aspirin, and several hours later she was found in a comatose state, and she died 3 days later. In an Oregon facility, a resident's catheter was to be irrigated daily; however, records indicated that the irrigation had not been done for approximately 6 weeks. Subsequently, the resident was sent to the emergency room and diagnosed with a urinary tract infection. An Ohio facility failed to notify a resident's physician that the resident had fallen at least 22 times and sustained head injuries. In that same facility, another resident fell 32 times over a 6-month period and was not evaluated for possible transfer to another facility for closer supervision.

The second most frequently cited problem area included issues related to staff qualifications and training and facilities having sufficient staff to care for the residents. For example, in a Florida facility, staff had not received any training in personal hygiene care or proper infection control procedures, which could result in exposure to a wide range of viruses and bacterial infections, including influenza and hepatitis. In Oregon, family members routinely assisted residents by changing soiled garments because the facility had insufficient staff.

The third most frequently cited problem area concerned medication-related deficiencies and complaints, such as not providing residents prescribed medication, providing them the wrong medication, or storing medication improperly. An Oregon facility was found to have numerous medication problems, including (1) staff inconsistently and inaccurately transcribing a physician's medication orders to the resident's medication administration records, (2) medications often being borrowed or shared between residents, (3) one staff member signing out narcotics but another staff member on a different shift administering them to residents, and (4) unlicensed caregivers altering residents' prescription labels. In a California facility, staff failed to provide psychiatric medication to a resident for 20 days.

Other commonly cited problems dealt with care plans and admission, discharge, and level-of-care issues. In one case, a Florida facility was cited for having four residents who had more care needs than an assisted living facility is allowed by state law. One of these residents required a special mechanical lift to transfer from bed to wheelchair, and the resident's room was on the second floor, which could prove extremely difficult to evacuate in an emergency. The three other residents were unable to respond to questions and had heavy care needs; they were all located on the second floor, which made them also incapable of evacuating in case of an emergency.

Oregon APS verified 48 cases of abuse in 21 of the 83 assisted living facilities over the 2-year time period. Oregon APS also found numerous cases of inadequate care, problems with care plans and assessments, and medication issues. For example,

- Investigators found a resident who had a serious stage III decubitus ulcer on her foot and three other open skin areas. The decubitus was not being treated or documented, and no physician had been notified.

- A resident was left on the toilet for 2 hours because the caregiver forgot to return to the resident's room and a call light was not within reach. Only one caregiver was scheduled for the night shift to care for 30 residents, some of whom had need for a high level of care.
- Staff ordered a resident's medications from a new pharmacy, but the medications received were the wrong ones. Methyldopa, a heart medication, was sent instead of Levodopa, a medication for Parkinson's disease. The error was not detected by the medication aides for 2 months. The medication mix-up was finally discovered by the admitting physician when the resident was hospitalized with low blood pressure and fever.

In Florida, the APS agency verified 39 cases of abuse in 25 assisted living facilities and 103 cases of neglect in 32 facilities. Florida cases included the following.

- A 90-year-old resident was admitted to a hospital with a stage IV pressure ulcer and found to be dehydrated and poorly nourished.
- A resident did not receive his medications over several days, resulting in the resident's having a seizure and being hospitalized. The facility had contacted the pharmacy several times for the medication, but the pharmacy did not deliver it because the pharmacy had run out of its supply. The facility and the pharmacy were both found negligent.
- A resident who was at the facility for respite care fell, bruising her face. Later that day, the resident was found nonresponsive and was transported to the emergency room. The physician diagnosed a hematoma that was inoperable because of her severe vein disease, and she subsequently died. The administrator admitted that he should have sought medical treatment after the resident's fall.

In addition to the other state agencies, the Oregon Attorney General's Office investigated three cases involving residents of assisted living facilities during 1996 and 1997. For example, the Office's Medicaid Fraud Control Unit investigated a case involving a resident with end-stage renal disease who was receiving dialysis treatments and was on a special diet. However, the facility had no certified or trained dietitian available, and the resident was not receiving proper nutrition. In another case, the Oregon Financial Fraud Unit investigated the death of a resident in an Alzheimer's secured unit. The resident had exited the unit through a window, subsequently dying of exposure and hypothermia. The unit qualified as "secure" under the applicable regulations, but the windows were easily opened wide enough for a person to pass through.

State officials attributed the most common problems identified in assisted living facilities to insufficient staffing and inadequate training. Inadequate care and medication issues were most frequently attributed to shortage of staff and inadequate staff training. The officials also cited high staff turnover rates and low pay rates for caregiver staff. When facilities do not have adequate numbers of staff, then residents may be more likely to receive inadequate ADL assistance or have their call lights left unanswered or have inadequate assistance in case of an emergency. Furthermore, if facilities do not adequately train their staff, residents' medication may be improperly administered, the facility may experience widespread infections, or staff may injure or harm the residents through improper lifting or bathing techniques.

Conclusions

As a growing number of elderly Americans reach the point where they can no longer live independently, many look to assisted living facilities as a viable, homelike setting to meet their long-term care needs. Currently, the assisted living industry is regulated by states and predominantly funded by private resources. However, as the states increase the use of Medicaid to help pay for assisted living, the contribution of federal financing will grow as well. These trends will likely focus more attention from consumers, providers, and the public sector on where assisted living fits on the continuum of long-term care, on the standards the states use to ensure quality of care and protect consumers, and on the approaches the states use to ensure compliance with those standards.

With attention on assisted living facilities growing, our work in four states suggests that two issues are likely to be at the forefront of discussions about potential oversight needs. First, many assisted living facilities are not routinely providing prospective residents with key information they need in advance so they can compare what several facilities offer and determine whether a facility is appropriate for their needs. Second, it is apparent that residents of a number of assisted living facilities are encountering problems with quality of care or consumer protection, which in some cases can have a serious effect on their health. State regulators, providers, consumer advocates, and the federal government will need to be attentive to these problems as they surface and will need to consider what additional steps, if any, may be advised to best ensure that adequate quality of care and consumer protections are in place.

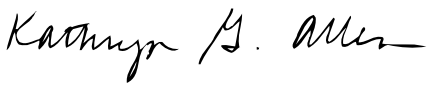
State and Other Comments

We obtained comments on the draft report's section on state oversight from officials representing licensing and ombudsman agencies in the four states we studied and also from Florida's and Oregon's APS and Medicaid agencies and Medicaid Fraud Control Unit. We also obtained comments on our draft report from expert reviewers and representatives of provider associations. All reviewers suggested technical changes, which we included in the report where appropriate.

The expert reviewers, who are nationally known researchers in the assisted living field, were Catherine Hawes, Ph.D., Senior Research Scientist at the Myers Research Institute, and Robert L. Mollica, Ed.D., Deputy Director of the National Academy for State Health Policy. Generally, they commented that the report is balanced, should help consumers and policymakers think more carefully about the potential of assisted living to meet the needs of the frail elderly, and should be useful to states as they review their regulations and monitoring activities for assisted living facilities.

The provider associations that reviewed and provided comments on the draft report included the American Association of Homes and Services for the Aging, the American Health Care Association, and the Assisted Living Federation of America. In general, these reviewers reiterated the importance of clear and complete information to help consumers select an appropriate assisted living facility. With regard to our findings on quality-of-care and consumer protection issues, they noted the importance of better understanding the seriousness of verified problems and the states' approaches to addressing and resolving them.

As agreed with your office, unless you publicly announce the report's contents earlier, we plan no further distribution for 30 days. We will then send copies to interested congressional committees and members and agency officials and will make copies available to others on request. If you or your staff have any questions about this report, please call me at (202) 512-7118 or John Hansen, Assistant Director, at (202) 512-7105. Major contributors to this report are listed in appendix IV.



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Abbreviations

ADL	activities of daily living
AL	standard assisted living
ALFA	Assisted Living Federation of America
APS	adult protective service
ECC	extended congregate care
IV	intravenous
LMH	limited mental health
LNS	limited nursing services
SSI	Supplemental Security Income

Scope and Methodology

Our study focused on four states with a range of experiences with assisted living facilities—California, Florida, Ohio, and Oregon. We chose these states because they have a large number of assisted living facilities and represent four distinct regions of the country. We selected Florida and Oregon because they have an assisted living licensing category and use Medicaid waivers to reimburse assisted living facilities for covered services for Medicaid-eligible residents. We used two methods to identify potential facilities. In all four states, we included the facilities that are members of trade associations that represent assisted living facilities.[31] In the two states with an assisted living licensing category, Florida and Oregon, we also included facilities that were licensed as of 1997.

To identify the facilities' services and their residents' needs, we conducted a mail survey of 955 randomly selected facilities of 2,652 identified facilities in the four states. We received responses from 721 facilities, or 75 percent of those we surveyed; 622 of those identified themselves on the survey as providers of assisted living services.[32] See table I.1 for details on the study sample by state. We also visited five facilities in each of the four states, met with facility administrators and staff, and interviewed more than 90 residents or family members.

Table I.1: GAO Assisted Living Study Sample

State	Number of potential assisted living facilities	Number of assisted living facilities returning survey	Number of assisted living facilities GAO analyzed for quality-of-care and consumer protection issues
California	387	134	150
Florida[a]	1,939	276	370
Ohio	243	140	150
Oregon	83	72	83
Total	**2,652**	**622**	**753**

[a]Florida assisted living licensing categories include standard assisted living, limited nursing services, and extended congregate care.

To determine whether prospective residents and their families receive sufficient information to make an informed decision about which facility

[31]The associations were the American Association of Homes and Services for the Aging, the American Health Care Association, and the Assisted Living Federation of America.

[32]We excluded from our analysis 32 respondents from Florida and Oregon that were identified as assisted living facilities by their association membership but were not licensed by the state as assisted living facilities. Of the remaining 689, we excluded from our subsequent analysis 67 respondents that indicated on the survey that they do not provide or arrange for any assisted living services.

to enter, we (1) asked several assisted living industry experts, including experts at AARP, the American Association of Homes and Services for the Aging, the American Health Care Association, and the Assisted Living Federation of America, to identify the kinds of information that would be useful to potential residents and their families in selecting an assisted living facility; (2) obtained information from our mail survey of assisted living facilities on which of these items they usually provide and in what form; and (3) evaluated written marketing materials and contracts of 60 facilities for completeness, clarity, and consistency with pertinent state statutes and regulations.

To determine how the states oversee assisted living facilities, we interviewed state officials in the four states and reviewed relevant state statutes, regulations, guidance, and policy manuals. We did not evaluate the effectiveness of the state agencies' oversight of assisted living facilities. To determine the type and frequency of quality-of-care and consumer protection problems the four states identified in assisted living facilities, we analyzed information obtained from the state licensing and ombudsmen agencies in each state, and the adult protective services (APS) agency in Florida and Oregon, for the period from January 1, 1996, through December 31, 1997, for a randomly selected sample of 753 of the 955 facilities that received our survey. See table I.1 for detail on the sample by state. We examined each facility's most recent licensing survey and all complaint investigations for the facility that had resulted in deficiencies or complaints the state had verified concerning quality of care or consumer protection. We assessed the reliability of the state data by testing multiple data elements to confirm their expected relationships to one another and by testing individual data elements for specific attributes. We consider the states' data to be reliable for the purpose of this study. However, the results of our study cannot be projected to all assisted living facilities in these states.

We considered the deficiencies or complaints that concerned resident care, services, medications, staffing—levels, training, qualifications—and outcomes of care to be quality-of-care problems. We considered the deficiencies or complaints related to contracts, consumer disclosure and financial issues, tenant-landlord issues, and resident access to information and participation in decisionmaking to be consumer protection problems. We did not analyze deficiencies or complaints that dealt with resident rights, quality of life, administration, safety, or physical plant or environment issues. These data may include cases that were investigated and verified by more than one state agency. For example, a licensing

agency may have cited a deficiency in a facility and also referred the case to the APS to investigate. In this case, if the APS agency also verified that allegation, then we would have counted two problems occurring as opposed to one. However, because of the agencies' data limitations, we were unable to identify when this occurred or the extent to which it occurred. We also obtained information on factors that may have contributed to the identified problems through interviews with officials from the four states' licensing, ombudsman, and APS agencies.

Our Survey of Assisted Living Facilities

U.S. General Accounting Office
Survey of Assisted Living Facility Directors

Introduction

The U.S. Senate Special Committee on Aging has asked us to collect information on assisted living residents, facilities and the information provided to potential residents and their families. This information will help to inform members of Congress about the role of assisted living in meeting the long-term care needs of the nation's elderly.

As part of our study, we are sending this questionnaire to a random sample of facilities that have been identified as possible providers of assisted living services in four states. This questionnaire should take approximately 15-20 minutes to complete. Most of the questions can be answered quickly and easily by checking boxes. A request for copies of certain written material provided to potential residents is included at the end of the questionnaire.

We will keep your responses to the questionnaire strictly confidential. Only those responsible for the analysis of the survey data will know how you have responded. When GAO reports the results of the survey, no questionnaire response will be attributed to any specific establishment. Your responses will be combined with those of other respondents and reported in the aggregate.

Instructions

For the purposes of this survey, we would like you to provide information for the facility at this address only, even if it is a part of a larger organization. Please return the completed questionnaire in the enclosed self-addressed envelope within 10 days of receipt.

If you have any questions regarding this questionnaire, please call Eric Anderson or Connie Barrow toll free on (888) 767-4960. In the event that the envelope is misplaced, please send your completed questionnaire to:

Eric R. Anderson
U.S. GAO
HEHS/HSQ&PH
441 G Street, N.W.
Washington, D.C. 20548

Thank you for your assistance.

Background

1. Does your facility provide or arrange any assisted living services, regardless of whether or not you are specifically licensed as an "assisted living facility" in your state? ***(Check one)*** (N=689)

   622 Yes
   67 No --> **STOP! Please return your survey in the enclosed envelope. Thank you for your assistance.**

2. Approximately how many years has your facility been providing assisted living services? ***If less than one year, please indicate the number of months.*** (N = 584)

   Mean = 10 years
   Median = 7 years
   Range = 2 mos. - 125 years

Note: 689 facilities returned the questionnaire; however, some did not respond to all the questions. The "N" for each question is the number of respondents who answered that question.

3. Does your facility provide assisted living services primarily for the frail elderly (persons age 60 or older)? ***(Check one)*** *(N=621)*

579 Yes
43 No --> Please indicate the population group you primarily serve:
6 1. persons with developmental disabilities
15 2. persons with mental illness
22 3. other ***(Specify)*** _____

4. Is your facility part of a corporation or organization that owns or operates more than one assisted living facility? ***(Check one)*** *(N=619)*

322 Yes
296 No
1 Don't know

5. Is your assisted living facility operated as a for-profit, non-profit, or a combination of a for- and non-profit organization? ***(Check one)*** *(N=620)*

419 For-profit
181 Non-profit
13 Combination of for-profit and non-profit
7 Don't know

6. Is your assisted living facility part of a multi-level facility that offers more than one type of care or living arrangement in addition to assisted living? ***(Check one)*** *(N=611)*

347 Yes --> Please indicate the types of care or living arrangements you offer in addition to assisted living. **Do not include any special care units within your assisted living facility.** ***(Check all that apply.)***

229 1. Skilled nursing facility or 2. Nursing facility
242 3. Independent living
76 4. Other ***(Specify)*** a._____
b._____

264 No

Please answer the remaining questions only for the facility, or portion of your facility, in which you provide assisted living services.

7. What is the maximum number of residents that may be provided assisted living services in your facility? (N=610)

   mean = 63
   median = 48
   range = 2-600

8. Is your facility that provides assisted living services licensed by your state? ***(Check one)*** *(N=615)*

598 Yes --> Please indicate in column:

(1) the name of the category(ies) under which you are licensed in your state (such as assisted living, residential care, extended care, etc.);
(2) the maximum number of residents you are licensed for in each category;
(3) the total number of individuals who currently reside in your facility in each category.

	(1) Licensure Category	(2) Maximum number of residents	(3) Current number residing
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

17 No --> How many individuals currently reside in your assisted living facility?

_____ residents

9. Does your assisted living facility have a special wing or unit to care for persons with Alzheimer's disease or other cognitive impairments? ***(Check one)*** *(N=619)*

124 Yes --> How many residents are currently in this unit?

mean = 23
median = 20
range = 0 – 75

495 No

10. Does your facility receive Medicaid funds or other sources of public assistance or subsidy to provide care to any residents? ***(Check all that apply)*** *(N=617)*

172 Medicaid
126 0ther public assistance or subsidy ***(Specify)*** a._____
b._____
c._____

361 None
4 Don't Know

11. What is the approximate average monthly rate paid by, or on behalf of, residents of this facility for basic and additional services combined in:

(a) general assisted living,

(b) a special dementia care unit ***(Check "does not apply" if you don't have a dementia care unit)***, *or*

(c) another special care unit ***(Check "does not apply" if you don't have another special care unit)***

Type of Accommodation	Less than $1000/ month	$1,000 to $1,499	$1,500 to $1,999	$2,000 to $2,499	$2,500 to $2,999	$3,000 to $3,499	$3,500 to $3,999	$4,000 or more	Does Not Apply
a. General assisted living (N=550)	79	103	170	129	52	15	2	0	0
b. Special dementia care unit (N=602)	4	8	24	20	25	16	10	2	493
c. Other special care unit, ***Specify*** (N=255) _____ _____	11	8	13	12	10	6	2	1	192

Residents

The following series of questions will focus on the needs of your current resident population and the degree to which you serve residents with different care needs.

12. Listed below are various activities that residents might need assistance with at your facility. Approximately what percentage, if any, of your current residents need staff assistance with each activity?

Staff assistance with.....	Percentage of residents that receive staff assistance. *(Check one for each activity)*				
	None	1-25 %	26-50%	51-75%	76-100%
a. Bathing (N=613)	15	107	174	141	176
b. Dressing (N=609)	26	191	188	142	62
c. Toileting and/or incontinence care(N=607)	62	258	164	95	28
d. Transferring (N=603)	174	302	91	27	9
e. Feeding (N=597)	343	211	29	12	2
f. Medication--supervision of self -administered medication (N=600)	50	170	75	94	211
g. Medication--dispensing of medication (N=572)	131	73	65	117	186
h. Ambulation (N=600)	140	293	103	47	17
i. Other *(Specify)* (N=61) _____	7	26	8	12	8

13. Approximately what percentage, if any, of your current residents are cognitively impaired--that is, have significant short-term memory problems, are disoriented all or most of the time, have difficulty making decisions about their daily lives, or have been diagnosed with Alzheimers or other dementia? Please include residents in both the general assisted living community and those in a special care unit for persons with cognitive impairment, if applicable. *(Check one)* (N=615)

35 None
243 1-25 %
165 26-50 %
108 51-75 %
64 76-100 %

14. Listed below are various needs and conditions that a potential resident of assisted living may have. For each, please indicate whether your facility would typically admit a person with the specified need or condition **regardless** of whether the facility or some other provider such as a home health agency is responsible for providing services to meet those needs.

Resident Need or Condition	Typically Admit? *(Check one)*	
	Yes	No
a. Requires a wheelchair to get around (N=605)	481	124
b. Requires assistance to transfer from bed to chair or wheelchair (N=603)	350	253
c. Is confined to bed for most or all of the day (22+ hrs) (N=604)	24	580
d. Lacks bladder control but can manage own incontinence supplies (N=609)	571	38
e. Lacks bladder control but needs assistance to manage incontinence (N=604)	452	152
f. Lacks bowel control but can manage own incontinence supplies (N=604)	495	109
g. Lacks bowel control but needs assistance to manage incontinence (N=602)	355	247
h. Wanders (N=593)	231	362
i. Has mild to moderate memory or judgement problems (N=610)	590	20
j. Has severe memory or judgement problems (N=596)	221	375
k. Has a short-term need for nursing care or monitoring by an LPN or RN (N=605)	464	141
l. Has an ongoing need for nursing care or monitoring by an LPN or RN (N=594)	204	390
m. Requires the use of an indwelling urinary catheter (N=600)	284	316
n. Requires colostomy or ileostomy care (N=598)	293	305
o. Requires tube feeding on an ongoing basis (N=608)	37	571
p. Requires intravenous (IV) medication or therapy (N=610)	51	559
q. Requires oxygen (O2) supplementation (N=602)	475	127
r. Requires a ventilator to assist with breathing (N=608)	52	556

15. Listed below are various needs and conditions that a resident of assisted living may develop after being admitted to an assisted living facility. For each, please indicate whether your facility would typically discharge a resident who develops the specified need or condition. **Do not include transfers within the facility such as from general assisted living to a dementia care or other special care unit within the same facility.**

Resident Need or Condition	Typically Discharge? *(Check one)*	
	Yes	No
a. Requires a wheelchair to get around (N=543)	53	490
b. Requires assistance to transfer from bed to chair or wheelchair (N=540)	134	406
c. Is confined to bed for most or all of the day (22+ hrs) (N=540)	415	125
d. Lacks bladder control but can manage own incontinence supplies (N=545)	9	536
e. Lacks bladder control but needs assistance to manage incontinence (N=540)	83	457
f. Lacks bowel control but can manage own incontinence supplies (N=544)	56	488
g. Lacks bowel control but needs assistance to manage incontinence (N=539)	151	388
h. Wanders (N=531)	274	257
i. Has mild to moderate memory or judgement problems (N=540)	4	536
j. Has severe memory or judgement problems (N=526)	250	276
k. Has a short-term need for nursing care or monitoring by an LPN or RN (N=536)	65	471
l. Has an ongoing need for nursing care or monitoring by an LPN or RN (N=533)	298	235
m. Requires the use of an indwelling urinary catheter (N=536)	212	324
n. Requires colostomy or ileostomy care (N=534	213	321
o. Requires tube feeding on an ongoing basis (N=544)	476	68
p. Requires intravenous (IV) medication or therapy (N=544)	455	89
q. Requires oxygen (O2) supplementation (N=530)	72	458
r. Requires a ventilator to assist with breathing (N=546)	481	65

SERVICES

16. Listed below are various services that might be available to residents of your facility. For each of the following services, please indicate in:

Part A: Whether or not the service is available to your residents, regardless of who provides the service—the facility or an outside provider such as a home health agency.

Part B: If you answered "**yes**" in Part A, indicate in Part B if the service is typically

(1) provided by the facility with its own or contracted staff;
(2) arranged by the facility but paid for privately by the resident or other third party; or
(3) arranged and paid for by the resident or other third party.

Part A				Part B *(Check one)*		
Service	Available? *(Check one)* Yes	No	If yes ---->	(1) Provided by the facility	(2) Arranged by the facility but paid for by resident or 3rd party	(3) Arranged and paid for by the resident or 3rd party
a. Housekeeping (N=621)	620	1		607	1	1
b. Laundry (N=621)	620	1	---->	579	21	5
c. Meals (N=619)	618	1	---->	604	1	1
d. Transportation to medical appointments (N=610)	576	34	---->	399	131	11
e. Special diets (i.e. diabetic, low salt, or other) (N=620)	590	30	---->	572	3	2
f. Tube feeding (N=614)	118	496	---->	47	45	19
g. Supervision of self-administered medications (N=619)	592	27	---->	546	27	5
h. Storage and dispensing of oral medications (N=619)	588	31	---->	544	27	7
i. Storage and administration of injectable medications (N=618)	527	91	---->	402	79	24
j. IV therapy (N=608)	155	453	---->	25	95	29
k. Skilled nursing services (N=615)	345	270	---->	101	151	56
l. Skilled therapy services (i.e. PT, speech, OT) (N=616)	535	81	---->	60	347	93
m. Hospice Care (N=607)	505	102	---->	38	326	100

17. Of the following types of oversight that might be provided to a resident in assisted living, please indicate whether your facility provides each type to your residents. ***(Check one for each type)***

Type of oversight	Yes	No
a. Supervision of residents by awake staff on a 24 hour basis (N=620)	557	63
b. Monitoring changes in residents' condition -- that is, health status and/or physical and cognitive functioning (N=619)	618	1
c. Notification of a resident's physician, family, or other responsible party when changes in a resident's condition are noted (N=621)	620	1
d. Regular health or wellness checks for residents provided by a nurse or other licensed health professional (N=620)	563	57
e. Other ***(Specify)*** (1)_____ (N=65)	65	
(2)_____ (N=27)	27	

Consumer Information

18. Listed in the table below are items of information that may be provided to **potential** residents and their families to assist them in selecting an assisted living facility. For each item, please indicate in:

Part A: Whether or not you usually provide this information to potential residents.

Part B: Whether it is provided orally and/or in writing.

Part C: If the information is provided in writing, please indicate whether it is contained in marketing material, resident agreements (contracts), or in other written material such as resident handbooks, state regulations, etc.

PART A				PART B			PART C		
Information	Usually provide to potential residents? *(Check one)*			How is it provided? *(Check all that apply)*			How is the written information provided? *(Check all that apply)*		
	Yes	No		Orally	Written		Marketing material	Resident agreement or contract	Other written material
a. Description of services included in the basic facility rate	619	2	**If yes** --->	361	605	**If Written** ---->	399	525	148
b. Description of services available beyond those included in the basic rate	573	37	--->	359	524	---->	301	389	163
c. Cost of the basic service package	606	9	--->	349	580	---->	336	470	118
d. Cost of additional services	549	50	--->	324	490	---->	225	338	177
e. Description of services not covered or available from the facility	448	151	--->	316	309	---->	106	213	115
f. Circumstances under which the cost of services may change	546	58	--->	355	445	---->	131	373	133

18. (Continued)

PART A				PART B			PART C		
Information	Generally provided? *(Check one)*			How is it provided? *(Check all that apply)*			How is the written information provided? *(Check all that apply)*		
	Yes	No		Orally	Written		Marketing material	Resident agreement or contract	Other written material
g. Discharge criteria – circumstances under which a resident may be required to leave due to a change in health status	582	28	**If yes** --->	329	480	**If Written** --->	58	405	169
h. Statement of residents' rights & responsibilities	594	19	--->	225	581	--->	73	357	357
i. Description of resident complaint or grievance procedure	552	56	--->	222	503	--->	41	260	329
j. Description of staff training and qualifications	372	231	--->	240	204	--->	52	62	131
k. Facility policy on medication assistance or administration	553	59	--->	317	446	--->	86	263	241
l. Facility practice for assessing or monitoring residents' health care needs	543	65	--->	339	406	--->	86	228	224
m. Other information *(Specify)* _____ _____ _____	34	1	--->	20	31	--->	9	16	22

19. Based on your professional experience in assisted living, how useful, if at all, do you believe the following sources of information are to potential residents and their families in determining whether a particular facility is appropriate for their needs and preferences.

Source of Information	How Useful is Each Source of Information for Potential Residents and Their Families *(Check one for each source)*					
	Very Useful	Generally Useful	As useful as not	Generally Not useful	Definitely Not Useful	Don't Know
1. Facility tour (N=619)	571	46	2	0	0	0
2. Personal interview (N=620)	574	44	1	0	0	1
3. Written marketing materials (N=617)	248	266	65	19	3	16
4. Sample resident agreement/contract (N=615)	219	222	103	48	4	19
5. Other written material *(Specify)* _____ (N=196)	95	66	14	8	2	11
6. Other source (*Specify)* _____ _____ (N=95)	74	14	0	1	0	6

20. Does your facility provide a copy or sample of the resident agreement to the consumer prior to their making a decision to apply for admission? ***(Check one)*** *(N=608)*

152 1. It is provided routinely to all interested parties along with other written material about the facility.
395 2. It is provided upon request to interested parties.
61 3. It is not generally provided.

21. **Finally, along with your completed questionnaire, please provide us with copies of the following written material if available:**

428 (1) All marketing material or other information provided to prospective residents and their families

354 (2) Pricing information about basic and additional services

378 (3) A copy or sample of the resident agreement or contract

Comments

22. Please use the space below to (1) clarify or qualify your responses to any questions on the survey or 2) provide any additional comments about how information assists consumers to choose an assisted living facility. *(If you need additional space for comments, please continue on the next page.)*

Please provide the following information about the person who completed the questionnaire, should additional information or clarification be needed.

Name of person to call: _____

Title: _____

Telephone number: ( ) _____

Thank you for participating in this study.

(108330)

13

Additional Information on Quality-of-Care and Consumer Protection Problems in Four States

Licensing agencies across the four states have different assisted living regulations—that is, the content, level of detail, and coding schemes for their assisted living licensing regulations all differ. Similarly, Florida's and Oregon's APS agencies have different allegation categories that they assign problems to. A problem or deficiency in one state may have one regulation requirement or allegation category, whereas another state may have four relevant regulatory requirements or allegation categories for the same problem. Therefore, the frequencies of licensing deficiencies should not be compared across states, and neither should frequencies of APS allegations be compared between Florida and Oregon. Only the ombudsman agencies across the four states use the same categories for complaints, which allows for the possibility of comparing the findings across the states. Furthermore, because of the inconsistencies with how licensing and APS agencies categorize deficiencies or allegations across the states, no comparisons should be made across the ombudsman, licensing and APS data.

Table III.1: California's Frequency of Quality-of-Care and Consumer Protection Problems by Agency, 1996-97

	Licensing		Ombudsman	
Problem	**Number of facilities**	**Number of problems**	**Number of facilities**	**Number of problems**
Quality of care				
Abuse			15	22
Admission, discharge, or level of care	25	39	12	29
Care plans or assessments	18	27	7	8
Inadequate care	28	53	23	40
Medication	25	43	8	10
Neglect	1	1	2	2
Nutrition or special diet needs			2	2
Restraints				
Staffing shortages, qualifications, or training	26	33	8	11
Other				
Consumer protection				
Access to information	1	1	4	4
Billing or charges			10	15
Contracts	3	3	3	3
Criminal background checks	11	12		
Exploitation			4	4
Other	5	11	5	6

Note: Number of facilities = 150. Numbers cannot be compared or aggregated across the licensing and ombudsman agency columns. A blank cell indicates that the agency database had no facilities with deficiencies in this problem category. These data may include cases that were investigated and verified by more than one state agency. However, the agencies' data limitations left us unable to identify when this occurred or the extent to which it occurred. Also, problems classified under the category of "admission, discharge, or level of care" may be related to either consumer protection or quality-of-care issues.

Table III.2: Florida's Frequency of Quality-of-Care and Consumer Protection Problems by Agency, 1996-97

	Licensing		Ombudsman		APS	
Problem	**Number of facilities**	**Number of problems**	**Number of facilities**	**Number of problems**	**Number of facilities**	**Number of problems**
Quality of care						
Abuse			6	9	25	39
Admission, discharge, or level of care	65	118	5	5		
Care plans or assessments	115	201	2	2		
Inadequate care	44	51	19	29		
Medication	116	266	5	5		
Neglect					32	103
Nutrition or special diet needs	38	49	3	3		
Restraints	38	38	4	4		
Staffing shortages, qualifications, or training	151	393	5	7		
Other	28	28				
Consumer protection						
Access to information	55	76	5	5		
Billing or charges	4	5	13	13		
Contracts	72	82	1	1		
Criminal background checks						
Exploitation			3	3	1	1
Other	55	73	1	1		

Note: Number of facilities = 370. Numbers cannot be compared or aggregated across the licensing, ombudsman, and APS agency columns. A blank cell indicates that the agency database had no facilities with deficiencies in this problem category. These data may include cases that were investigated and verified by more than one state agency. However, the agencies' data limitations left us unable to identify when this occurred or the extent to which it occurred. Also, problems classified under the category of "admission, discharge, or level of care" may be related to either consumer protection or quality-of-care issues.

Table III.3: Ohio's Frequency of Quality-of-Care and Consumer Protection Problems by Agency, 1996-97

	Licensing		Ombudsman	
Problem	Number of facilities	Number of problems	Number of facilities	Number of problems
Quality of care				
Abuse			3	3
Admission, discharge, or level of care	3	3	6	6
Care plans or assessments	17	25	1	1
Inadequate care	8	14	1	2
Medication	8	12		
Neglect			2	2
Nutrition or special diet needs	4	4		
Restraints	2	2		
Staffing shortages, qualifications, or training	9	10	3	3
Other	2	2		
Consumer protection				
Access to information	6	6		
Billing or charges	2	2	2	3
Contracts				
Criminal background checks				
Exploitation				
Other	2	2	2	2

Note: Number of facilities = 150. Numbers cannot be compared or aggregated across the licensing and ombudsman agency columns. A blank cell indicates that the agency database had no facilities with deficiencies in this problem category. These data may include cases that were investigated and verified by more than one state agency. However, the agencies' data limitations left us unable to identify when this occurred or the extent to which it occurred. Also, problems classified under the category of "admission, discharge, or level of care" may be related to either consumer protection or quality-of-care issues.

Table III.4: Oregon's Frequency of Quality-of-Care and Consumer Protection Problems by Agency, 1996-97

	Licensing		Ombudsman		APS	
Problem	**Number of facilities**	**Number of problems**	**Number of facilities**	**Number of problems**	**Number of facilities**	**Number of problems**
Quality of care						
Abuse	2	6	4	7	21	48
Admission, discharge, or level of care			10	14	2	2
Care plans or assessments	34	86	11	18	13	18
Inadequate care	15	26	26	74	26	50
Medication	24	33	10	20	9	17
Neglect			4	4	14	16
Nutrition or special diet needs			6	8	5	7
Restraints			2	2		
Staffing shortages, qualifications, or training	10	12	20	59	1	1
Other						
Consumer protection						
Access to information			5	6		
Billing or charges			15	27	1	1
Contracts			1	1	1	1
Criminal background checks						
Exploitation			2	3	3	3
Other			4	5	5	5

Note: Number of facilities = 83. Numbers cannot be compared or aggregated across the licensing, ombudsman, and APS agency columns. A blank cell indicates that the agency database had no facilities with deficiencies in this problem category. These data may include cases that were investigated and verified by more than one state agency. However, the agencies' data limitations left us unable to identify when this occurred or the extent to which it occurred. Also, problems classified under the category of "admission, discharge, or level of care" may be related to either consumer protection or quality-of-care issues.

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