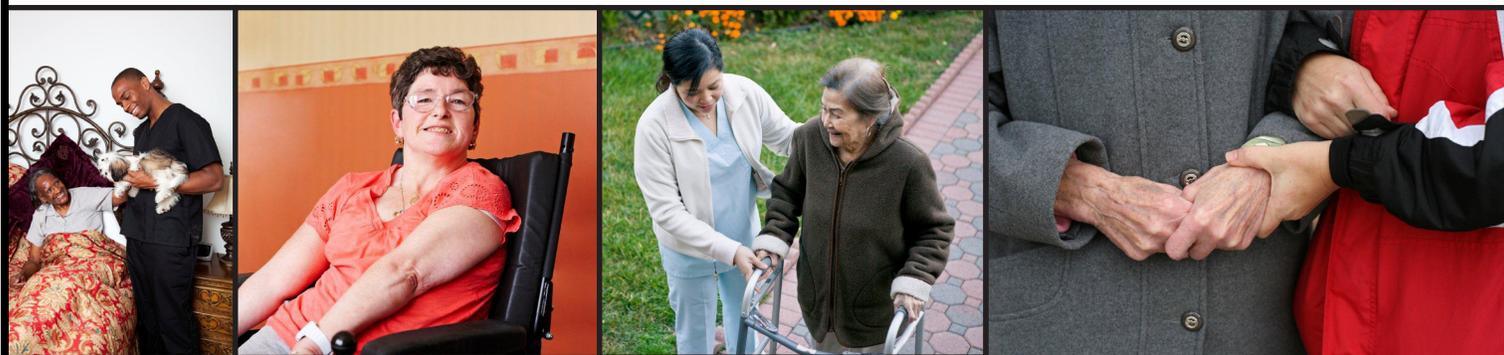


ADULT FAMILY HOME QUALITY ASSURANCE PANEL REPORT

Recommendations to the Governor and Legislature per ESHB 1277



December 1, 2012

Date: December 1, 2012

To: Office of the Governor
Health and Long-term Care Committee, Washington State Senate
Health and Wellness Committee, Washington State House of Representatives

RE: Adult Family Home Quality Assurance Panel Report

Enclosed for your consideration and action is the report of the Adult Family Home Quality Assurance Panel, established by the 2011 Legislature in ESHB 1277. Our charge was to review problems of neglect and abuse in adult family homes, and with oversight of new providers, de minimus violations, and overall licensing, investigation and enforcement issues regarding adult family homes. HB 1277 also directed the Panel to provide a report with recommendations to the Governor, the Senate Health and Long-Term Care Committee, and the House of Representatives Health and Wellness Committee.

The Long-Term Care Ombudsman along with DSHS, selected members for the Panel who represented the key adult family home stakeholder groups. Members were asked to share meeting discussions with their constituents for input and feedback to the Panel. Additionally, the public was invited to participate and observe Panel meetings and encouraged to share their comments.

Adult family homes are businesses, mostly owned by sole proprietors that provide home-like housing and care to individuals who have functional limitations and have broadly varying degrees of service needs. Meeting these needs is a key component to Washington's long-term care system. The majority of the 2,803 adult family homes are contracted to provide Medicaid services.

The AFHs serve a wide array of people, including younger adults with developmental disabilities, adults with physical disabilities, chronically mentally ill adults, and frail elders. All individuals residing in AFHs are considered vulnerable; their health and well-being are dependent upon their caregivers and the owners of the homes. By law, the health, safety, and well-being of these vulnerable adults should be the paramount concern in all decisions made when determining licensing and enforcement rules for adult family homes.

The following report presents a list of 13 recommendations divided into three categories: legislative statutory, DSHS regulatory, and DSHS internal actions. Our recommendations specify improvements to internal management at DSHS, the adult family home industry, and assistance for consumers. The report includes good and bad examples from DSHS enforcement files, and also includes what is working well in the adult family home industry in oversight and the Panel's wish to support these efforts.

The Panel would like to thank all those who contributed to this report, including DSHS, many ombudsmen, the Panel members, and the report writers. We look forward to working with the Governor's Office and the Legislature in continuing to move forward on improving this vital industry and the protection of vulnerable adults.



Patricia Hunter, Chair of HB 1277 Adult Family Home Quality Assurance Panel

EXECUTIVE SUMMARY

In 2011, the Washington State Legislature examined problems with the quality of care and oversight of some adult family homes (AFHs). Washington has over 2,800 AFHs, serving approximately 14,000 vulnerable residents and/or residents with disabilities in small residential homes. The 2011 Legislature passed [HB 1277](#) to address these care quality and oversight issues. The new law increased requirements for AFHs—the homes now had to have a qualified caregiver on-site, as opposed to on-call; owners needed to understand English; and more prior caregiving experience was required of new AFH owners. HB 1277 also augmented the civil fine authority of the Department of Social & Health Services (DSHS), the agency that licenses and inspects AFHs, and directed the agency to increase penalties for AFHs that are consistently deficient. The changes went into effect in January 2012. In addition, through [Initiative 1163](#) and effective January 2012, the basic training requirements for newly licensed AFH owners and newly hired caregivers in AFHs were increased.

In order to examine the issues more fully, HB 1277 also directed DSHS to convene a Quality Assurance panel, selected by DSHS and the State Long-Term Care Ombudsman (LTCO) and chaired by the latter, to review problems with neglect and abuse in AFHs, and the oversight of new providers, de minimus violations, and overall licensing, investigation and enforcement issues regarding AFHs. The Panel was directed to provide a report to the Governor and Legislature by December 1, 2012.

The Long-Term Care Ombudsman (LTCOP) and DSHS assembled a Panel representing AFH associations and providers, resident advocates and families, nursing/hospice, public guardianship, and DSHS oversight and management divisions. The Panel met five times over the past year and discussed a broad array of topics and recommended action steps. These steps are not based upon a rigorous study, but upon the pooled knowledge of an experienced, diverse group of stakeholders working in this field.

A team of ombudsmen also reviewed a random sample of 160 unredacted DSHS licensing and investigation files, and a representative sample of those cases was then considered by the Panel. The case reviews revealed both effective and ineffective enforcement actions. For example, an AFH teetering on the brink of financial crisis and with staff mistreating residents was shut down promptly. On the other hand, an AFH with residents with dementia who were wandering repeatedly out of the home, and a caregiver who could not read residents' records, was permitted to operate for a year before DSHS required a second caregiver.

Summary of Recommendations

While not every member of the Panel agreed with the every statement in this report, overall, nearly all members of the panel concluded that the quality of care in AFHs would be improved, and abuse and neglect would decline, if some caregivers and AFH owners received better training and mentoring, residents and their families were better informed and selected the right AFH, and DSHS oversight was more vigorous and prompt against poorly performing AFHs. The panel specifically makes the following recommendations.

Legislature, Statutory:

1. Establish additional AFH specialty designations for homes serving residents with skilled nursing needs or traumatic brain injury.
2. Require all AFHs to issue a standardized disclosure form regarding care capacities and specialties for prospective residents, family, and designated decision makers.
3. Direct DSHS to place conditions on a home's license, such as to hire a consultant or obtain more training, in conjunction with a stop placement of admissions when the AFH has violations that are repeated, uncorrected, pervasive, or potentially life-threatening.
4. Allow DSHS to refrain from citing a minor violation by an AFH, so long as it is corrected during an inspection, is not a repeat violation, and does not pose a significant risk.

DSHS, Regulatory:

5. In conjunction with stakeholders, expand and improve specialty training course requirements for AFHs serving residents with dementia, mental health, or developmental disability related needs, and add additional specialty trainings not addressed by Initiative 1163.
6. Require AFH owners to meet with, review the assessment of, and develop a preliminary care plan for potential residents prior to their admission to the home.
7. Clarify the rules concerning the inspection of the homes of multiple-facility owners when serious or repeat deficiencies are found in one of their AFHs.

DSHS, Internal Actions:

8. Require AFH owners to successfully complete the revised 48 hour administrator training program when substandard business practices have been demonstrated.
9. Comply more closely with the RCW 70.128.160 requirement to maintain a stop placement until the AFH has corrected the violations that caused the stop placement and shown it can maintain the corrections.
10. Create an accessible, consumer-friendly website for family members and residents to use when making informed decisions about care in an AFH or other long-term care (LTC) facility.
11. Work with the Office of Administrative Hearings to determine the extent of delays in holding fair hearings, particularly for AFHs that have received a license revocation; work to ensure timely hearings and monitor residents' well-being during such delays; and request additional resources if necessary.
12. Revise the DSHS/LTCOP information poster in AFHs and other LTC facilities to include specific language prohibiting retaliation.
13. Provide more written information on the resolution of unsubstantiated allegations as part of the complaint investigative report, in order to better document the investigation.

Many AFHs provide excellent care and are the preferred alternative to a larger nursing home or assisted living facility. The AFH Quality Assurance panel wants to note that its review focused on problems in the current system and AFHs with violations. With residents' well-being as our goal, we urge the Washington State Legislature, the Governor, and DSHS to implement the recommendations contained in this report.

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1.0 INTRODUCTION

1.1 Panel Charge

In 2011, the Washington State Legislature called for the DSHS to convene a Quality Assurance panel to be chaired by the state's Long-Term Care Ombudsman (LTCO). The Panel's charge is cited below per Sec. 502 of [ESHB 1277](#):

The department shall convene a quality assurance panel to review problems in the quality of care in adult family homes and to reduce incidents of abuse, neglect, abandonment, and financial exploitation. The state's long-term care ombudsman shall chair the panel and identify appropriate stakeholders to participate. The panel must consider inspection, investigation, public complaint, and enforcement issues that relate to adult family homes. The panel must also focus on oversight issues to address de minimus violations, processes for handling unresolved citations, and better ways to oversee new providers. The panel shall meet at least quarterly, and provide a report with recommendations to the governor's office, the senate health and long-term care committee, and the house of representatives health and wellness committee by December 1, 2012.

1.2 Process

The members of the Panel engaged in a yearlong process to develop the enclosed report and its recommendations for the Governor and Legislature. The Panel included groups representing AFH associations, resident advocates and families, nursing/hospice, and DSHS oversight and management divisions. The Panel met for five full day sessions between September 2011 and September 2012. In addition to the full Panel meetings, a team from the LTCOP reviewed a random sample of unredacted DSHS licensing and investigation files covering a one year period, and a representative sample of those case reviews was then considered by the full Panel.

The focus of the Panel was on AFHs, and the facility oversight by DSHS, as opposed to investigations into allegations about individual caregivers. The Panel did not examine the separate investigation system that DSHS has for allegations of abuse or neglect by individual caregivers. Thus, the Panel did not examine DSHS's Resident and Client Protection Program (RCPP), which is charged with investigating abuse and neglect by specific caregivers or with a broader issue relating to the coordination of cases involving allegations of serious neglect and abuse among agencies, such as the Department of Health, Medicaid Fraud Control Unit, RCPP, local law enforcement agencies, and coroners.

2.0 BACKGROUND

2.1 History of AFHs

Washington is a national leader in support of choice, options, and alternatives for individuals who need long-term care services. The large array of options range from living in one's own home with assistance to living in a smaller (AFHs, supported living homes) or larger (assisted living facilities, nursing homes) residential setting with various services.

AFHs arose in the 1970s as a small, community alternative to nursing homes. These homes are located in most neighborhoods and are licensed to provide room, board, and care for two to six adult residents who are vulnerable and/or have disabilities. The range of personal care needed may be from minimal assistance with daily activities, such as bathing or dressing, to complete care equal to a nursing home.

The number of AFHs has steadily grown over the past decade. There were 2,070 licensed AFHs in October 2002, and as of June 2012 there are 2,803. While many AFHs open each year, many also close for various reasons; 130 new homes opened in 2011, while 210 closed. Overall, it appears that the number of AFHs is leveling off.

Of the current 2,803 AFHs, 2,416 (86%) hold Medicaid contracts with DSHS. AFHs are allowed to decide how many Medicaid clients they will serve; currently about 45% of AFH residents are Medicaid clients. Over half of the licensed AFHs in Washington are located in King, Pierce, Snohomish, and Clark counties. Less populous counties have fewer AFHs and it is currently unknown where the need for AFHs may exceed the available homes.

About 2,100 of 2,803 AFHs are operated by sole proprietors, with the owner either living in the home or staffing the AFH with caregivers and a manager. The remaining 700 AFHs are operated by multi-facility owners. Good care and problematic care are seen in both models of ownership.

2.2 History of State Oversight of AFHs

In the mid-1990s, the AFH industry experienced a large surge of growth, increasing from roughly 1,300 licensed homes in January 1995 to 2,100 homes in August 1996. At the same time, Washington extended a Residents Rights Law, [RCW 70.129](#), to AFH residents in 1994 and directed the Long-Term Care Ombudsman Program (LTCOP), which advocates for residents, to report on the quality of care in AFHs and their oversight by DSHS. The LTCOP issued reports to the Legislature in 1995, 1996, 1998, and 2000. These reports led to significant changes in the law. For example, residents' rights could no longer be waived, staff had to meet minimum training standards, and DSHS had to impose sanctions for serious or repeated violations.

AFH caregiver and owner/manager training standards have increased over the years, in response to problems reported in the past LTCOP reports, the recent [Seattle Times articles](#), and by DSHS and others. The most recent change occurred in January 2012 as a result of Initiative 1163, which increased the basic training standards for *newly hired* caregivers. There were also changes to the specialty training requirements for AFHs that serve residents with dementia, developmental disability, or a mental illness. Most AFHs have two or more such specialty designations. Prior to the January 2012 implementation of [Initiative 1163](#), AFH owners could train their own caregivers on specialty care without the requirement of a competency exam. An exam is now required, although Initiative 1163 did not increase the course requirements for specialty care. The dementia training for AFH caregivers is 6 hours long. The mental health training for AFH caregivers is 4 hours long.

The regulation of an industry that serves vulnerable people in isolated settings, and in some cases operates for long stretches of time without outside scrutiny, is necessarily a delicate business. The state wants to encourage the development of small home-like care settings, while also trying to improve competence and penalize poor care. Serving in the consultant role raises a potential conflict when it comes time to enforce the law. However, it is also important to the safety and protection of LTC residents, to have DSHS working with the industry, advocates, and others to help shape the evolution of the AFH industry in a positive way. It is this tension that plays out in the state oversight process.

The DSHS Oversight Process

The applicable licensing, complaint investigation, and enforcement laws are found mostly at [RCW 74.39A.060](#) and [70.128.160](#). DSHS conducts full licensing inspections, where all aspects of a home are examined, on average every 15 months per home. In 2011, DSHS conducted 2,029 full licensing inspections. DSHS also conducts complaint investigations. DSHS assigns the complaint a response time based upon its apparent severity: two working days, ten days, 45 days, or at the next license inspection. Since 1997, the DSHS investigator has been statutorily required to interview the complainant, unless anonymous; the resident, if possible; staff; and available sources of independent information, including the resident's family. A complaint may contain multiple allegations. The investigator determines whether the allegations are substantiated or unsubstantiated, based upon the AFH licensing requirements. These determinations are reviewed by a DSHS district office field manager. In 2011, DSHS conducted 1,979 AFH complaint investigations.

A violation or deficiency is a failure to follow one of the AFH licensing laws, [RCW 70.128](#) or [WAC 388-76](#). A citation is issued for the violation or deficiency, although sometimes there is just a verbal consultation. DSHS also sometimes notes there is a "failed practice" without issuing a citation, apparently generally when the violation has already been corrected. There are written policy criteria for when a consultation or "failed practice" notation is given. When citations are issued by DSHS, the formal written document that establishes them is the Statement of Deficiencies (SOD). When complaint allegations are not substantiated, a very brief summary of the DSHS investigation is set forth in an Investigation Summary Report (ISR).

If the violations rise to a certain level, DSHS takes an enforcement action and imposes a "remedy." The available enforcement remedies, which can be combined, are: (1) civil fine, including a daily fine for each violation; (2) "reasonable condition" on the license, such as more staff training or correction within a specified time; (3) stop placement, prohibiting the admission of any new residents (sometimes including the readmission of current residents who leave temporarily); (4) license revocation, which can shut down the home; and (5) summary suspension of the license, which immediately shuts down the home. Appendix D contains the "Enforcement Action Options" grid used by DSHS when determining the remedy based upon the severity of the violations. The DSHS field office recommends the enforcement action(s), but the decision is made by DSHS headquarters. A consultation is not an enforcement action. By analogy, a speeding ticket is an enforcement action whereas a warning to slow down is a consultation.

The AFH can challenge citations and/or remedies in two ways. The first is by Informal Dispute Resolution (IDR), where the case is reviewed by a senior management person within DSHS who is not involved in the original decision. The second is through a formal fair hearing (FH) before an independent judge known as an administrative law judge (ALJ). Seeking an IDR or a FH,

however, does not suspend a stop placement, condition on license, or summary license suspension.

If a stop placement is imposed by DSHS, it is not supposed to be lifted until DSHS determines the violations have been corrected and the AFH demonstrates the capacity to maintain the correction. If the violations were serious, recurring, or uncorrected from a prior citation, then DSHS must make an on-site visit to the home to ensure correction. HB 1277 strengthened the civil fine authority of DSHS. Previously, DSHS could fine \$100 per day per violation. Now DSHS can impose a fine of up to \$3,000 per day per violation. HB 1277 did not change the other enforcement remedies and powers of DSHS.

Since 1997, DSHS has been required under the law to impose prompt and specific enforcement remedies on AFHs with resident care problems that are “serious, recurring, or uncorrected, or that create a hazard that is causing or likely to cause death or serious harm to one or more residents. In the selection of remedies, the health, safety, and well-being of residents must be of paramount importance.” [RCW 74.39A.051\(6\)](#). Over the past ten years, DSHS undertook a number of steps to improve AFH oversight—these are listed in an appendix prepared by DSHS, Appendix C of this report. Following the *Seattle Times* series about AFHs and DSHS, the 2011 Legislature strengthened the statutory language regarding DSHS oversight in HB 1277, now [RCW 70.128.160\(7\)](#), adding the requirement that AFHs “consistently found to have deficiencies will be subjected to increasingly severe penalties.”¹

HB 1277 also strengthened several requirements directly applicable to AFHs, notably: the home generally must have a qualified caregiver on site (as opposed to on-call); AFH owners must know how to read/write English; new AFH owners must have 1,000 hours prior relevant caregiving experience; AFH owners may apply to open another AFH only if the current home has gone for at least one year without significant violations of licensing laws and regulations; and AFH license fees were increased to more closely approximate state oversight costs.

2.3 Key Stakeholders and Roles

Consumers: Residents and their Family members

Consumers can be the AFH resident and/or family members of the resident. Some residents may have a substitute decision maker, such as a power of attorney or legal guardian. Consumers entering the long-term care system expect to receive appropriate services, be treated with courtesy, and continue to enjoy their basic civil and legal rights. The initial role for consumers is to know what care is needed and then interview and select the AFH that can deliver the appropriate services. Navigation of the LTC system can be is very cumbersome and

¹ The full text of RCW 70.128.160(7) provides: “The department shall by rule specify criteria as to when and how the sanctions specified in this section must be applied. The criteria must provide for the imposition of incrementally more severe penalties for deficiencies that are repeated, uncorrected, pervasive, or present a threat to the health, safety, or welfare of one or more residents. The criteria shall be tiered such that those homes consistently found to have deficiencies will be subjected to increasingly severe penalties. The department shall implement prompt and specific enforcement remedies without delay for providers found to have delivered care or failed to have delivered care resulting in problems that are repeated, uncorrected, pervasive, or present a threat to the health, safety, or welfare of one or more residents. In the selection of remedies, the health, safety, and well-being of residents must be of paramount importance.”

difficult for consumers. Accessible, understandable consumer information is critical in order for residents and their designated decision makers to make informed choices about their care, safety, and quality of life.

Once consumers move to AFHs, they and their family members or decision makers should try to participate in seeing that residents receive care that meets their physical, emotional, and mental health needs. They need to know how to advocate for improved care or get assistance, if necessary.

Consumers new to the long-term care system will need to learn about the system of oversight and quality assurance in AFHs. They should read the inspection reports on the AFH to see if the AFH is working within the licensing standards. These reports are not always readily available or visible in the AFH. If there are problems with the care, consumers also need to know how to make a report to DSHS or the LTCO for investigation. Fear of retaliation is a serious issue that needs to be recognized in all oversight, outreach, and trainings. Lack of information about how or where to report, inability to report and fear of retaliation are barriers to reporting care issues. Consumers' information about the day-to-day operations of an AFH can be the early warning system to identify problematic care.

Department of Social and Health Services/Aging and Disability Services Administration/Residential Care Services

Residential Care Services (RCS) is one of five divisions within the Aging and Disability Services Administration (ADSA) of DSHS. The Secretary of DSHS reports directly to the Governor of Washington. The mission of DSHS is to improve the safety and health of individuals, families, and communities by providing leadership and establishing and participating in partnerships. RCS's focus is to promote and protect the rights, security, and well-being of individuals living in licensed or certified residential care facilities. RCS is responsible for provider/facility licensure/certification and investigating reports of abuse, abandonment, neglect, and financial exploitation of vulnerable adults in long-term care facilities and supported living. DSHS is in a constant process of reviewing and updating/changing processes to better meet the needs of individuals who need long term services and supports. (For a list of initiatives, see Appendix C)

Adult Family Home Owners

AFH owners possess vastly differing experiences and professional preparation. While many homes are owned by licensed nurses and others in the healthcare field, some homes do not have that background. Many AFH owners also come from a wide array of cultural backgrounds including owners from Romania, Vietnam, African countries, the Philippines, Germany, and other diverse geographies and cultures.

If the AFH has at least one resident whose services are paid by Medicaid, then the AFH must be a member of the Washington State Residential Care Council (WSRCC). WSRCC offers its members approved educational offerings, consultation, legislative support via lobbying efforts, and updates on licensing trends and issues as well as representation during collective bargaining for daily Medicaid rates and educational issues.

Ombudsman – LTCOP

The Washington State LTCOP has served under federal and state law since 1972 as an advocate and provider of direct referral and assistance to residents in long-term care facilities: nursing homes, assisted living facilities, and AFHs. Initially the LTCOP was housed within DSHS, but in 1989, in order to provide the LTCOP greater independence, the Washington State Legislature

removed the program from DSHS and located it in a private, non-profit organization. The role of the LTCOP is to assist residents and advocate for improved quality of life and care. This is done through providing information to residents (and their families) about their civil and human rights, problem solving at the facility level, assisting with care planning, providing referrals to benefit programs, acting as representation at FHs, monitoring the enforcement of the laws by DSHS, and advocating for overall improvements in the long-term care system. The authority of the LTCOP is set forth in [RCW 43.190](#) and [WAC 365-18](#).

The state-wide LTCOP consists of a network of 13 regions, approximately 25 staff ombudsmen and over 400 trained and certified volunteer ombudsmen. The ombudsmen try to visit facilities every few weeks to build relationships with residents, provide information and assistance, and investigate complaints. The LTCOP is not an arm of DSHS and does not have regulatory or enforcement authority. The ombudsmen try to resolve issues before they become big. In 2011, the LTCOP received 5,538 complaints and over 90% were resolved at the facility level without referring the complaint to DSHS or other government agencies. When referrals are made to DSHS, the ombudsmen work closely with the DSHS inspectors/investigators. Complaints are received from residents of facilities, family members and friends, guardians, facility staff, DSHS case managers and others connected to the residents. In 2011, LTCO volunteers contributed 54,000 hours of service statewide, which included 9,120 visits to AFHs, with 77% of AFHs routinely visited by a volunteer or staff ombudsmen. The most frequent complaints received by the LTCOP about AFHs are civil and human rights concerns and problems with care, admission, transfer, and discharge.

3.0 ISSUES FOR PANEL REVIEW AND DISCUSSION

HB 1277 gave the Panel the broad charge to review problems in the quality of care in AFHs and suggest ways to reduce abuse and neglect, and the more specific direction to examine DSHS oversight and enforcement, including the handling of minor violations and the oversight of new AFH owners. The State LTCO was directed to chair the Panel and select its members. The LTCO, with DSHS, selected a broad membership representing all the different AFH stakeholder groups (e.g. consumers, consumer advocacy groups, DSHS, AFH providers and provider associations). The members were representatives of their organizations and were selected because they were well-informed, often with decades of experience in their field. They were instructed to bring discussion points back to their organizations for input and feedback to the Panel.

The five meetings of the Panel were broad ranging in their discussions, and not always in agreement, but drew upon the accrued knowledge of the Panel members and their organizations. The Panel also requested and received aggregate data from DSHS concerning AFHs, such as the number of AFHs, the number with “specialty” designations, the most frequent citation categories, and the like. DSHS also shared with the Panel its Investigation Protocols, Enforcement Guidelines, and similar documents. Past quality improvements initiatives by DSHS of its complaint investigation system were not provided to the Panel, but are listed in Appendix C.

To supplement the work of the Panel, the LTCOP conducted an in-depth review of a random sample of DSHS enforcement files. A midpoint summary of these reviews was provided to the Panel, with redacted copies of representative case summaries and reviews later provided to the Panel.

From a combination of the above input and discussions, the Panel organized its observations into several topic areas. These are not based upon a rigorous study, but upon the pooled knowledge of an experienced and diverse group of stakeholders working in this field. In answer to the HB 1277 charge, the Panel determined that the quality of care in AFHs would be improved, and the incidence of abuse and neglect would decline, if the following three areas were addressed:

- The quality of some caregivers and AFH owners were improved through better training and mentoring;
- Residents and their families were better informed and residents better matched with the right AFH; and
- DSHS oversight was more vigorous and prompt in providing enforcement action against poorly performing AFHs and their owners.

The discussion areas below set forth these points in greater detail. Not every member of the Panel agreed with each of the statements below, which is understandable given the diversity of experiences. These descriptions are a summary of what may be a multi-faceted issue, but, for the sake of brevity in a report, must be summarized. Some members of the Panel expressed the need for more data to support the system-wide generalizations made below. The majority of the Panel, however, believes that the following statements accurately reflect the current issues, and agree with the Recommendations set forth in Section 4.0.

3.1 Panel Discussion Areas

Training

- Specialty training does not result in an expert level of “specialization” of service, contrary to what the public may assume is implied by the term “specialty.” Historically, specialty training has covered three areas: dementia, mental health, and developmental disabilities. Specialty training of AFH caregivers hired before January 2012—still the majority of staff in AFHs—has been done by the AFH owner, did not use standardized materials, and had included no competency testing. Specialty training for AFH caregivers hired since January 2012 and Initiative 1163 requires testing, but the course material and requirements remain inadequate. The DSHS-created dementia training for caregivers is 6 hours long. The DSHS-created mental health training for caregivers is 4 hours long. Neither course contains practical components that may allow the worker to integrate coursework into “real life” situations. The DSHS case reviews section below contain examples of “dementia specialty” AFHs with serious problems in their dementia care, particularly for wandering residents. The developmental disabilities training for AFH caregivers is 18 hours long, which is more complete, but still does not create true specialization without demonstrated continuing competency opportunities.
- Because AFHs serve such a diverse resident population with unique care needs, new areas of specialty training are needed, in particular for residents with traumatic brain injuries, which may include many returning veterans.
- A higher license level or designation is needed for AFHs serving residents with skilled nursing needs, when nurse delegation and nurse consultation are not adequate to meet the nursing needs of the residents. These AFHs are similar to small nursing homes and should have additional educational and staffing requirements to ensure that they can meet the residents’ needs.
- The 48-hour AFH owner training done in the past did not adequately prepare some of its graduates to operate an AFH, mostly due to lack of appropriate trainer selection, course review, and program monitoring. A recently revised 48-hour course², required for new AFH owners, has been substantially improved with standardized curricula, student homework/projects, enhanced trainer selection and monitoring processes, and final exam to demonstrate successful completion. The new 48 hour training is not widely available across the state; DSHS is working with community colleges to enhance availability.
- Some AFH owners do not know how to effectively use nurse delegation or a qualified consultant to better serve their residents, including, for example, for the development of safe medication practices or when to assess a resident’s changing needs. These resources are therefore underutilized. The DSHS case reviews contained examples of this problem. The high citation rate by DSHS for errors in medication systems, record keeping, and storage is an illustration of the need for greater use of a consultant in the AFH settings. For residents needing nursing care or nurse oversight, this would improve resident outcomes.

² More formally known as “The 48 Hour Residential Care Administrator Training”

- Historically, there has been little collaboration between DSHS and the AFH owner associations about quality assurance measures. For example, there has been little discussion about the Department's aggregate citation data and potential related training topics or other preventative quality assurance measures. Starting in September 2012, meetings on such topics have begun between WSRCC and DSHS. These should continue in order to raise the overall quality of care in AFHs.

Newly licensed AFHs

- The closure rate for new AFHs, during the first three years, is 27%. It is 36 % for homes that have operated for three to six years. This high closure rate can be harmful to residents, who may experience poor care in the home or transfer trauma when forced to move. These closure rates indicate that many owners entering the industry may underestimate the skills needed to care for residents and operate an AFH, or miscalculate the market saturation for their area, or have "burned out" after a relatively brief period.
- There is a need for more mentoring of new or relatively new AFH owners. This could occur in a variety of ways, including direct mentorship from experienced, successful owners and indirect mentorship from the AFH associations' trainings.
- Orientation for potential AFH owners is not widely available, nor is it offered often enough. The Panel supports DSHS's current work with WSRCC in joint planning to ensure geographically accessible orientation classes. The orientation should also frankly discuss the need to examine market saturation in the urban areas before opening an AFH.
- Overall the initial licensing process lacks clarity and step-by-step processes, which would increase the likelihood that new AFH owners are better prepared to open and successfully operate an AFH. The Panel recognizes and supports DSHS's efforts in offering "early visits" by staff to new owners; these visits are designed to offer technical support early in the home's licensure.

Resident Placement/Admission

- There is no standardized form for AFH owners to disclose the types of clients they serve or the level of care they offer. This minimizes the consumer's ability to compare care and service levels at different AFHs and amongst different licensed care settings, such as assisted living facilities. Families and residents (if feasible) should visit an AFH before making an admission decision, however, this is often a stressful time for most families and residents and they are often not aware about what an AFH can or should provide. The lack of a standardized disclosure form can contribute to inappropriate placements and subsequent moves, which are costly and hard on the residents. Assisted living facilities, by contrast, have successfully used a standardized disclosure form for nearly a decade.
- Consumers and others seeking admission for residents oftentimes experience difficulty in identifying homes that truly specialize in specific populations and/or services. Approximately 80% or more of the state's AFHs have a specialty designation of dementia or mental health or both, as the standards to obtain the specialty designation are low, making it difficult to actually compare the homes.

- The state's CARE assessment for Medicaid residents, who comprise 45 % of AFH residents, is done before admission to a home or facility. Although the prudent practice would be to do so, there is no requirement that the AFH owners must meet with their prospective residents, or participate in a brief assessment prior to admission of the residents. This contributes to some inappropriate and unsafe admissions.
- Different licensing levels or designations for AFHs, based upon the education, experience, and training of the AFH owner and caregivers would be helpful to more appropriate and safe placement of residents in a home that could meet their needs.

Licensing and Complaint Investigations

- The AFH regulations are numerous and include many topic areas in addition to those related to outside of resident care, service, and safety. They are not indexed for easy reference, which may contribute to a lack of understanding and, subsequently, unwitting violations by AFHs. Most residents, families, and staff have little familiarity with the rules applicable to AFHs.
- Residents, families, and staff are not always aware of their rights against retaliation from AFH owners and care providers. This can lead to fear and lessen cooperation with DSHS and LTCOP investigations.
- When a multi-facility owner is cited by DSHS for serious noncompliance in one home, DSHS does not always inspect the owner's other AFHs to see if they have the same or similar deficiencies. This is now required by HB 1277 and should be done more consistently in order to better protect residents. In the case reviews by the LTCOP of multi-facility owners, when such inspections were done, often the more serious violations were found in the other homes.
- Minor or "de minimus" violations are sometimes cited when instead they could be handled through a consultation. This is particularly frustrating for AFH owners when a prior inspector did not consider the issue to be a violation. Citations for "de minimus" matters take on an exaggerated importance because they appear to be an abuse of power by the licenser. On the other hand, some owners lack an understanding of the importance of certain system development and implementation rules and incorrectly consider such violations of these rules to be de minimus.
- It appears that most DSHS complaint investigations of AFH facility practices are initiated in a timely manner, consistent with the priority levels of two days, ten days, 45 days, and next on-site visit. Some investigations, however, take more than a month to complete, and there can be an additional month or more from investigation to enforcement action, if enforcement actions are imposed. This may be an indication that DSHS oversight resources have not kept pace with the increase in complaints filed each year.
- The recent shift by DSHS to writing short Complaint Investigation Summary Reports for unsubstantiated allegations has resulted in less information being available to the public, residents, and the owners about these investigations, including whether the investigations were thorough. This has led to frustration and an apparent lack of transparency, whether intended by DSHS or not.

Enforcement

- The view of DSHS enforcement varied greatly on the Panel, depending on personal experience and/or the review of multiple cases. Some felt that collaboration and consultation should precede punitive enforcement actions. Others agreed but felt that enforcement actions were used for too long, or repeatedly, as a training tool for unqualified owners at the expense of residents' well-being, leading to resident neglect.
- DSHS attempts to be strategic, proportional, and progressive in its approach to enforcement. Some Panel members felt that there was too often a lack of connection between enforcement actions and improved resident care, particularly with the frequent usage by DSHS of stop placements without also imposing other conditions on the AFH owner to encourage prompt correction. When the enforcement remedies are inadequately or too slowly used, there is the potential for resident neglect. The DSHS case reviews in Section 3.2 below show sufficient examples of inadequate enforcement to warrant further changes in the state's oversight system.
- Some AFH owners do not understand the difference between IDRs and Administrative FHs. These are, respectively, informal and formal ways to appeal DSHS citations and penalties. As a result, some AFHs feel they are not given due process. Greater education in this area will lessen resentments from AFH owners toward DSHS.
- The FH appeals process appears to take too much time, particularly for license revocations, where it may be extended for six months or longer. The residents can choose to remain in a home while the AFH awaits the administrative hearing/appeal. This raises the public policy and resource concern about the extent that DSHS can monitor the well-being of residents for a prolonged period of time in a home where care has been poor enough that DSHS believes it should be closed.

Transparency & Consumer Orientation

- While the regulations state that certain required information, such as the state's complaint hotline number and most recent DSHS inspection, must be posted in the AFH, the actual location of these documents is inconsistent among homes. For example, some AFHs clearly display this information, while it is inconspicuous in other homes or requires asking the AFH staff or owner. This minimizes a consumer's ability to access and review necessary items when touring the home and/or reviewing compliance history.
- The DSHS/ADSA website is not consumer-friendly; there are multiple steps one must take in order to reach the AFH page, and there are no links on the website for residents and their families, specifically, to access the information they need. While the Panel supports DSHS's efforts to place enforcement letters online for public review, not all inspection results and associated letters are included on the site, as well as other information that would be helpful to residents and their families. Some Panel members voiced the desire to have favorable inspection reports posted on the website, in addition to negative ones.

3.2 DSHS Enforcement Cases File Review

Background and Review Process

One of the charges to the Panel in HB 1277 was that it "consider inspection, investigation, public complaint, and enforcement issues that relate to AFH." DSHS is responsible for enforcement, and the LTCO has access to the complete, unredacted DSHS files. It was decided the LTCOP would look at a random sample of DSHS licensing and complaint investigation files

and pare them down to a smaller set for review by the Panel. The review covered the period of July 2011 through June 2012. DSHS had adopted new rules in January 2012 to implement HB 1277, so this review examined *pre* and *post* HB 1277 case files. Reviewers noted that in 2012, stiffer penalties were administered by DSHS and attributed this change to the implementation of HB 1277.

A random statewide sample of 90 *pre*-HB 1277 AFH files and 60 *post* HB 1277 AFH files were examined. The samples covered four categories: (1) complaint investigations with an enforcement action by DSHS (i.e., a remedy or penalty imposed); (2) full licensing inspections; (3) complaint investigations with a citation but no enforcement action; and (4) complaint investigations involving multi-home owners with enforcement actions against two or more homes. Further details about the sampling technique are found in Appendix F.

In addition, the LTCOP asked AFH provider associations to identify examples where DSHS had issued citations for minor or “*de minimus*” violations. There had been some testimony before the 2011 Legislature that minor violations were being cited that should not be. HB 1277 directed the Panel to examine this issue. The AFH associations provided 15 examples, and nine case files were available for review, bringing the total cases reviewed by the LTCOP to 160.

The Panel believes that many AFHs—probably the great majority—provides good to excellent care for residents in a close, family like setting. Data from DSHS indicate that many AFHs have few citations in their licensing inspections. Excellent and appropriate care can be received in AFHs, and they are the preferred alternative for many residents rather than living in to the larger setting of an assisted living facility or nursing home for many residents. This sample of state oversight files looked almost exclusively at the AFHs where complaints were filed with DSHS and violations substantiated. Thus, this case review is skewed toward homes with problems. That is, however, appropriate when looking at a state oversight system, because problems can arise in a facility or home and it is important to know how the state responds to those problems.

The DSHS files were reviewed by a team of ombudsmen, overseen by the State LTCOP and the LTCOP attorney. The same reviewers participated in all case reviews. For the in-depth reviews, the LTCOP asked for the complete, unredacted file for the specified period. Based upon the information in the files, the cases were then distilled into one to four or more page case summaries. From the 160 files, about 50 representative cases were selected based upon the completeness of the file and geographic diversity. These were shared with a subcommittee of the Panel, with the opportunity for questions and comments. This is not a “gold standard” study. The parameters for the review, however, were agreed upon and provided an opportunity to review, in-depth, the DSHS regulatory enforcement activities for AFHs.

DSHS shared with the Panel its enforcement grid for AFH remedies, attached in Appendix D. In addition, when reviewing the cases, the ombudsmen were told to consider three questions that DSHS applies to its enforcement decisions:

1. Is the enforcement proportional to the level of harm or threat of harm?
2. Is the enforcement strategic, i.e., will it help prevent repeats violations and ensure compliance?
3. Is the enforcement progressive, i.e., does it take into account repeat violations?

AFH Case Examples from DSHS Enforcement Files

The cases described below illustrate both poor enforcement and good enforcement by DSHS. The cases also illustrate problems caused by AFH owners and/or caregivers, particularly related to dementia care and responding to residents wandering out of the home. The review also examined the claim that DSHS cites AFHs for minor technical problems, and found that this rarely occurred in the sample of reports reviewed.

For the sake of brevity, only 14 case examples are included in the body of this report. Another 6 cases are contained in Appendix F. The 20 cases listed in this report were drawn from the 50 cases reviewed by the LTCOP and Panel subgroup. They were also shared with DSHS with an identification key for the homes, and DSHS was given over a month to provide clarifications and corrections. A larger sample of the DSHS enforcement files would undoubtedly contain more examples, both good and bad. Finally, again for the sake of brevity, few of the case reviews concerning multi-home owners with violations are included here. As a rule, those cases contained such a complex and extended story that they could not be summarized in less than a page each. The same problems are illustrated more briefly in the following cases.

1. *Insufficient or Ineffective Penalties*

- **AFH #805, Snohomish County.** On 3/26/2012, an elderly resident was sent unaccompanied in a cab to the emergency room. According to the ER admission notes, the resident was gray, barely breathing, in a semi-conscious state, heart rate in the 120s, oxygen levels very low, and had pneumonia and sepsis. She had a note pinned on her and written by the AFH owner that said the resident was, *“very weak today— wheezing please check her out, fell [sic] free to give us a call if you need any further info.”*

The resident never returned to the AFH. She was admitted to the critical care unit and died seven days later from severe pneumonia, sepsis, COPD, and respiratory failure. DSHS issued a fine of \$1,000 to the AFH for not calling 911. No other citation or sanction was imposed. The investigation was narrow. There was no evidence in the file of DSHS investigating how this resident ended up in this dire state of health, nor of the investigator reviewing the resident’s records at the AFH. The investigation shows that the ER admitting nurse, however, had said, “she didn’t get this way overnight.” There was no documented investigation as to whether the resident was on hospice, or had a nurse delegator, and whether they or her doctor were notified when her health began to decline. No investigation was evident as to whether the AFH had given this resident appropriate care. No citation or penalty was issued for violating the resident’s right to be treated with dignity and not be neglected or abandoned.

- AFH #510, Snohomish County.** This home has been in stop placement for over a year. In 2/2011, the owner was cited for failing to provide care and services and to prevent neglect regarding one resident's constant eloping. A stop placement was imposed and the facility directed to discharge the resident. For the next year, DSHS received reports from neighbors, the police, and 911 about other residents who were not being supervised. No further citations or sanctions were imposed. DSHS conducted monthly monitoring and corrective action planning. In 1/2012, DSHS did a thorough investigation, which revealed: Resident #1 was wandering often along the highway, required care that was not provided, and had been taken to the hospital by the police. Resident #2 had a traumatic brain injury and also wandered out of the home. Resident #3 had a mental illness and a long history of elopements since 2010. None of their care plans included interventions for wandering. Caregiver #1, who had been employed for over two years, did not understand English well enough to comprehend the residents' assessments, care plans, or medication orders. The DSHS enforcement remedy was to continue the stop placement of 2/2011, and impose a condition on the AFH's license that a second caregiver be present when caregiver #1 was there. DSHS did not impose a civil fine, or require more staff training, or require a nurse consultation to improve the residents' care plans. DSHS also did not require a second caregiver be there at all times even though three of the home's four residents eloped frequently.
- AFH #512, Pierce County.** This is a case about the heavy reliance by DSHS on stop placements, rather than a stop placement in combination with other remedies. The case involved a new AFH that had three residents. DSHS visited the facility on a "quality assurance" visit, saw significant problems, and issued a Stop Placement Pending Investigation. On 3/8/2012, DSHS continued the stop placement and issued a SOD with ten citations, including: no written assessments or care plans for three of three residents; problems with the medication log, medication organizer, and medication administration; and no personnel records or background checks of personnel. No other remedy was imposed, such as a requirement to hire a consultant to help with the medications system or residents' care plans.

On 3/30/2012, the stop placement was lifted on the basis that the deficiencies had been corrected or sufficiently improved. Two months later DSHS again found a number of violations, most of them repeat deficiencies, such as: no resident assessments or care plans, and problems with the medication log, medication organizer, and medication administration. It is difficult to understand how the inspector had concluded that the earlier deficiencies were corrected, since some of them—not having three of three residents' assessments and care plans—were the same ones found two months later. It is unlikely that all three residents had died/moved and the home had admitted three new residents.

The standard letter sent by DSHS when lifting stop placements says that the deficiencies had been corrected "or sufficiently improved." However, RCW 70.128.160(3) requires that a stop placement not be lifted until the "violations necessitating the stop placement have been corrected" and "the provider exhibits the capacity to maintain correction of the violations previously found deficient." "Sufficiently improved" is not the standard. When a home is new, without a track record, it particularly does not make sense to prematurely lift a stop placement.

This home continued to receive citations and stop placements in 6/2012 and 8/2012 for medication errors, improper care plans, and failure to prevent dehydration and pressure sores. DSHS finally added a condition on license effective 9/14/2012 that the AFH hire a nurse consultant. It would have been appropriate, and would have better protected residents, for DSHS to require sooner than 9/2012 that the provider obtain more training and/or hire a consultant.

2. DSHS Failing to Issue Citations for Clear Violations

- **AFH #117, Grant County.** This home had several examples of clear violations not being cited. One is described here. On 4/10/2011, the AFH owner “dumped” an elderly, ill resident at the emergency room. The resident had underlying diagnoses of depression, anxiety, left side paralysis from a stroke, urinary tract infection, and pain. Upon arrival to the ER, she was vomiting, disoriented to time and place, and covered in dried feces. The owner left, but knew the resident was expected to return to the AFH. The hospital treated and cleaned the resident. That night, she was then taken in an ambulance back to the AFH. The ambulance called the owner, who didn’t answer his phone. Concerned, the ambulance contacted the Sheriff to assist with readmitting the resident. It was nighttime. The ambulance went to the AFH, and the Sheriff knocked and rang the doorbell. He could see lights going on and off within the AFH, but no one came to the door. The resident was returned to the hospital. The next day the provider claimed that he was asleep and didn’t hear his phone, door knocks at his door, or doorbell. DSHS concluded that the provider had a “failed practice” of not answering the door, but no citation was written or sanction imposed.
- **AFH #802, Snohomish County.** In 11/2011, a guardian filed a complaint that the resident was not getting sufficient food. He’d lost 11 pounds in ten weeks, and a dietician had informed the guardian the resident was at risk of malnutrition. The DSHS investigator stopped by the home and saw the resident eating a “healthy meal” and concluded that there was no deficiency. There is no evidence in the file of the investigator contacting the dietician or reviewing the resident’s file. Because this was an “unsubstantiated” complaint, the only report available to the public is an ISR, which contains just a few sentences describing the allegations and the investigator’s actions, rendering it impossible for the public to determine the thoroughness of the investigation or the reasons for its conclusions.

3. *Inadequate Staff Training*

- AFH #504, Franklin County.** This case involved a resident with dementia who had 18 falls over a year. She was legally blind, hard of hearing, and had arthritis. Her care plan said the AFH was to use her wheelchair when taking her to the toilet. In 4/2012, the complaint investigation found that while two of the AFH caregivers were outside bringing in the groceries, the resident “insisted” on ambulating to the bathroom without assistance. The resident’s wheelchair was not in her room because it was being used by the caregivers to transport the groceries from the car. The AFH manager told the resident to sit down, and then came to assist her. She “nudged” the resident forward too forcefully, causing the resident to fall and break her hip. The resident died six days later. The caregiver witness testified that the AFH manager then lied to the resident’s son about the severity of the fall and told the caregiver witness to “keep quiet.” DSHS conducted a thorough investigation and imposed a \$3,000 fine for neglect. What’s troubling, however, is the lack of basic and dementia care related knowledge by the AFH manager and staff—which caused them to leave the resident without her wheelchair and, then, to escort her too roughly. It is also troubling that the AFH manager was not cited for her apparent cover up and threats of retaliation against the caregiver.
- AFH #124, Pierce County.** This “dementia specialty” designated AFH had a long history of leaving its residents unsupervised, apparently when the provider was running errands. The DSHS file contains complaints by neighbors, fire department staff, and police about residents wandering out of the AFH unescorted. Eventually this led to SODs on 7/12/2011 and 9/7/2011 for leaving the residents unattended, resident elopement, and putting residents at risk for harm. DSHS imposed fines and stop placements, but did not require the AFH to obtain more dementia training or have a second caregiver on site when the provider was running errands. In 10/2011, the DSHS field manager asked her compliance specialist: “Fines not enough. What can we do?”

On 11/16/2011, a neighbor was awakened at night by a female resident who had left the facility and was knocking on her door. She was clearly distressed and said she needed help because she was bleeding. 911 was called and the resident was taken to the ER, where it was discovered she was hemorrhaging from the recent removal of an in-dwelling catheter. The neighbor stated that he went over to the AFH and tried to contact the provider, by knocking on the homes’ doors. No one answered but he saw another elderly resident looking out one of the windows. He said there were no cars at the home and, it appeared, no staff present, and that he had reported this situation to the state before. The owner later claimed that he was asleep and hadn’t heard the resident or the neighbor.

DSHS imposed a \$3,000 fine regarding the resident who was hemorrhaging and \$500 x three for putting the other residents at risk by leaving them alone at night. On 11/30/2011, DSHS imposed a condition on license that another caregiver be present if the staff was gone on errands. Imposing this condition would have been appropriate months earlier, after the SODs on 7/12/2011 and 9/7/2011.

4. *Effective DSHS Investigation and/or Enforcement Case Examples*

- **AFH #513, Pierce County.** This is an example of a prompt investigation, appropriate remedy, and good resolution. This was a new AFH visited by DSHS for quality assurance. The home had four residents and the caregiver also cared for her two and a half year old child. Two of the residents had bedrails without safety assessments, the residents' care plans were inadequate, and it did not appear likely that the caregiver could evacuate the residents safely. The investigation was done on 2/10/2012 and 2/15/2012, and a Stop Placement Pending Investigation and Conditions on License (specifically to have two awake staff/pm members at night) was issued 2/10/2012. The SOD was completed on 2/27/2012. DSHS did a site visit on 3/5/2012 and found the deficiencies remained. DSHS visited again on 4/3/2012 and found the deficiencies corrected. In addition, the home was down to three residents, which the inspector felt could be safely managed by one caregiver. In other words, there was a concrete basis for the inspector concluding that the AFH could "maintain correction." The stop placement and condition on license were therefore lifted.
- **AFH #106, Clark County.** In this case, DSHS initially did not impose an adequate penalty, given the number of violations, but then increased the sanction to obtain compliance from the owner. On 10/3/2011 during a full yearly inspection, DSHS determined that the AFH needed awake staff at night due to the night time care needs (frequent toileting) of one of its residents. DSHS imposed a condition on license for the AFH to provide an awake staff at night. A few days later, DSHS received a complaint that the owner was verbally abusive to the resident, probably from feeling overwhelmed by the resident's night time care needs. DSHS investigated and issued a SOD on 10/27/2011, citing 12 deficiencies, including verbal dignity, emergency lighting and evacuation procedures, and CPR training. Importantly, DSHS also cited the AFH for non-compliance with the earlier condition to have awake staff at night. DSHS issued only a \$100 fine. By 11/17/2011, the owner had not complied with the awake staff condition. He said he'd hired a relative to help, but could not verify any documentation on this individual. DSHS then applied a higher and more appropriate fine of \$100/day x 20 days for the period from 10/27/2011 to 11/17/2011. The owner then complied. DSHS verified continued compliance with a site visit on 12/28/2011.
- **AFH #101, King County.** This AFH had been open for one and a half years and for most of the time was in foreclosure crisis. The home's atmosphere was tense and uncertain. The owner told the residents "if it sells, we just be gone from here." The owner worked several jobs and often left the home to unqualified caregivers with no background checks. DSHS received the complaint about this AFH on 8/24/2011 and started its investigation almost immediately. One resident who had quadriplegia told the investigator that the night caregivers refused to do toileting or hygiene care so he was left to lie in his own feces at night. Also, his call light was broken. If he called out for help, he was chastised by the caregivers. The owner would yell at the residents and then deny it. All of the residents were afraid to complain for fear of retaliation. The DSHS investigation was quick and thorough. The investigator interviewed each resident, their families, staff, the provider, the LTCO, and the foreclosure company. DSHS issued a summary suspension and revocation, and closed the AFH on 9/8/2011.

- **AFH #420 and AFH #421, Skagit County.** DSHS received several complaints in 8/2011 alleging resident to resident sexual abuse in AFH #420. DSHS immediately began an investigation of the home, and then initiated a concurrent investigation of the owner's other facility, AFH #421, because the residents moved freely between the two homes on a daily basis. DSHS issued a stop placement and SOD on both homes on 8/17/2011, five days after starting its investigation. The homes were cited for lacking the ability to provide care and services, and failing to prevent sexual abuse. A Summary Suspension/License Revocation was issued against both homes six days later. The owner requested an IDR, which resulted in no change to the citations or penalties. The owner also requested on 8/30/2011 a fair hearing to contest DSHS's actions. The FH was scheduled for 10/2012, more than a year later. It is not clear from the file whether the delay in the hearing date is because of attorney-requested continuances or an insufficient availability of judges for the FH. In summary though, DSHS acted promptly and appropriately given the severity of the events and the intermingling of the two homes.

5. *DSHS Rarely Cites AFHs for "de minimus" Violations*

- **AFH #907, King County.** In 12/2011 this owner was cited for eight deficiencies and appealed seven. At the IDR, five citations were upheld: safety issues of water temperatures being too high and not storing toxic cleaning products properly; not having an emergency water supply; leaving laundry water in the bathroom for toilet flushing in unmarked buckets, accessible to residents; cluttered, unclean common areas; and not having policies to prevent abuse and neglect. Two of the citations were converted, at the IDR, to a consultation: placement of the residents' rights poster; and holding fire drills. No penalty was imposed in the case. The owner objected to being cited for these violations, thinking they were minor ones, when in fact they were not minor.
- **AFH #902, Benton County.** In 8/2011 this owner was cited for the third time for not having five of five residents' medications organizers labeled and filled according to the medical log and doctor's orders. Because this was a repeat citation, the AFH was fined \$100 x five residents. The AFH did not appeal, but has identified this as a case where no citations or penalty should have been imposed, despite them being repeats.
- **AFH #901, Clark County.** This is the "pile of leaves" case that was raised several times before the 2011 Legislature. The owner has operated this AFH for about 15 years. In 11/2010 he was cited for three deficiencies: leaves and debris on a path outside his AFH; the residents' rights poster was too high (six feet); and the water temperature was too hot. No penalty was imposed. The owner appealed all three citations. The owner said that the pile of leaves was on a side path not accessed by the residents, who do not exit the home without assistance. He further said that he usually parked his truck in front of that side path but on that day it was parked at another spot on the driveway. At the IDR, the citation for the "pile of leaves" was dismissed. Regarding the residents' rights poster, the owner said it had been in that location for years and he'd not been cited by previous inspectors. He'd asked for direction during the inspection about the appropriate location. At the IDR this citation was converted to a consultation. Regarding the water temperature, the owner noted that while the inspector was still there he corrected the problem by draining and re-filling the water tank. At the IDR this citation was also converted to a consultation. This case was one of the very few reviewed where it appears that citations were given for "de minimus" violations that either should have been handled by an informal consultation or not cited if they were corrected on the spot and were not repeat violations.

4.0 RECOMMENDATIONS

Based on the issue discussion areas and the DSHS case reviews, the Panel recommends the following 13 actions, separated into three categories:

- Those requiring legislative and/or statutory changes,
- Those requiring DSHS to make regulatory changes, and
- Those requiring DSHS to take internal administrative actions.

4.1 Legislative Changes

Recommendation #1: RCW 70.128.060 should be amended to create additional categories of AFH designation and/or certification to better identify AFHs trained to serve specific populations, including residents with traumatic brain injury or ongoing skilled nursing needs.

Currently there are three “specialties” that AFH may designate based on training. Because there are many more specialties to which AFHs cater, additional specialties must be identified with enhanced educational and other requirements for the designations of such specialties. These clearly identified designations could assist consumers and other agencies in better identifying appropriate placement locations for clients with specific care needs.

Recommendation #2: AFH owners should be required to issue a standardized disclosure form on care capacities/capabilities for consumers, as has been required of assisted living facilities in Washington since 2004 by [RCW 18.20.300](#).

The purpose of a standardized disclosure form is to facilitate the comparison of homes and appropriate matching of homes and residents. Prior to admission, the disclosure should be given to the resident or the resident’s representative, and to interested consumers upon request. It should disclose the scope of care and services offered or available at the AFH, using a form developed by the DSHS in conjunction with stakeholders. It can also include any supplemental information that may be provided by the home. The form that the department develops should be standardized, reasonable in length, and easy to read. The form should address such topics such as levels of assistance with personal care and activities of daily living, availability of nursing support, and whether and how the home serves residents with special needs.

Recommendation #3: [RCW 70.128.160](#) should be amended to provide that when DSHS finds deficiencies that are repeated, uncorrected, pervasive, or present a threat to the health, safety, or welfare of one or more residents, the Department should not impose repeated stop placements without also imposing a condition on license or other remedy to facilitate or spur more prompt compliance.

A few examples supporting this recommendation are: (1) successful completion (with competency testing) of a dementia or other specialty class, not taught by the home’s owner or manager, should be imposed when the owner and/or caregivers demonstrate a lack of understanding and/or inadequate care for that specialty population; and (2) requiring the home to hire a consultant should be imposed on homes that demonstrate,

for example, an inability to appropriately develop care plans or establish and follow a safe medication management system.

Recommendation #4: [RCW 70.128](#) should be amended to provide the same approach to certain minor, non-repeat violations by an AFH that it has used for years with assisted living facilities under [RCW 18.20.400](#), allowing for the AFH to immediately correct the problem without being cited.

[RCW 70.128](#) should be amended to provide that if during an inspection, reinspection, or complaint investigation, an AFH corrects a violation found by DSHS, the Department shall record and consider such violation for purposes of the home's compliance history, however the violation shall not be cited if the violation:

- Is corrected to the satisfaction of the Department prior to the exit conference;
- Did not pose a significant risk of harm or actual harm to a resident, and
- Is not a recurring violation, meaning that it was not previously found by the Department under the same rule or statute in one of the two most recent preceding inspections, reinspections, or complaint investigations.

This approach focuses the Department staff on important violations and encourages the AFH to stay in compliance and not repeat "minor" violations.

4.2 Regulatory Changes

Recommendation #5: DSHS should expand, standardize, and improve instruction of specialty trainings (i.e. mental health, developmental disability, dementia, etc.) and add additional specialty trainings not addressed by Initiative 1163.

Specialty training courses on dementia, mental health, and developmental disabilities must be re-designed to expand on content and current best practice. Initiative 1163 expanded basic training but did not revise the requirements for specialty training. The specialty courses must be standardized in both curricula and instruction techniques, and be accompanied by tools used to effectively and fairly evaluate successful student completion. The course design and development must include participation by experts in the given specialty, as well as providers and consumers. As is in current regulation, AFHs with poor compliance history should not be the specialty trainers of their staff.

Recommendation #6: DSHS should improve the resident admission process to require that the AFH provider or manager should personally meet the prospective resident, review the resident's assessment, and develop a preliminary care plan with the case manager prior to admitting the resident into the AFH.

Medicaid rules require that the assessment of Medicaid clients be independent so that the assessment is not influenced by service providers. However, if the potential AFH owner or manager is unfamiliar with the resident's needs, admission of the resident into that AFH can lead to a mismatch, inadequate care, and possibly a move with transfer trauma. The current Medicaid admission process is lacking in the inclusion of the potential AFH owner/manager. In addition, the resident and their family member or guardian also needs to be included in the process, as their input is very important to the proper selection of a home or facility.

Recommendation #7: DSHS should clarify the law concerning the inspection of the homes of multiple facility owners when serious or repeat deficiencies are found in one of their AFHs

[RCW 70.128.065](#) requires DSHS to inspect the other AFHs operated by a multi-facility owner when a serious or repeat deficiency is found in one home. DSHS needs to adopt a regulation defining what constitutes a serious deficiency.

4.3 Administrative Changes

Recommendation #8: DSHS should more frequently require, as a condition on the AFH license, the completion of the revised 48-hour AFH owner training when the owner demonstrates poor performance specific to the business operations of the AFH.

The Panel supports the DSHS standardization of the improved 48-hour Residential Care Administrator Training Program, which now includes a standardized curriculum, teaching standards, and community college-based coursework.

Recommendation #9: DSHS should more closely comply with the stop placement provisions of [RCW 70.128.160](#).

When deciding to lift a stop placement, [RCW 70.128.160](#) requires that the AFH has corrected the deficiencies necessitating the stop placement and exhibited the capacity to maintain correction of the violations. The current letter sent by DSHS to owners when lifting a stop placement does not meet these criteria and should be revised. [RCW 70.128.160](#) further requires DSHS to make an on-site visit to ensure correction of violations that are serious, recurring or uncorrected, and created an actual or threatened harm to residents. The current DSHS enforcement files sometimes do not contain proof of such on-site visits. In order to better protect residents, DSHS should revise its enforcement procedures to ensure such visits, or if such visits have occurred but were not documented, should immediately start documenting them.

Recommendation #10: DSHS should work with consumers and the LTCOP to create a transparent and consumer friendly website for the family members and residents of AFH and other licensed long-term care facilities in Washington.

The website should be easy to navigate and have a “Consumer/Residents” page with links to important, useful information. Elements of the information included should be:

- Explanation of the types of licensed LTC facilities, including AFHs, and the levels of care they can provide and the different specialty designations;
- Lists of suggested questions for a consumer to ask when looking for an AFH or other care facility;
- Warning signs of abuse or neglect;
- Contact information for DSHS and the LTCOP for further information and/or how to file a complaint; and
- Lists of all licensed AFHs in the state by county, and corresponding links for assisted living facilities and nursing homes, providing contact information for the home/facility, the identity of the licensee, any specialty designations held by the home/facility, whether it accepts Medicaid, and links to such information as:

- The inspection and investigation reports by DSHS for the prior two years; and
- Enforcement letters/actions by DSHS for the prior two years, including modifications or dismissals of the actions, if any.

Recommendation #11: DSHS should work with the Office of Administrative Hearings to determine the extent of delays in holding FH, particularly for facilities who have received a license revocation, work to ensure timely hearings and monitor residents' well-being during such delays, and request additional resources if necessary.

Residents who remain for months in a home pending a fair hearing or appeal (particularly with a revocation action) may be placed at ongoing risk of harm. DSHS must monitor the care and safety of residents during this period. Without sacrificing due process, DSHS should work with the Office of Administrative Hearings and the Board of Appeals to determine the extent of the problem, and investigate ways to lessen delays in the current FH/appeals system.

Recommendation #12: DSHS should revise the standard informational poster required to be posted in all facilities to include specific language prohibiting retaliation. DSHS should also provide clarification to facilities on where this poster and the facility's most recent licensing inspections and complaint investigations need to be posted so that they are publicly accessible.

The revised poster should more directly inform residents, family members, and staff of their right to be free from retaliation for cooperating with DSHS or the LTCOP. DSHS should also develop with the LTCOP a written handout it can provide as needed during an investigation or inspection to residents, families, and staff, setting forth their rights against retaliation. Some AFHs need clarification on where the most recent DSHS inspections and investigation reports should be posted, and that they need to be accessible to the public and current residents and families for review without needing to request a copy from the facility.

Recommendation #13: DSHS should provide more written information on the resolution of unsubstantiated allegations as part of its complaint investigative report.

Unsubstantiated allegations need to be documented with more written records explaining the DSHS investigation and reasons for its conclusions. While DSHS verbally communicates its rationale and supporting information to complainants, a better written record in the investigative report would give more transparency and information to residents, AFHs, and the public, and would help remove the concern about whether DSHS has conducted an adequate investigation. The current Investigation Summary Report (ISR) typically includes only a few sentences regarding the unsubstantiated allegations. The ISR is the only report available to the public, residents, advocates and AFH owners regarding these allegations. There is not a need for multiple pages to describe unsubstantiated allegations, as was done in the past, but in order to restore or maintain public confidence in the DSHS investigation process, there should be significantly more narrative information in the reports about these allegations.

LIST OF APPENDICES

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Quality Assurance Panel Roster and Report Writing Group

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List of Acronyms

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List of DSHS AFH Improvement Initiatives

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DSHS Enforcement Actions Chart

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Appendix F

Additional DSHS case review examples, and case review sampling protocols

APPENDIX A PANEL ROSTER

- Shirley Bondon, Office of Public Guardianship, Washington State Administrative Office of the Court
- Nancy Brubaker, DSHS – HCS
- Candace Chaney, Assured Hospice/LHC Group
- Barbara Cochran, University of Washington School of Nursing Community/Healthcare
- Alice Dupler, Washington State University School of Nursing
- Jim Harvison , AARP
- Patricia Hunter, Washington State Long-Term Care Ombudsman
- Robin Low, Regional Long-Term Care Ombudsman for Snohomish County
- Richard Lundgren, Consumer/Family Caregiver
- Vicki McNealley, WSRCC- Executive Director
- Lori Melchiori, DSHS – RCS
- Kara Panek, DSHS – DBHR
- Hope Reffett, AFH Provider, WSRCC Board President
- Janet Rhode, AFH Provider, WSRCC
- LeAnne Riley, AFH Provider, AFH United- President
- Shaw Seaman, DSHS – DD
- Betty Schwieterman, Disability Rights Washington
- Cynthia Stevenson-Phelps, WSRCC- Education Director
- Amy Thomas, AFH Provider, AFH United
- Paul Tosch, Regional Long-Term Care Ombudsman for Lewis, Mason, and Thurston County

PANEL REPORT WRITING GROUP

- Marietta Bobba, DSHS—ADSA, Assistant Secretary's Office
- Jeff Crollard, Washington State LTC Ombudsman Program Attorney
- Patricia Hunter, Washington State Long-Term Care Ombudsman
- Richard Lundgren, Consumer/Family Caregiver
- Vicki McNealley, WSRCC- Executive Director

CASE FILE REVIEWERS

- Jeff Crollard, Washington State LTC Ombudsman Program Attorney
- Sammi Hopkins, Staff, King County LTCO Program
- Patricia Hunter, Washington State Long-Term Care Ombudsman
- Paul Iver, Pierce County LTC Ombudsman
- David Kiesig, Certified LTCO, Pierce County
- Gay Rutter, Certified LTCO, Snohomish County
- Sylvia Tinio, Certified LTCO, Pierce County
- Paul Tosch, Regional Long-Term Care Ombudsman for Lewis, Mason, and Thurston County

APPENDIX B LIST OF ACRONYMS

ADSA: Aging and Disability Services Administration, a subdivision of DSHS

AFH: Adult Family Home

ALJ: Administrative Law Judge, employed by the Office of Administrative Hearings, and presides over a fair hearing requested by the AFH or others

CRU: Complaint Resolution Unit, a part of Residential Care Services, central intake responsible for establishing the initial priority for investigative response to complaints/incidents.

DD: Division of Developmental Disability, a division of Aging and Disability Services within DSHS

DSHS: Department of Social and Health Services, largest state agency in Washington

FH: Fair Hearing, a formal administrative hearing before an administrative law judge where an AFH can contest the citations or penalties issued by DSHS

HCS: Home and Community Services, a division of Aging and Disability Services within DSHS, includes Medicaid case managers and Adult Protective Services

IDR: Informal Dispute Resolution, a process by which an AFH owner can provide additional clarifying information to DSHS relating to a Statement of Deficiency.

ISR: Investigation summary report, written by RCS investigator

LTC: shorthand for long-term care

LTCO: Long-term Care Ombudsman

LTCOP: Long-term Care Ombudsman Program, independent advocacy and assistance organization for residents

RCPP, Resident and Client Protection Program, investigates abuse and neglect by individuals

RCS: Residential Care Services, a division of Aging and Disability Services within DSHS that licenses and inspects long-term care facilities, including AFH

RCW: Revised Code of Washington, law passed by the Legislature

RN: Registered nurse

SOD: Statement of Deficiencies, written report of violations of the licensing laws, written by DSHS

WAC: Washington Administrative Code, regulation written by a state agency in response to a statute

WSRCC: Washington State Residential Care Council of AFHs, largest association in Washington representing AFHs

APPENDIX C LIST OF DSHS AFH IMPROVEMENT INITIATIVES

DSHS has identified key issues as the industry has grown and diversified. Those issues and opportunities can be categorized into three areas: (1) Licensing, (2) Complaints, and (3) Protection Programs. The following list initiatives addresses efforts undertaken by DSHS.

Licensing

The minimum licensing requirements are regularly reviewed and amended for clarity and updates as are processes to better meet the needs of vulnerable adults living in residential settings. Examples of the continuous quality improvement process include:

- 2004: Centralized license application processes to improve consistency.
- 2005: Centralized AFH initial licensure to ensure greater efficiency and consistency.
- 2006: Replacement of facility database with the Facility Management System (FMS). Improvements increase the ability to identify repeat citations by the same providers across multiple settings.
- 2006: Methods instituted to improve consistency in licensing application review and decision processes.
- 2007: Implemented early provider visits to new AFHs to improve care, services and compliance with licensing rules.
- 2007: Ability to impose conditions and/or stop placement immediately if resident harm may occur pending completion of a complaint investigation.
- 2008: Licensing requirements in Chapter 388-76 WAC were written in “Plain Talk” to decrease potential confusion to providers. The resident rights requirements in Chapter 70.129 RCW were also incorporated into the licensing requirements so they would be readily available for both providers and residents.
- 2008: Literacy challenges were identified as a barrier to quality care. AFH WAC was updated to ensure that language barriers did not create barriers to resident services or responses to emergency situations.
- 2008-2010: The inspection process was reviewed and revised with an emphasis on increasing the resident sample size and a greater focus on resident observation and interview.
- 2012: National fingerprint- based background checks put in place.

Complaints

Complaint processes are regularly reviewed to ensure decreased barriers to reporting. Examples of reviews and updates include:

- 2007
- Developed and implemented Complaint Investigation Protocols to enhance thoroughness and consistency of investigations
- Trained staff in protocols used for unlicensed homes, pressure ulcers and insufficient staffing.
- Incorporated formal on-going auditing (Complaint Quality Reviews) of a sampling of completed investigations.

- Developed a tool to assess major components of the investigative process and identify strengths and areas for improvement.
- Created an eighteen¹⁸ element quality assurance tool to define the “thoroughness” of investigations.
- Internal Quality assurance (QA) tool results are analyzed at three different levels, including performance of each field unit, the results of the headquarters Panel review, and division-wide.
- Bi-annual reviews, since August 2007, of a random mix of complaint investigations across all settings.
- 2009:
- Complaint Quality Assurance review included an analysis of trends associated with all of the Quality Assurance reviews was conducted. That analysis revealed that complaint investigation performance has been stable and overall performance improvements have been noted since the pilot QA Quality Assurance process was initiated in 2007.

Protection Programs

Protection programs continue to expand and coordinate for better identification of abuse, neglect and exploitation. Examples include:

- 1996: Investigations of individuals associated with nursing homes alleged to have abandoned, abused, neglected, exploited, or financially exploited vulnerable adults begun.
- 2006: RCS began investigating similar individuals in the Certified Community Residential Services and Support Program (supported living).
- 2008: Investigations expanded into adult family AFHs, boarding homes and Intermediate Care Facilities for Persons with developmental disabilities.

As a result of both RCS and HCS’ Adult Protective Services investigations, approximately 2,700 individuals are listed in the adult abuse registry and cannot be contracted by the Department to provide care in long-term care settings. Since 2009, regulations continue to be updated to improve resident choice and provider requirements in the areas of:

- Multiple Home Licensing
- Inspection and Complaint Investigation report disclosures
- Background Checks
- Resident Privacy Rights
- Updated Complaint investigation, documentation and communication systems
- Expanded training
- Revised enforcement of Operational Principles and Procedures
- AFH application updated and expanded verification of information
- Enforcement letters published on-line
- Expanded training on Mandated Reporting requirements

APPENDIX D DSHS ENFORCEMENT ACTIONS CHART

PRE-HB 1277: ADULT FAMILY HOME AND BOARDING HOME ENFORCEMENT ACTION OPTIONS – January 2010

- Decisions about enforcement actions must be based on statutory and regulatory requirements.
- The following tool is intended as a guideline only.
- Each situation is unique and needs to be looked at on a case by case basis.

NO HARM		MINIMAL OR MODERATE		SERIOUS		IMMINENT DANGER OR THREAT OF HARM
INITIAL	REPEAT/ UNCORRECTED	INITIAL	REPEAT/ UNCORRECTED	INITIAL	REPEAT/ UNCORRECTED	
<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>
Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies within 48 hours
Consultation No Plan of Correction Attestation	Obtain Plan of Correction Attestation	Obtain Plan of Correction Attestation	Obtain Plan of Correction Attestation	Obtain Plan of Correction Attestation; except for revocation and summary suspension	Obtain Plan of Correction Attestation; except for revocation and summary suspension	No Plan of Correction Attestation
	On-site <i>or</i> Documentation follow-up	On-site <i>or</i> Documentation follow-up	On-site follow-up	On-site follow-up <i>OR</i> Monitoring visits for revocation	On-site follow-up <i>OR</i> Monitoring visits for revocation	Monitoring Visits
	ENFORCEMENT RECOMMENDATIONS -Civil Fine up to \$50 per violation (3 rd occurrence in 15 months or from the last full inspection)	Civil Fine up to \$100 per violation; <i>and/or</i> -Condition(s)	ENFORCEMENT RECOMMENDATIONS -Civil Fine up to \$100 per violation; <i>and/or</i> -Condition(s) <i>and/or</i> Stop Placement for pervasive non-compliance	ENFORCEMENT RECOMMENDATIONS -Civil Fine up to \$100 per violation; <i>and/or</i> -Condition(s); <i>and/or</i> -Daily Civil Fine; <i>and/or</i> -Stop Placement; <i>and/or</i> -Revocation & Stop Placement	ENFORCEMENT RECOMMENDATIONS -Civil Fine up to \$100 per violation; <i>and/or</i> -Condition(s) <i>and/or</i> -Daily Fine; <i>and/or</i> -Stop Placement; <i>and/or</i> -Revocation and Stop Placement	ENFORCEMENT RECOMMENDATIONS -S/Suspension; and -Revocation; <i>and</i> -Stop Placement. <u>May also do:</u> -Daily Civil Fine; <i>or</i> -Civil Fine; <i>and/or</i> -Condition

Severity: Severity means the seriousness of a violation as determined by the actual or potential negative outcomes for residents and subsequent actual or potential for harm. Outcomes include any negative effect on the resident's physical, mental, or psychosocial well being (i.e., safety, quality of life, quality of care).

Levels of severity:

- Minimal: Violations that result in little or no negative outcome and/or little or no potential harm for the resident.
- Moderate: Violations that result in negative outcome and actual or potential harm for the resident.
- Serious: Violations that result in negative outcome and significant actual harm for the resident that does not constitute imminent danger; and/or, there is a reasonable predictability of recurring actions, practices, situations, or incidents with the potential for causing significant harm to a resident.
- Imminent Danger/Immediate Threat: Serious physical harm to or death of a resident has occurred, or there is a serious threat to a resident's life, health, or safety.

POST-HB 1277: ADULT FAMILY HOME ENFORCEMENT ACTION OPTIONS – September 2011

- Decisions about enforcement actions must be based on statutory and regulatory requirements.
- The following tool is intended as a guideline only.
- Each situation is unique and needs to be looked at on a case by case basis.

NO HARM		MINIMAL OR MODERATE		SERIOUS		IMMINENT DANGER OR THREAT OF HARM
INITIAL	REPEAT/ UNCORRECTED	INITIAL	REPEAT/ UNCORRECTED	INITIAL	REPEAT/ UNCORRECTED	
<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>	<u>ACTIONS</u>
Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies	Statement of Deficiencies within 48 hours
Consultation No Plan of Correction Attestation	Obtain Plan of Correction Attestation	Obtain Plan of Correction Attestation	Obtain Plan of Correction Attestation	Obtain Plan of Correction Attestation; except for revocation and summary suspension	Obtain Plan of Correction Attestation; except for revocation and summary suspension	No Plan of Correction Attestation
	On-site <i>or</i> Documentation follow-up	On-site <i>or</i> Documentation follow-up	On-site follow-up	On-site follow-up <i>OR</i> Monitoring visits for revocation	On-site follow-up <i>OR</i> Monitoring visits for revocation	Monitoring Visits
	ENFORCEMENT RECOMMENDATIONS - Civil Fine up to \$100 per violation	ENFORCEMENT RECOMMENDATIONS -Civil Fine up to \$500 per violation or a daily civil fine of at least \$250 per day; <i>and/or</i> -Condition(s)	ENFORCEMENT RECOMMENDATIONS - Civil Fine up to \$1000 per violation or a daily civil fine of at least \$500 per day <i>and/or</i> -Condition(s) <i>and/or</i> Stop Placement for pervasive non-compliance	ENFORCEMENT RECOMMENDATIONS - Civil Fine up to \$2000 per violation or a daily civil fine of at least \$1000 per day; <i>and/or</i> -Condition(s); <i>and/or</i> -Stop Placement; <i>and/or</i> -Revocation & Stop Placement	ENFORCEMENT RECOMMENDATIONS - Civil Fine up to \$3000 per violation or a daily civil fine of at least \$1500 per day; <i>and/or</i> -Condition(s); <i>and/or</i> -Stop Placement; <i>and/or</i> -Revocation and Stop Placement	ENFORCEMENT RECOMMENDATIONS - Civil fine of \$3000 or daily civil fine of at least \$2000 per day; -S/Suspension; and -Revocation; <i>and</i> -Stop Placement. <u>May also do:</u> -Condition

Severity: Severity means the seriousness of a violation as determined by the actual or potential negative outcomes for residents and subsequent actual or potential for harm. Outcomes include any negative effect on the resident's physical, mental, or psychosocial well being (i.e., safety, quality of life, quality of care).

Levels of severity:

- Minimal: Violations that result in little or no negative outcome and/or little or no potential harm for the resident.
- Moderate: Violations that result in negative outcome and actual or potential harm for the resident.
- Serious: Violations that result in negative outcome and significant actual harm for the resident that does not constitute imminent danger; and/or, there is a reasonable predictability of recurring actions, practices, situations, or incidents with the potential for causing significant harm to a resident.
- Imminent Danger/Immediate Threat: Serious physical harm to or death of a resident has occurred, or there is a serious threat to a resident's life, health, or safety.

APPENDIX E MEETING AGENDAS

Panel Meeting #1**September 29, 2011 | 8:30am – 12:30pm****A G E N D A**

- 9:00 Welcome & Introductions Patricia Hunter, State LTC Ombudsman**
- Why did you decide to participate on this panel?
 - What are your hopes and expectations for this process?
- 9:30 Workgroup Overview Patricia**
- Review and discuss the legislative charge to the group
 - Review and discuss draft meeting plan
 - Review and discuss draft roles and responsibilities
- 10:00 Current System Assessment All**
- Review current system from State, provider, and client perspectives
- 11:30 Roundtable Reflections & Next Steps All**
- Determine future meeting dates
 - Final thoughts on day's meeting, process, etc.
- 11:45 Public Comment**
- 12:00 Adjourn**

Panel Meeting #2

December 16, 2011 | 8:30am – 12:30pm

A G E N D A

Meeting Purpose

- To come to common understanding and agreement around the problem issues identified in the Legislative Charge to the Quality Assurance panel

8:30 Welcome and Introductions

8:50 Small Group Breakout #1 – Inspection

- Brainstorm around what's not working related to inspection, what the data needs are, and the key questions to address around inspection (*15 minutes*)
- Report out from each small group (*5 minutes each, 15 minutes total*)
- Assign leads to gather data (*15 minutes*)

9:35 Small Group Breakout #2 – Investigation

- Brainstorm around what's not working related to inspection, what the data needs are, and the key questions to address around inspection (*15 minutes*)
- Report out from each small group (*5 minutes each, 15 minutes total*)
- Assign leads to gather data (*15 minutes*)

10:30 Small Group Breakout #3 – Public Complaint

- Brainstorm around what's not working related to inspection, what the data needs are, and the key questions to address around inspection (*15 minutes*)
- Report out from each small group (*5 minutes each, 15 minutes total*)
- Assign leads to gather data (*15 minutes*)

11:15 Small Group Breakout #4 – Enforcement

- Brainstorm around what's not working related to inspection, what the data needs are, and the key questions to address around inspection (*15 minutes*)
- Report out from each small group (*5 minutes each, 15 minutes total*)
- Assign leads to gather data (*15 minutes*)

12:00 Public Comment

12:15 Roundtable and Adjourn

Panel Meeting #3

March 30, 2012 | 8:30am – 12:30pm

A G E N D A

Meeting Purpose

Review issues related to Prevention and quality assurance for Adult Family Homes; presentation from DSHS about their processes and protocols, and how they're adapting to HB 1277

8:15 Welcome and Introductions

- Agenda Overview
- Review of Information Request and project update

8:40 DSHS Presentation

- Overview from each division and what they focus on
- Protocols around inspection, investigation, and enforcement
- Review changes from HB 1277

10:20 Break

10:30 Small Group Breakout #1 – Recruitment, Application, and Licensing

- Brainstorm around what's not working related to recruitment, application, and licensing, what the data needs are, and the key questions to address around recruitment, application, and licensing (*15 minutes*)
- Report out from each small group (*5 minutes each, 15 minutes total*)
- Assign leads to gather data (*15 minutes*)

11:15 Small Group Breakout #2 – Admissions, Transitions, and Assessments

- Brainstorm around what's not working related to admissions, transitions, and assessments, what the data needs are, and the key questions to address around admissions, transitions, and assessments (*15 minutes*)
- Report out from each small group (*5 minutes each, 15 minutes total*)
- Assign leads to gather data (*15 minutes*)

12:00 Summary and Next Steps

- Next meeting agenda and date
- Next steps on data gathering

12:15 Roundtable

12:30 Adjourn

Panel Meeting #4

June 28, 2012 | 8:30am – 3:00pm

A G E N D A

Meeting Purpose

Update on case file/data review and report writing process; review system map and discuss outcomes and metrics for a high-quality adult family home system; being drafting recommendations for the Legislative Report

8:30 Welcome & Introductions

- Agenda Overview

8:45 Housekeeping

- Update on case file review process and request for participation
- Update on Quality Assurance Panel process and timeline
- Request for assistance in drafting the Legislative Report

9:15 Legislative Charge & System Map Review

- Review Legislative Charge for the QA Panel and discussion of Inspection, Investigation, and Enforcement System Map

10:15 Break

10:30 Small Group Breakouts – Outcomes & Metrics

- Brainstorm around desired outcomes and metrics for these outcomes related to Inspection, Investigation, and Enforcement
- Discuss possible recommendations that would help achieve these outcomes
- Report out from each small group

12:00 Lunch

1:00 Large Group – Drafting Recommendations

- Review recommendations made in the Small Groups and throughout the Panel process, and generate additional recommendations
- “Taking the temperature:” begin evaluating which recommendations have the most consensus among the panel

2:30 Public Comment

2:45 Roundtable and Adjourn

Panel Meeting #4
September 24, 2012 | 8:00am – 3:00pm
A G E N D A

Meeting Purpose

Advance recommendations forward for the Legislative Report

8:00 Welcome & Introductions

- Agenda Overview

8:05 Case File Review

- Update and conclusions on case file review process

8:35 Defining Consensus

- Voting – Strive for unanimity.
- What if we can't get to unanimous consensus? Options?

9:00 Recommendation Review

- Quickly review previous recommendations
- Solicit additional recommendations
- Work to determine which ones have general agreement and which ones are disputed. Further, determine if the disputes are because of the identified problem or the proposed recommendation

10:15 Small Group Breakout

- Work to resolve issues with outstanding recommendations
- Attempt to get to a higher level in terms of recommendations—move back on the specificity spectrum (i.e. where do we agree?)

11:30 Small Group Report Out

- Report out from each small group
- Status of where the disputes lie—what can be advanced, what's been tabled

1:15 Advancing Recommendations

- Similar exercise to the Recommendation Review—where is there general agreement and what is still disputed? Is it because of the identified problem or the proposed recommendation?
- What is it about this recommendation that you can't live with? Variations on this question—what is preventing you from supporting it?
- Find some way to advance these recommendations/come to consensus.

3:00 Public Comment**3:30 Adjourn**

APPENDIX F ADDITIONAL DSHS FILES CASE REVIEW EXAMPLES**Insufficient or Ineffective Penalties**

AFH #706, Skagit County. In 4/2012 this AFH failed to fill a resident's prescription for morphine taken for chronic pain, resulting in the resident missing 11 doses, and failed to tell the resident's doctor the resident was developing a swollen, draining eye, resulting in severe conjunctivitis and the need for emergency room care. DSHS issued citations, but imposed no sanction. This facility had a long history of serious care-related deficiencies from 12/2010 to 3/2012. One of the most important new charges to DSHS in HB 1277 is that "homes consistently found to have deficiencies will be subjected to increasingly severe penalties."

AFH #406, Snohomish County. This multi-home owner had two AFHs and violations in both. In one home, AFH #405, he was cited in 10/2011 for retaining an abusive caregiver and using another caregiver who had no training. In AFH #406, the owner was cited in 5/2011 for multiple resident elopements. He was also cited three times for not having a qualified resident manager to run the home, being cited on 4/22/10, 9/8/11, and 9/29/11. After the third citation DSHS imposed a sanction, a \$100 fine. DSHS had the authority at this time to impose \$100 fines per day per violation, and could have fined the home for the days it was without an AFH resident manager. Having a qualified AFH manager can matter. The 9/8/11 SOD during this time also found illegal bed rails and deficiencies in the home's fire drills, evacuation plans, and emergency supplies.

AFH #125, King County. In 9/2011, DSHS substantiated a complaint that this AFH dropped a resident during a transfer when not using his gait belt, resulting in a fracture. The AFH waited two days before getting medical care. The facility also failed to provide the resident other needed care and safety precautions, resulting in the resident developing severe perineal rash, dizziness, fainting, and falling out of bed onto his head. The AFH failed to post the Notice of Condition on License earlier imposed by DSHS in 5/2011, which, ironically, required the owner to receive training on safe transfer techniques. DSHS did a thorough investigation and cited the owner for a number of violations, including repeat deficiencies. The penalty was a \$500 fine--\$400 for the delay in getting medical treatment, and \$100 for not posting the Condition on License notice. DSHS did not fine the owner for the other violations (e.g., not providing basic care, not keeping the resident's records at the AFH), or impose other sanctions.

AFH #617, Kitsap County. This is an example of a thorough investigation, but slow enforcement. DSHS received six complaints from 11/21/11 to 1/30/12 that were combined and addressed in one large SOD issued on 2/27/12. Sanctions were imposed 3/20/12—four months after the first complaint was received. The first complaint on 11/21/11 was by a resident's guardian, whose ward was being left in urine soaked clothes and his skin had become raw. This was documented by photos by the resident's health care provider, and confirmed by DSHS. The second complaint was on 12/19/11 by a DSHS case manager about the house being cold. The DSHS investigator visited the house with a thermometer. It was 62 degrees.

On 1/23/12, the guardian complained further that the owner took light bulbs out of the resident's room, wouldn't assist the resident, who had use of only one arm, with access to smoking outside, and that the assessment and care plan were inaccurate. The guardian reported the resident was aphasic, had low vision, and used a cane to walk. However, the care plan noted no sensory deprivations and stated the resident used a wheelchair. The allegations were verified by DSHS. On 1/26/12, the guardian was informed by an ex-employee that if his ward is late for breakfast, then he doesn't get any breakfast or food in the morning. On 1/30/12 the guardian called in more complaints, including that the owner underpaid the caregivers and

fired them if they complained. Eventually, this resident lost 68 pounds in six months. The guardian searched for a new AFH, but found it very difficult because the resident smoked.

DSHS investigated in late 1/2012 and early 2/2012. The above allegations were substantiated, as were other violations discovered by DSHS, including: staff lacking required TB testing, criminal background checks, CPR training, and/or specialty training; missing fire extinguishers and blocked doors; inaccurate assessments of residents and medication log documentation errors, etc., a total of 22 violations. The investigator was thorough and sensitive to the needs of the residents, gathering information from collateral sources and residents, and communicating via gestures with the non-verbal resident. Why the earlier complaints could not have been completed sooner is unclear. On 3/12/12, the DSHS field manager recommended license revocation, and asked headquarters to review the case “ASAP, as it’s really late.” On 3/20/12, DSHS issued a stop placement, license revocation, and license conditions—requiring the AFH to hire a nurse consultant to help with medication delivery, records management, residents’ assessments, and service delivery for all residents.

Effective DSHS Investigation and/or Enforcement

AFH #116, King County. This is a complex case with both good and bad features. It involved a relatively new AFH with specialty designations for dementia, developmental disability, and mental health care. The AFH admitted residents with known elopement behavior, yet was not able to redirect or safely control the behaviors. For example, the provider locked the exit doors and the residents’ bedroom doors. One 97 year old resident broke her finger on 11/2010, trying so hard to get out. She was hospitalized on 3/2011 after becoming combative and hitting the provider. Two other residents were chemically restrained with psychotropic medications. They suffered falls, skin tears, bruising and other adverse side effects. DSHS did a licensing inspection of the AFH on 3/2011, but did not interview these residents.

In 8/2011 DSHS received two extensive complaints about poor care, verbal and physical abuse, illegal restraints, and other problems in the home. A former resident reported that his caregivers pushed and yelled at him, and were “mean people.” This resident’s blood thinner medications were too high because the provider hadn’t followed doctor’s orders. He had many bruises on his body. The DSHS investigator immediately visited the home on 8/26/11, and did so nearly every day for a week. Her investigation was prompt and thorough. A SOD was issued one week later and then enforcement remedies. DSHS did not revoke the home’s license or impose a civil fine. But DSHS opted to impose a stop placement and an array of conditions on the license: (1) retake fundamentals of caregiving training, (2) meet with DSHS to discuss residents’ rights, (3) new residents can be admitted after (1) and (2) above are satisfied, (4) no admission of residents with dementia until retake dementia training, and (5) can admit residents with developmental disabilities or mental health needs after passing a licensing inspection with no deficiencies. This unusual and complicated remedy perhaps illustrates the carrots and sticks approach that is sometimes needed to ensure that an owner will make the needed corrections and demonstrate over time, the ability to remain in compliance. It remains unclear, though, whether the AFH was sufficiently penalized for the harm it caused.

4.4 DSHS Rarely Cites AFHs for “de minimus” Violations.

AFH #905, King County. In 11/2011 this owner was cited for 5 violations including a third repeat citation for failing to prevent resident elopement from the home, and failing to report resident elopement. The residents’ care plans at the AFH still did not identify elopement as a behavior challenge and had no plan or system in place to protect residents from potential harm from elopements, accidents, or getting lost, despite a prior condition on license to do so. DSHS

imposed a stop placement and a civil fine of \$1,800 (\$100 x 3 residents x 6 days), plus license revocation. The owner appealed and at IDR no citations or penalties were reversed. A FH was requested and is pending. In this case, the main basis for the owner's appeal appears to be that no actual harm occurred. It is unclear why the AFH has identified this as a "de minimus" case given that the violations were not minor.

Explanation of Random Sampling of DSHS Case Files

Pre-HB 1277 Sample: July 2011 – December 2011

Complaint Investigations with Enforcement

Data was sorted by district and then enforcement = yes. Each enforcement action was reviewed. Only those AFHs with complaint investigations or complaint follow-up visits resulting in enforcement were included. From each district, all AFHs meeting the criteria were copied to a separate worksheet. For each district, the AFHs meeting the criteria were counted. District 1 did not have 10 AFHs so all District 1 enforcement was included. District 2 and District 3 each had more than the requested sample size of 10. The count for each District was divided by the requested sample size of 10 to get the selection "frequency". Approximately every 3rd AFH was selected for District 2 and every AFH or every other AFH was selected for District 3.

Licensing (Full) Inspections

Data was sorted by full visit = yes and then by district. From each district, all AFHs meeting the criteria were copied to a separate worksheet. Any AFHs on "File List #1" were excluded from this list. For each district, the AFHs meeting the criteria were counted. The count was divided by the requested sample size of 10 per district to get the selection "frequency". Approximately every 16th AFH was selected for District 1, every 54th AFH from District 2, & every 27th for District 3. Whether a deficiency = yes or no was not considered in the selection. To determine whether residents were in the home, each AFH full visit in the proposed sample was reviewed to determine if residents were in the AFH at the time the full inspection occurred. Any AFHs without residents were eliminated from the proposed sample and another AFH selected to replace it.

Complaint Investigations with Citations & No Enforcement

Data was sorted by complaint deficiencies yes or no, then enforcement yes or no and finally by district. From each district, all AFHs meeting the criteria were copied to a separate worksheet. Any AFHs on "File List #1" or "File List #2" were excluded from this list. For each district, the AFHs meeting the criteria were counted. The count was divided by the requested sample size of 5 to get the selection "frequency". Approximately every 5th AFH was selected for District 1, every 22nd AFH from District 2, & every 11th for District 3.

Complaint Investigations Involving Multi-owners

The sample requested could not be provided. The number of multiple home providers with two or more enforcement actions resulting from complaints was six not five from each District. District 1 = had zero, District 2 = had five, and District 3 = had three complaints.

The data provided is based on the number of multiple home providers with two or more facilities imposed with enforcement. All enforcement was included whether it resulted from a complaint or not. Data was sorted by multiple homes = yes, then by licensee name, and finally by enforcement action = yes. From each district, all AFHs meeting the criteria were copied to a

separate worksheet. Any AFHs on "File List #1", "File List #2" and "File List #3" were excluded from this list. For each district, the AFHs meeting the criteria were counted. District 1 and District 3 did not have 5 multiple home providers with enforcement imposed at two or more AFHs. The list contains all AFHs meeting the criteria without regard for the number in each District.

Post-HB 1277 Sample: January 2012 – June 2012

Complaint Investigations with Enforcement

Data was sorted by district and then enforcement = yes. Each enforcement action was reviewed. Only those AFHs with complaint investigations or complaint follow-up visits resulting in enforcement were included. From each district, all AFHs meeting the criteria were copied to a separate worksheet. For each district, the AFHs meeting the criteria were counted. The count for each district was divided by the requested sample size of 5 to get the selection "frequency". Approximately every 3rd AFH was selected for District 1, every 9th AFH was selected for District 2 and every 3rd AFH was selected for District 3.

Licensing (Full) Inspections

Data was sorted by district, then alphabetically. This is the way the report is sorted when it is created. No AFHs with full visits were excluded from this list. For each district, the AFHs meeting the criteria were counted. The count was divided by the requested sample size of 5 per district to get the selection "frequency". Approximately every 31st AFH was selected for District 1, every 136th AFH from District 2, & every 61st for District 3. Whether a deficiency = yes or no was not considered in the selection. To determine whether residents were in the home, each AFH full visit in the proposed sample was reviewed to determine if residents were in the AFH at the time the full inspection occurred. Any AFHs without residents were eliminated from the proposed sample and another AFH selected to replace it.

The number of deficiency-free full visits in the initial sample was 37.5%. The number seemed high. Statewide data was checked. The deficiency-free full visits were 14.7% statewide. The sample size was increased to 8 for each District. Three (3) AFHs were added to the original sample of 5. The 1st AFH in the original sample was identified. Counting was started with the next AFH listed. Approximately every 19th AFH was selected for District 1, every 85th AFH for District 2 and 38th AFH for District 3 until 3 additional AFHs were selected.

Complaint Investigations with Citations & No Enforcement

Data was sorted by complaint deficiencies = yes, then enforcement = no and finally by district. From each district, all AFHs meeting the criteria were copied to a separate worksheet. Any AFHs in the sample called "Complaint-Yes Enf Sample" or "Full Visits Sample" were excluded from this list. For each district, the AFHs meeting the criteria were counted. The count was divided by the requested sample size of 5 to get the selection "frequency". Approximately every 9th AFH was selected for District 1, every 30th AFH from District 2, & every 16th for District 3.

Complaint Investigations Involving Multi-owners

The sample requested could not be provided. The number of multiple home providers with two or more enforcement actions resulting from complaints was 14, all located in District 2. District 1 = 0 and District 3 = 0. The data provided is based on the number of multiple home providers with two or more facilities imposed with enforcement. All enforcement was included whether it resulted from a complaint or not. Data was sorted by multiple homes = yes, then by licensee name, and finally by enforcement action = yes. From each district, all AFHs meeting the criteria were copied to a separate worksheet. Any AFHs on "Complaint-Yes Enf Sample", "Full Visits Sample" and "Complaint-No Enf Sample" were excluded from this list. For each district, the AFHs meeting the criteria were counted. District 1 and District 3 did not have any multiple home providers with enforcement imposed at two or more AFHs. The list contains all AFHs meeting the criteria without regard for the number in each District.