

Filling the Gap: Assisted Living Facilities

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Assisted living is often described as the fastest growing form of housing for seniors. But that statement reveals more than the growth of a niche industry. It also reflects the fact that assisted living facilities are considered as much, if not more, housing than health care facility. It is this fact which complicates state efforts to regulate the area. This article will address some of the major regulatory and policy issues in the assisted living industry and how different states are approaching them.

Assisted living is a loosely defined combination of housing, personal care and health services. Estimates of the number of “assisted living facilities” throughout the United States range from 20,000 to 36,000 with a resident population of approximately one million¹. The numbers of individuals receiving what is essentially assisted living care is even greater if you factor in the number of people who are living in adult communities or senior residences receiving home health services.

This compares with about 16,000 nursing homes although the number of nursing home residents is closer to 1.5 million because the facilities tend to be larger. Clearly a large percentage of the population sees assisted living facilities as an attractive alternative to nursing home care. What the general public does not realize is the vast difference in the regulatory scheme. Nursing homes are strictly regulated by the federal government. There are hundreds of standards which they must meet governing every aspect of their operation. Assisted living facilities are much less strictly regulated. They are regulated only by individual states; many of whom have only basic licensing laws. In addition, the survey process which is such an important part of regulating the nursing home industry is completely absent.

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As more people use assisted living facilities as an alternate to nursing home care, the question emerges as to where the line between the different levels of care lies and what that distinction really means in practical terms.

SERVICES AND POPULATION

While the definition of assisted living varies greatly from state-to-state, it is generally understood that residents are unable to live in their own homes because of limiting physical and/or mental conditions. More than a quarter of the residents suffer from significant cognitive impairment, and more than half require assistance with bathing. However, the services provided to these residents vary greatly. Some facilities provide health care that is comparable to nursing homes. Others basically provide three daily meals and some supervision. Some of the services that are commonly provided include:

- 24-hour monitoring;
- personal services including assistance with activities of daily living;
- Health-related services including medication management and administration;
- Social services;
- Recreational activities;
- Meals;
- Housekeeping and laundry;
- Transportation.

Many states define the type of care which can or must be provided by an assisted living facility. Most states also include a list of disqualifying medical condition, basically drawing the line between an individual who can be served in an ALF versus a SNF. These disqualifiers often include needing assistance with more than a certain number of ADLs and being nonambulatory.

Sixteen states have a multi-level system with different quality standards and regulatory requirements for each level. In general, this approach distinguishes between basic

assisted living services and a higher level of care which includes more personal care and nursing services. Many states have moved to a two or three tier system. Another emerging trend is to require specialty facilities such as those serving residents with dementia to meet a separate set of standards. Often they must provide more detailed disclosure on the services provided and staffing information. However, most state dementia specific “standards” do not specify minimal staffing levels or procedures. One notable exception is Alabama which licenses “specialty care” assisted living facilities designed to care for residents with severe cognitive impairment. It imposes staffing ratios, specialty staff training, and a requirement that a facility employ a medical director and a nurse.

The advantage of a multiple-level system is that it makes it easier to determine if a particular facility can meet the needs of an individual. It also allows for stricter quality standards to be imposed as the level of care approaches the SNF level. Such a graduated system goes a long way to dealing with the concerns about the regulatory gap between ALFs and SNFs. However, one disadvantage is that a continuum of care cannot be provided within one facility therefore residents are required to move as their needs increase.

A few states take a much more laissez-faire approach leaving the issue of services largely to be addressed by the contract between facility and resident. In these states, facilities are generally required to outline the services provided and any disqualifying medical conditions in the contract.

WHO DECIDES WHEN A RESIDENT OR PROSPECTIVE RESIDENT IS TOO SICK

Except where a disqualifying medical condition is present, assisted living facilities are generally free to decide whether they can and will meet a resident's health care needs.²

Moreover, when a resident's health deteriorates, most states leave it up to the discretion of

the facility to determine whether it will provide the necessary services or evict the resident. Assisted living facilities seem to be entitled, but not obligated, to admit and retain individuals with medical needs.

An interesting question is raised as to whether facilities are discriminating illegally when they refuse to provide services required by a resident with a disability. The Americans with Disabilities Act, section 504 of the Rehabilitation Act and the Fair Housing Act each prohibit discrimination based on an individual's physical or medical condition.

The lack of governmental oversight on this issue can result in two significant problems. Some facilities may accept or retain residents who they are ill-equipped to care for. This, combined with a lack of regulation and supervision, has led to a number of tragic incidents.³ In one case, the staff of an assisted living facility failed to recognize and appropriately address a resident's severe diabetes. Instead of administering emergency medication, the staff fed the resident waffles with sugar-free syrup. In another case, a facility failed to recognize a resident's rapidly declining health. When the patient was finally admitted to a hospital as a result of a fall, he was dehydrated, had a 105-degree fever and was septic. He was diagnosed with advanced colon cancer.

The opposite problem occurs when a facility discharges a resident because it cannot or will not meet his or her needs. In this case, the ADA is generally the only recourse. Unfortunately, facility discretion in this area can mean that private pay patients are retained but those who have turned to Medicaid are found to be "too ill".

Most states rely on disclosure requirements to address this issue. New Jersey has refined this approach. Facilities may choose to exclude residents with any of eight specific conditions. The disqualifying conditions include dependence in four or more ADLs, need

for 24 hour supervision, immobility, and advanced dementia. However, if a facility wishes to use any one of the disqualifying conditions, the facility must specifically address this in the admission agreement.

STAFFING ISSUES

Perhaps the most significant issue in regulating the assisted living industry is staffing requirements. The staffing standards in most states differ significantly from those in nursing homes. The direct-care staff in ALFs generally have substantially less training and experience than their counterparts in nursing homes. Unfortunately, this distinction is not readily apparent to consumers.

Most states impose minimal training requirements regulating only the broad topics such as “knowledge of first aid or CPR”. Only 19 states have hourly minimums for the training of direct-care workers. Of those, only 10 states require 25 or more hours. Four states – Connecticut, Kansas, New Jersey, and Washington – require direct-care staff to pass competency exams. In Connecticut and New Jersey, the staff must be certified as nurse aides or home health aides.

Staffing ratios are also generally much lower than in nursing homes. Only 18 states have minimum staffing ratios. The standards vary substantially among the states. Maine has set one of the strongest minimums: 1 to 5 during the day shift; 1 to 10 during the evening shift; and 1 to 15 during the late-night shift. However, California requires only one awake employee for a facility with up to 100 residents, with at least one other employee capable of arriving at the facility within 10 minutes. Moreover, in assisted living facilities, direct-care staff often have other duties besides direct patient care. It is

not uncommon for the same staff to also do housekeeping and clerical work. In nursing homes, nurse aides are not responsible for such tasks.

One of the most concerning issue for resident safety is the lack of nursing supervision in many facilities. While 26 states require that ALFs employ at least one nurse, many times these nurses are not on-site on a regular basis. They are generally used to conduct assessments and review care plans. For example, in the District of Columbia, a facility must have a registered nurse conduct a medication review once every 45 days. Other states require a much higher level of involvement. New Jersey requires a registered nurse to direct health care services and to be on telephone call at all times. Of course, states that have adopted a multi-level system tend to have nursing requirements for the higher levels of care and specialty care.

By way of comparison, federal nursing home law requires that a nursing home have a LPN on duty at all times and an RN at least eight consecutive hours a day, seven days a week. In addition, a RN must serve as a full-time director of nursing.

Because the limited role that nurses play, many states allow direct-care staff to administer medications. Even those states that do not expressly authorize medication administration, it is common practice. In nursing homes, only nurses can do this. Other nursing tasks are expressly authorized only by a handful of states, but again, in actual practice the line between nursing and personal care assistance is often blurred.

Another by-product of not having health care professionals on-site is the facilities inability to honor DNRs and living wills. In most states, only licensed health care providers have the authority to follow these documents. As a result, the resident's wishes may not be followed and 911 will be called.

THE IMPACT OF MEDICAID

The economics of long term care significantly favor assisted living. Both federal and state governments support the diversion of Medicaid funds from nursing facility care to assisted living which can cost as little as half of SNFs. About 100,000 ALF residents are receive care paid by Medicaid through a waiver program. This number is likely to rise significantly. First, because of the relative cost savings and because many seniors prefer assisted living, waiver programs continue to expand.

The new Deficit Reduction Act provisions are also likely to contribute to increased use of assisted living. This legislation included two provisions which expand the use of Medicaid funds for non-nursing home long-term care services including assisted living. Previously Medicaid coverage was only provided if the individual required SNF level care. The legislation allows states to develop new needs-based criteria. Another DRA provision allows for direct reimbursement to individuals eligible for Medicaid for alternative long-term care services.

The DRA transfer of asset provisions also could result in more people looking toward assisted living. The law penalizes all gifts made within five years of Medicaid application. It also changes the running of the penalty so it becomes effective just at the time that the individual has used their private funds and is applying for Medicaid. As a result, many more seniors may find themselves ineligible for Medicaid because of even small gifts made years earlier. This makes it much more attractive to remain in assisted living facilities.

ALTERNATIVES FOR QUALITY REFORM

Nursing homes are subject to extensive federal regulation as a condition of participating in Medicare and Medicaid. Assisted living facilities are not subject to these

rules, even if they receive Medicaid payment through a waiver program. Some advocates have argued that since assisted living facilities are garnering more Medicaid funds, they should be subject to the same regulation. While this would seem to be a logical and easy solution to the concern regarding consistent quality and safety in the industry, it would also eliminate many of the benefits of assisted living. Costs would rise substantially and the facility would likely “feel” more like a nursing home.

Another possible approach is private accreditation through an agency like JCAHO. In 2000, JCAHO began an accreditation program for assisted living facilities. The Commission on Accreditation of Rehabilitation Facilities and the Continuing Care Accreditation Commission also accredits assisted living facilities. However, only a small fraction of facilities have chosen to become accredited. Currently, the market strongly favors the facility and there is not public demand for accreditation. This will only change if there is more information to the public about accreditation.

The goal should not be to turn assisted living facilities into nursing homes. However, the current approach of many states to leave things primarily to the market is not working either. Federal regulation is appropriate for facilities receiving federal funding. It is time to stop pretending that assisted living is merely housing. State and/or federal regulation should clearly define a middle level of care—or more likely a number of levels—with standards for care and services, staffing, resident rights and such areas that are appropriate for that care.

¹ Eric Carlson, *Critical Issues in Assisted Living: Who's In, Who's Out, and Who's Providing the Care*, National Senior Citizen Law Center, 2005.

² Even if a state provides for a disqualifying medical condition, most also include a whole host of exceptions.

3 Eric Carlson, *Critical Issues in Assisted Living: Who's In, Who's Out, and Who's Providing the Care*, National Senior Citizen Law Center, 2005.