JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

November 9, 2026



Virginia's Assisted Living Facilities and In-Home Care Services for Older Adults

Commission Briefing

Study resolution

- Review the availability and quality of assisted living facilities and non-skilled in-home care for aging Virginians
  - number of providers, their capacity, and relative differences in supply by region
  - service quality and contributors to poor quality
  - effectiveness of state quality oversight
  - ways to enhance affordability

Commission resolution (December 2025)

Primary research activities

- Interviews with state and local agency staff, assisted living facility and home care agency administrators, assisted living and in-home care industry representatives and associations
- Surveys of assisted living facility administrators, VDSS inspectors, AAAs, and local department of social services staff
- Analysis of VDSS and VDH licensing, inspection, and complaint data; DARS in-home care data; Medicaid data; assisted living facility operating costs and staffing practices; and Census data
- Review of public assistance programs providing services for older adults in Virginia and other states
- Observations of VDSS inspections of assisted living facilities

AAA = area agency on aging, VDSS = Virginia Department of Social Services, DARS = Department for Aging and Rehabilitative Services, VDH = Virginia Department of Health

In brief

- Supply of assisted living and in-home care is often lowest in Virginia regions where older adults' needs are highest.
- Most older Virginians' income is not sufficient to afford assisted living or more than a few weekly hours of in-home care; many older Virginians own assets that can help pay.
- Auxiliary grant helps relatively few older adults afford assisted living; direct cash assistance or a Medicaid waiver could be more helpful and cost-effective.
- VDH's oversight of home care organizations is weak; licensure process allows ill-prepared businesses to operate, while required biennial inspections are years overdue and lack client interviews.

In brief (cont.)

- JLARC identified 122 facilities (21%) whose quality is cause for concern.
- Publicly available information about the quality of assisted living facilities is insufficient for older Virginians and their families to assess quality; other states publish much more.
- Virginia's assisted living facility staffing standards do not follow best practices and are widely viewed as insufficient.
- Complaints about assisted living facilities have increased, but VDSS inspectors' workloads prevent timely investigations into them.

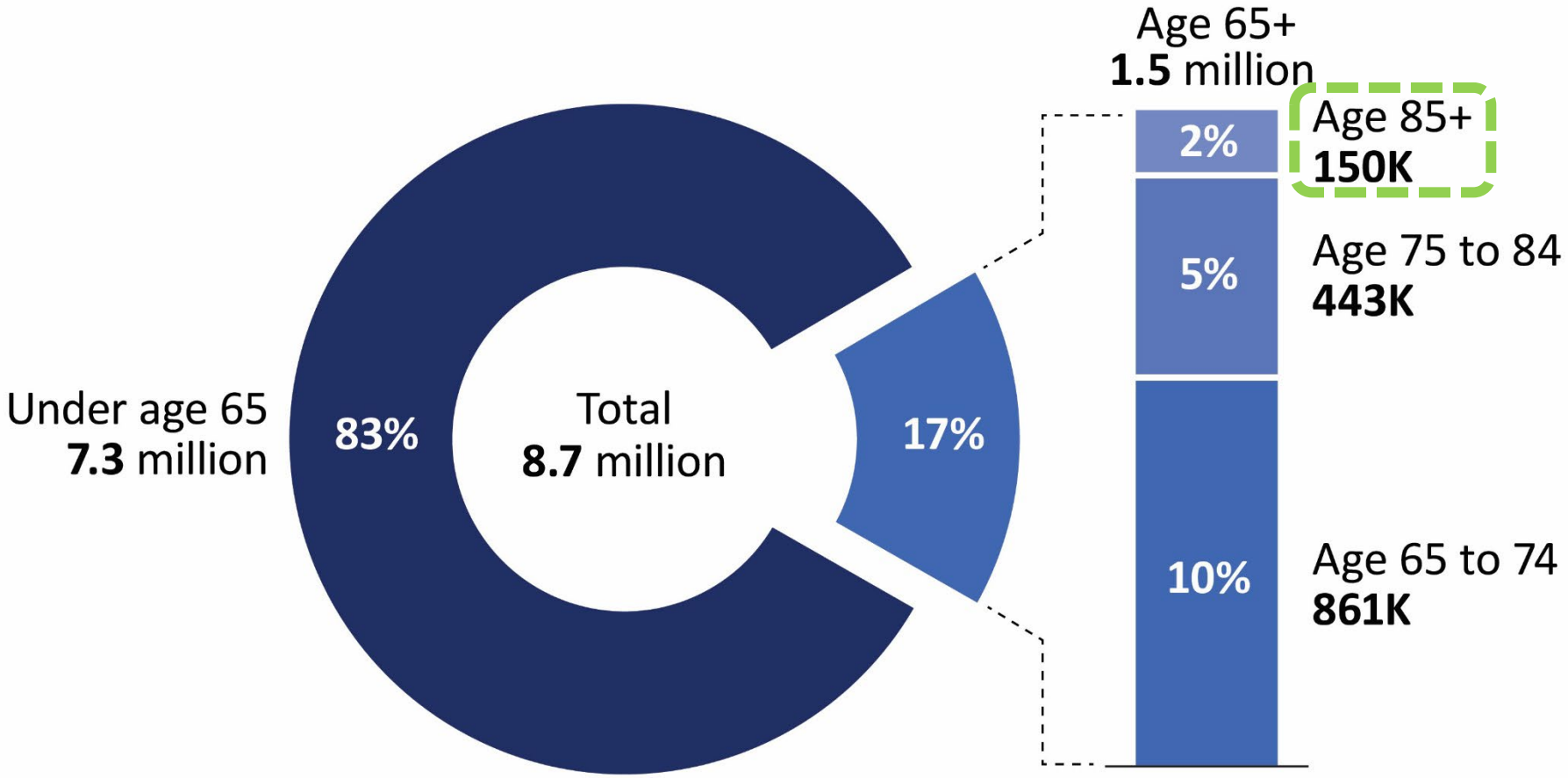
In this presentation

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Section 5	Quality and oversight of assisted living facilities

Section 1

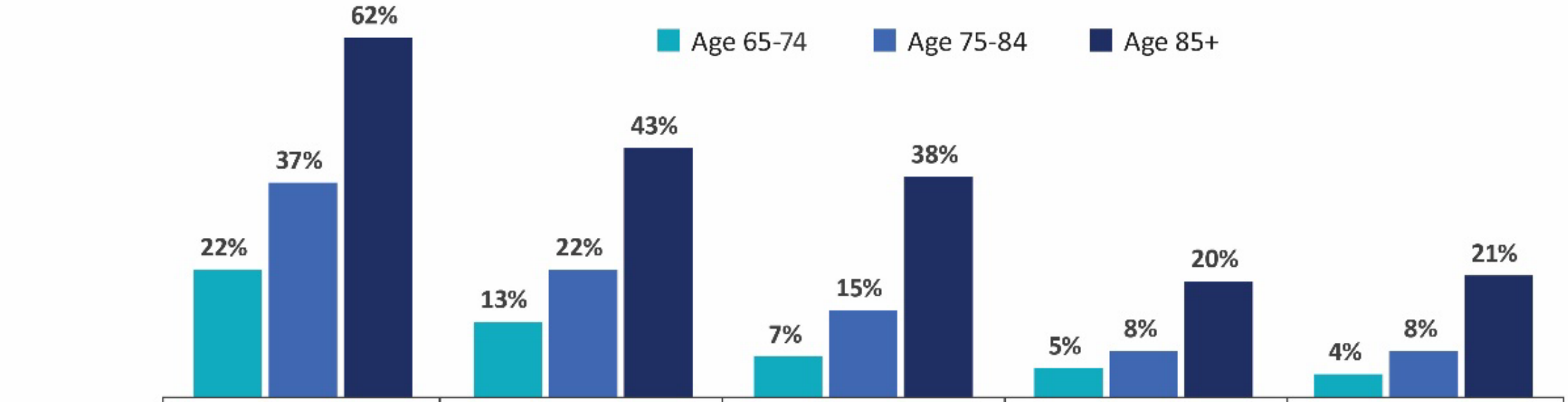
Background

Virginia's 1.5 million older adults (65+) are 17% of statewide population



2024 American Community Survey 5-year estimates.

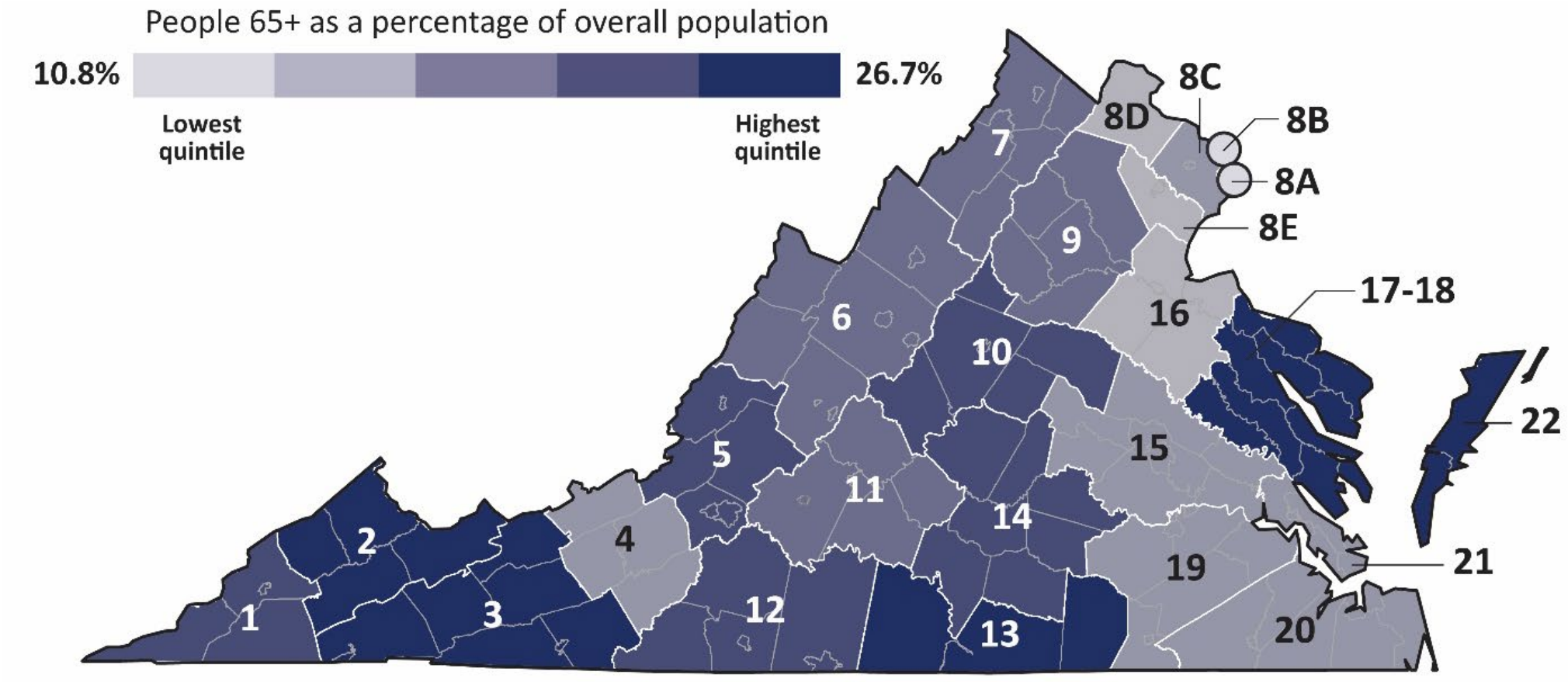
Older adults often have characteristics that indicate potential need for services and support



	Disability (one or more)	Ambulatory difficulty	Independent living difficulty	Cognitive difficulty	Self-care difficulty
Age 65+ (combined)	**31%**	**19%**	**12%**	**7%**	**7%**

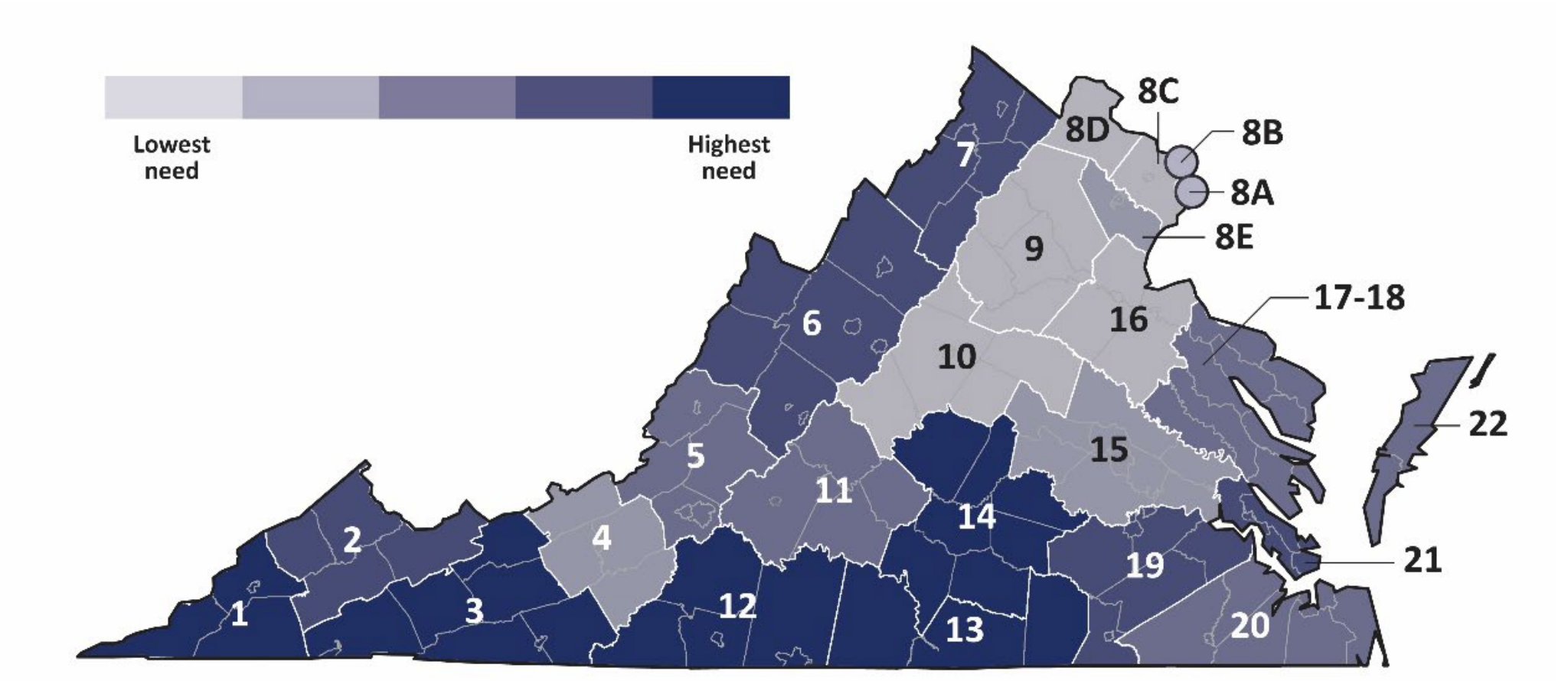
2023 5-year American Community Survey data prepared for JLARC by Weldon Cooper Center at the University of Virginia.

Virginia's rural regions have higher proportions of older adults, accounting for over one-quarter of population in some regions



U.S. Census Bureau 2024 American Community Survey 5-year estimates. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging.

Older adults in Southwest and Southside regions have the highest needs

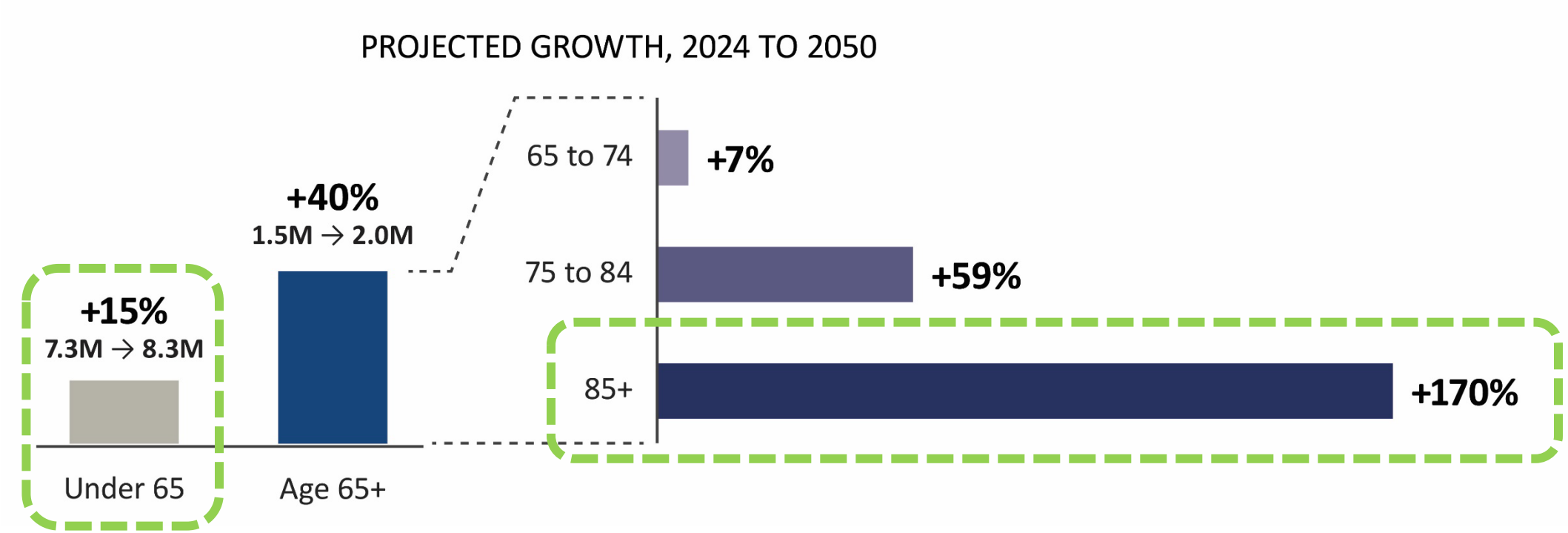


Overall need combines six measures, such as the share of older adults age 85+ or living alone. See Appendix D of written report for additional data about overall need by PSA. Regions are PSAs, which correspond to local area agencies on aging.

Older adults' financial resources affect their ability to pay for services and supports they need

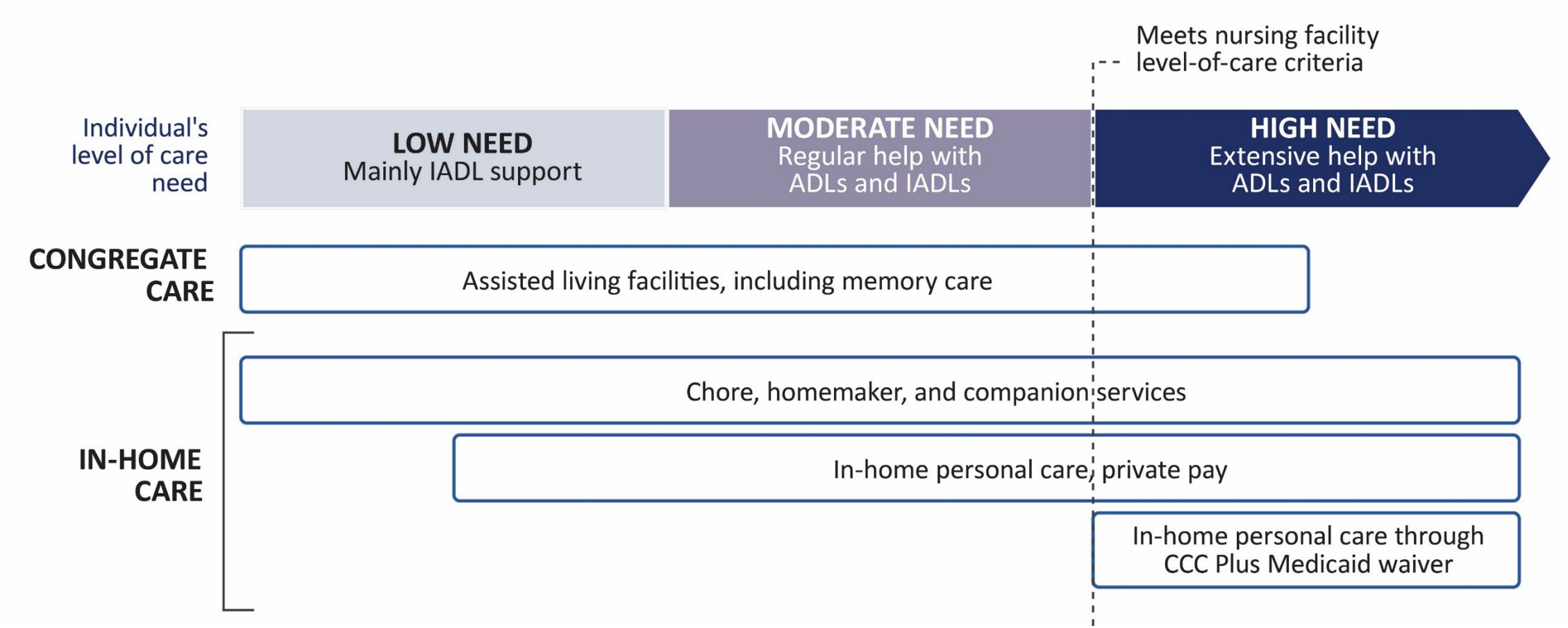
- Share of older adults below the poverty line ranges from about 5% in Loudoun to about 16% in far Southwest localities
  - 8% statewide
- Family median income ranges from ~$4,500/month in some Southwest localities to ~$14,000/month in Arlington
  - ~$8,600 statewide
- Over half of older adults in some Northern Virginia localities have more than $50,000 in individual income, compared with only 16 percent in some Southwest localities
- About half of older adult households have $500K+ in assets; about one in five have less than $100K

Older adult population projected to grow 40% by 2050, especially those age 85 and older



2024 American Community Survey 5-year population estimates and Virginia population projections from the Weldon Cooper Center at the University of Virginia.

Assisted living facilities and non-skilled, in-home care are part of a broader continuum of care and services for older adults



Nursing facilities and medical in-home care (e.g., “home health”) were excluded from study scope. IADL = Instrumental Activities of Daily Living. ADL = Activities of Daily Living.

About 30,000 individuals live in Virginia's assisted living facilities

- Virginia has 580 assisted living facilities, ranging from a few to over 300 residents
- Assisted living facilities provide three levels of care
  - residential: minimal help with daily activities (~6K residents)
  - assisted living: at least moderate help (~18K residents)
  - memory care: units for residents with dementia (~6K residents)
- About half offer memory care

Over 2,000 HCOs provide in-home care

- In-home care services help with daily activities, such as bathing, dressing, and mobility, as well as chores, meal prep, and companionship
- Home care organizations vary in size, ranging from 1 to over 1,000 direct care employees; most have 50 or fewer employees
  - ~38,000 direct care workers employed statewide
- *Total* number receiving in-home care is unknown; many pay privately
- About 39,000 older Virginians received publicly funded in-home care (FY25), mostly through Medicaid's CCC Plus waiver
  - AAAs and LDSS provide in-home care services to non-Medicaid recipients, but at a much smaller scale

AAA = area agency on aging. LDSS = local departments of social services. CCC Plus = Commonwealth Coordinated Care Plus, Medicaid's waiver for in-home care.

Section 2

Supply: Assisted living and in-home care

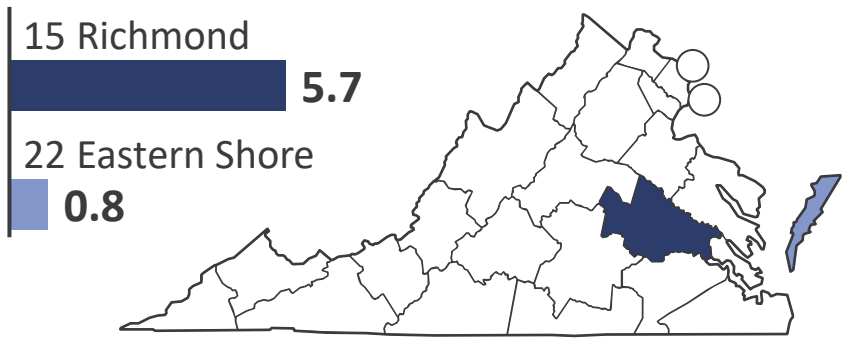
Finding – Assisted living facility and in-home care supply

Supply of assisted living and in-home care does not align with where older Virginians most need these services.

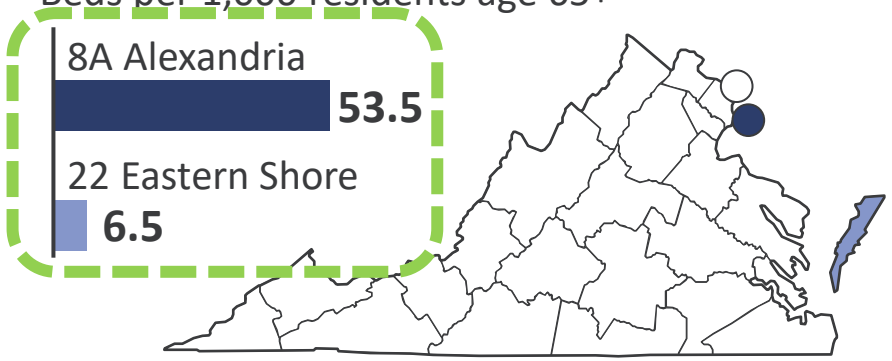
Assisted living and in-home care supply varies widely by region

ASSISTED LIVING

Facilities per 10,000 residents age 65+

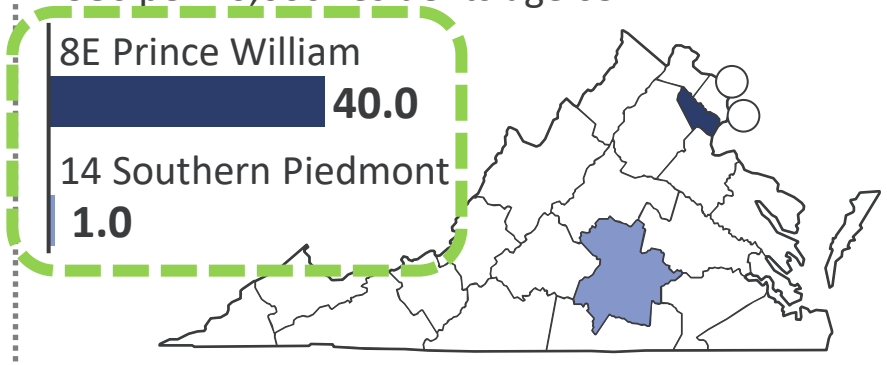


Beds per 1,000 residents age 65+

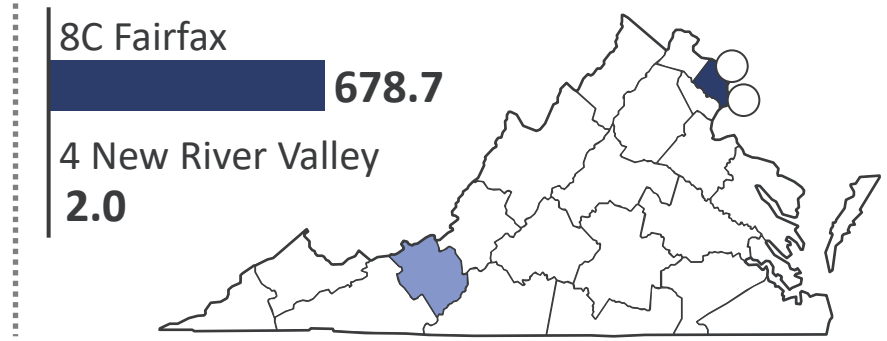


IN-HOME CARE

HCOs per 10,000 residents age 65+



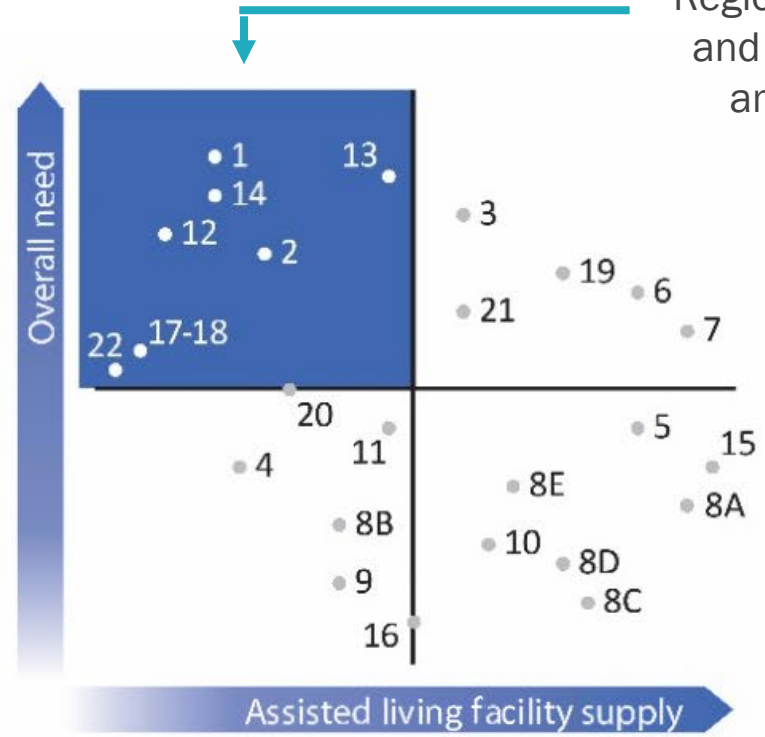
Direct care staff per 10,000 residents age 65+

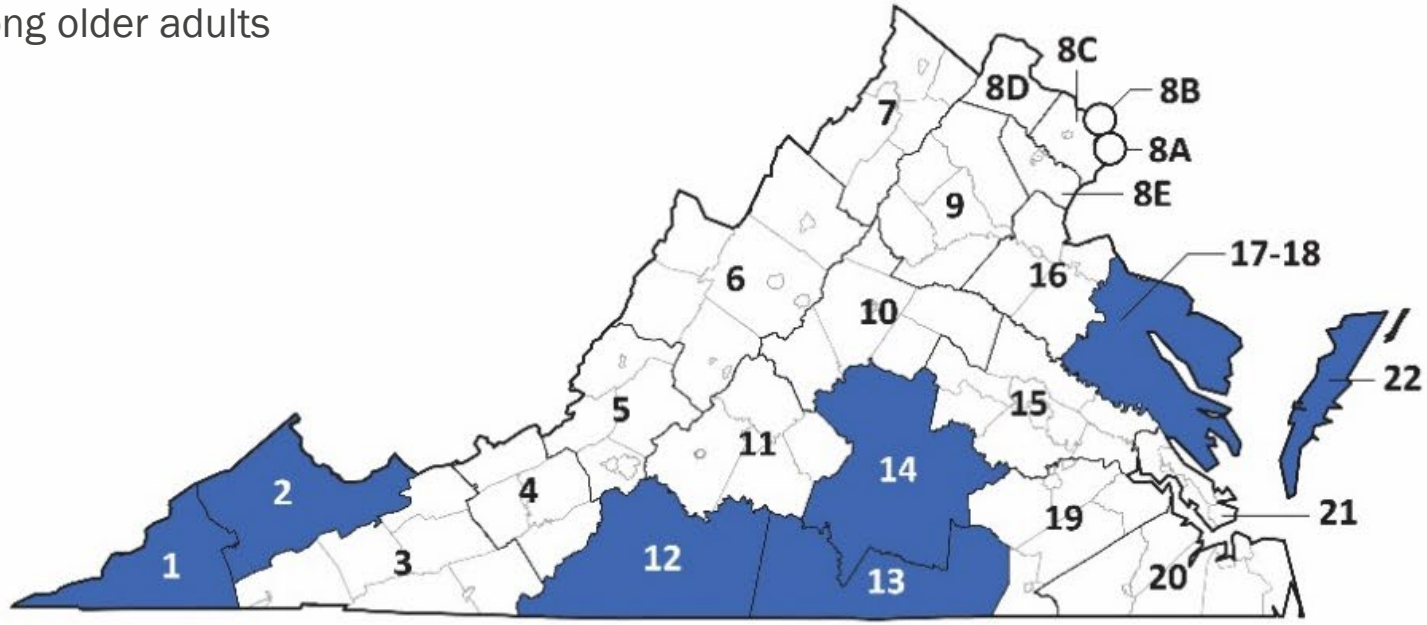


HCO = home care organization. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging.

Seven regions with lower assisted living supply have higher levels of need among older adults

Regions with lower supply and higher overall need among older adults





Regions are ranked based on average ranking across two measures of assisted living supply (beds per capita of older adults and facilities per capita of older adults) and across six individual measures of need. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging.

Need for memory care beds is especially high in some regions

- Substantial regional disparities exist in the availability of memory care beds
  - PSA 8A Alexandria has the highest memory care bed supply (150 memory care beds per 1,000 older adults with cognitive difficulty)
  - Three PSAs with the lowest supply (PSA 2 Southwest Coalfields, PSA 13 Southside, and PSA 1 Far Southwest) have 10 or fewer memory care beds per 1,000 older adults with cognitive difficulty
  - PSA 1 Far Southwest has no memory care beds across its five localities

PSA 1 localities include Wise, Lee, Scott, and Dickenson counties and the City of Norton.

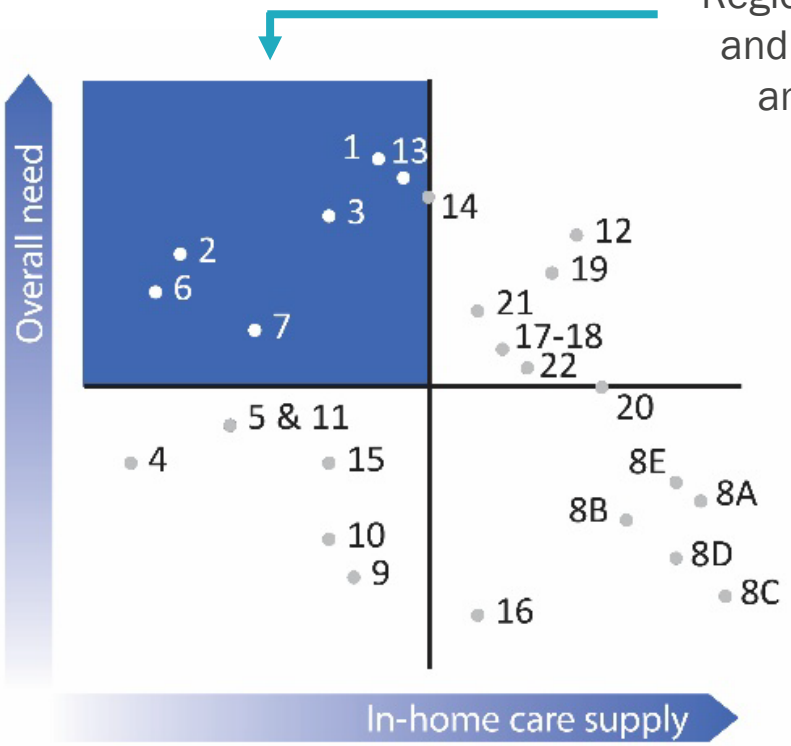
Most assisted living facilities report that they are full relative to staffed capacity, and about half report having waitlists

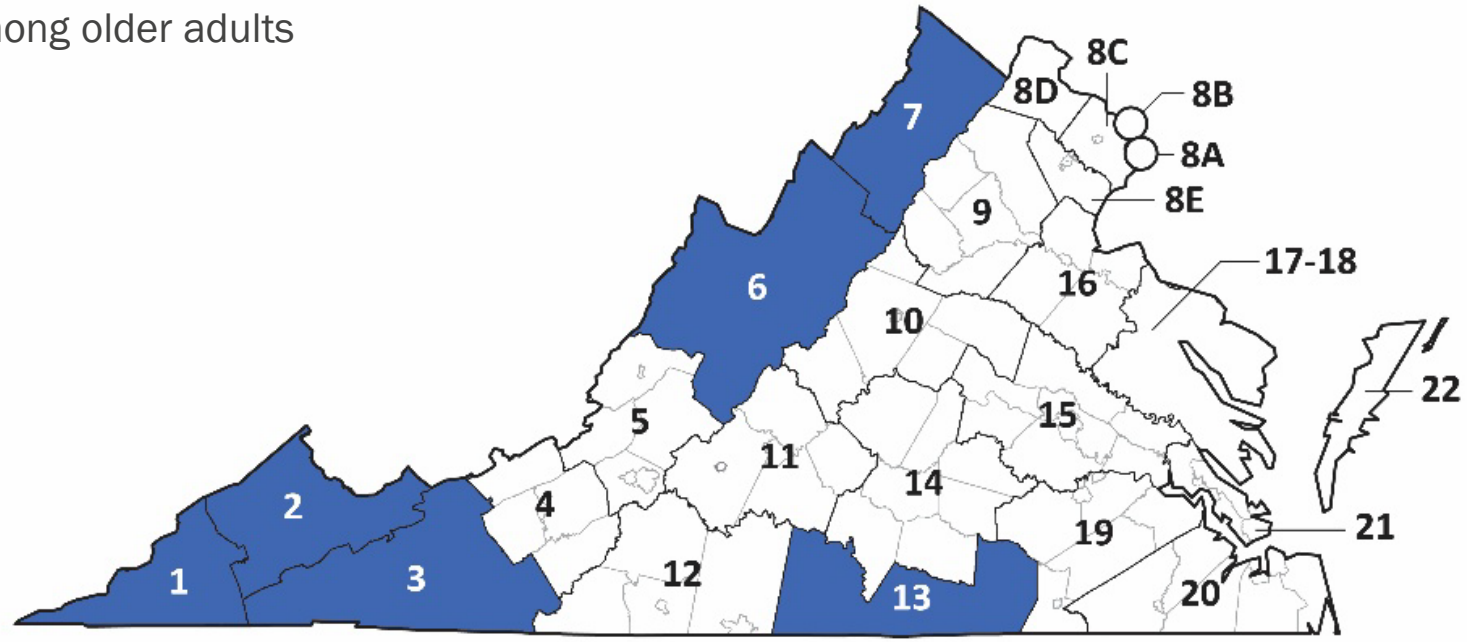
- JLARC surveyed assisted living facility administrators on facility capacity and waitlists. Facilities reported:
  - Being filled to about 80% of their licensed capacity, on average
  - Staffing constraints often prevent them from using all licensed beds
  - Being at 96% occupancy in terms of staffed capacity, with a majority being completely full
- 46% of facilities reported having a waitlist; the number of people on waitlists was equal to about 20% of their current residents, on average
  - Waitlists for memory care beds are longer (24% of current residents)

Staffed capacity = residents an administrator believes the facility can safely serve at current staffing levels. 160 facilities provided responses for the facility capacity and waitlist portion of the survey.

Six regions with lower in-home care supply have higher levels of need

Regions with lower supply and higher overall need among older adults





Regions are ranked based on average ranking across measures of in-home supply per capita of older adults (HCO providers, in-home care direct care workers, CCC Plus agency-directed in-home care recipients, CCC Plus consumer-directed in-home care recipients, and recipients of in-home care from AAAs and LDSSs) and across six individual measures of need. Regions are planning and service areas (PSAs), which correspond to local area agencies on aging.

Area agencies on aging provide in-home care to a broad population, but receive minimal state funding

- AAA-funded in-home care is available to a broader population of older adults than Medicaid-funded in-home care
  - Lower-income older adults not eligible for Medicaid
  - Must have some care needs, but not nursing home level of care
- AAAs spent $10 million on in-home care in FY25, with the state providing just one-third of the funding
- An estimated 3,200–5,500 eligible older adults have unmet need for the type of in-home care that AAAs provide, and waitlists are long
- Most AAAs currently provide these services and are willing to expand

Unmet need estimated by AAAs in response to JLARC survey.

Recommendation #1

The General Assembly may wish to consider including funding in the Appropriation Act expressly for area agencies on aging to expand in-home care services to older adults who are eligible but are not currently served.

Section 3

Affordability: Assisted living and in-home care

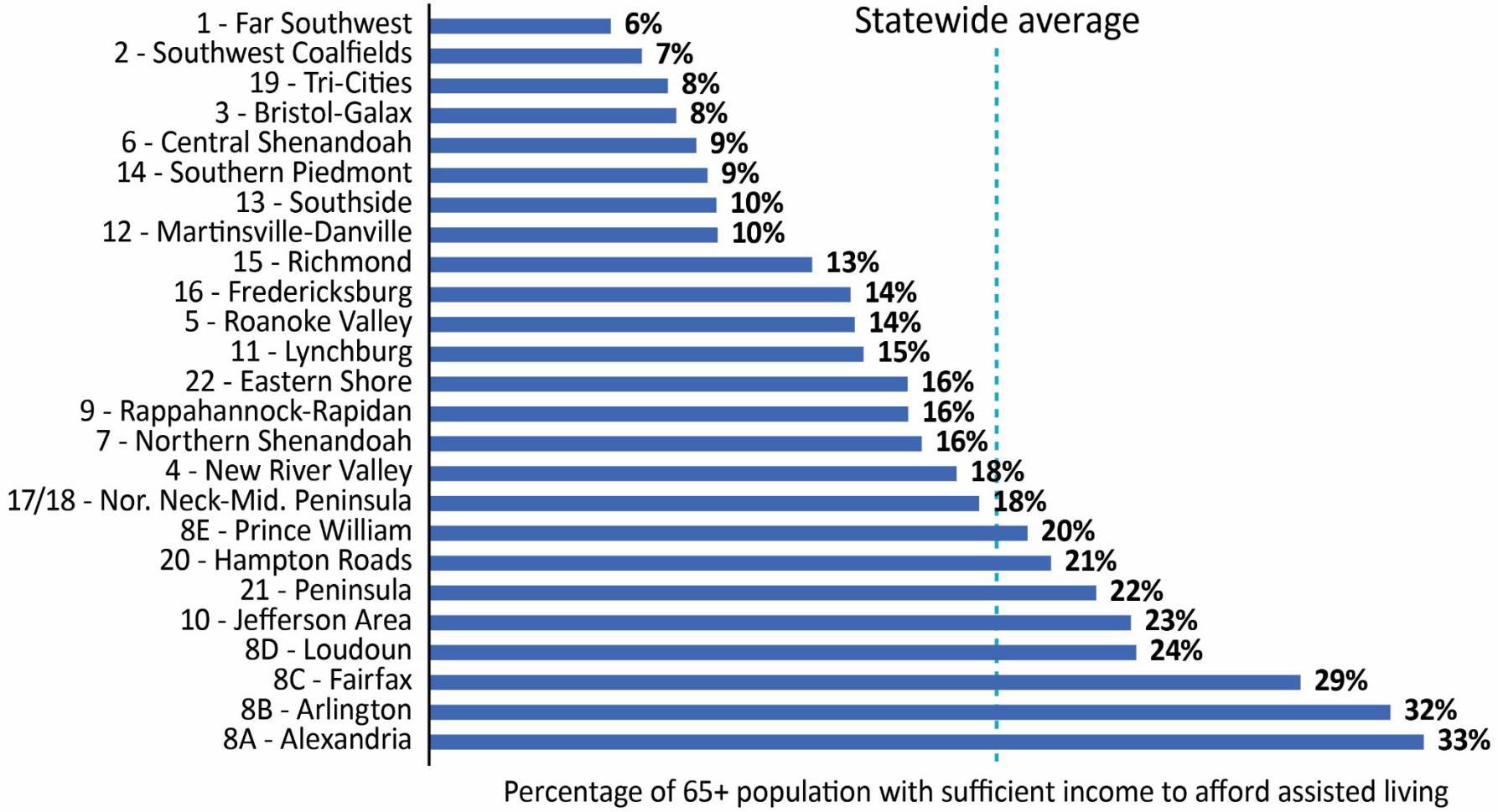
Finding – Assisted living and in-home care affordability

Most older Virginians do not have enough income to pay for assisted living or more than a few hours per week of in-home care.

Average monthly cost of assisted living was nearly $7,000 in 2025, up 32% since 2021

- Costs vary by more than 50% across regions, from ~$5,700 per month in PSA 7 (Northern Shenandoah) to ~$8,700 per month in Northern Virginia
- Memory care is about 30% more expensive than assisted living
- Private health insurance and long-term care insurance pay for these services in some instances, but Virginians mostly rely on their own financial resources

Though affordability varies widely across regions, only 18% of older Virginians have enough income to afford assisted living



Affordable = average cost is no more than 90% of individual income. Excludes assets. Values are rounded to nearest whole percentage.

In-home care costs less than assisted living, but is still unaffordable for many older adults

- Median cost is $35 per hour, or about $3,800 per month for 25 hours per week
- At 25 hours per week, nearly all older adults would be financially burdened paying for in-home care (i.e., spending 30% or more of their individual income)
- Affordability is typically lowest where need is greatest; 25 hours costs 78% of median family income in Far Southwest
- 38% of older adults have no excess income beyond basic living expenses and cannot afford any in-home care [a]

25 hours per week reflects a "typical" amount of in-home care. [a] Excess income is individual income remaining after basic living expenses, as measured by the Elder Index (Gerontology Institute, University of Massachusetts Boston).

When assets are included, most older adults can afford at least some care

- Nearly all older Virginians have assets (e.g., savings, home equity, retirement funds) in addition to their income that could help pay for care
- About four in five older adults could cover at least 14 months of assisted living or 26 months of in-home care using their assets
  - Nearly half could cover about six years of assisted living or 11 years of in-home care
  - However, about one-fifth could not cover more than a few months of either

Estimates do not factor in income. Assets are finite, and older adults using assets to pay for goods and services beyond care may exhaust their resources more quickly than timeframes specified here. Not all assets are available to be drawn upon in all cases.

Findings – Auxiliary grant program

State's auxiliary grant serves relatively few older adults and has not kept pace with assisted living cost growth.

Allowing direct cash assistance and expanding the auxiliary grant's use to in-home care could serve more adults.

Auxiliary grant makes assisted living more affordable for a small minority of facility residents

- Grant is state's only program to improve assisted living affordability
  - Income supplement for low-income aged, blind, or disabled adults who receive or nearly qualify for supplemental security income (SSI)
  - Recipients must need residential or assisted living level of care, meet income and assets eligibility, and live in an assisted living facility
- Just under 10% of assisted living facility residents receive auxiliary grant, and fewer than half of recipients are older adults
- Only about 1/3 of facilities house any grant recipients

Maximum rate paid to facilities excludes $87 personal needs allowance; monthly income eligibility threshold is $2,217 per month ($2,537 in Northern Virginia)

Eligible older adults often cannot find a facility that accepts the auxiliary grant

- Number of facilities accepting auxiliary grant recipients has declined each year, even after the General Assembly increased rate in 2024
- Fewer facilities accepting the grant means:
  - Individuals may have to relocate far from family, friends, and health-care providers
  - Some forgo care until they need a nursing facility, which is more restrictive and expensive
- About $9 million in appropriated funding went unspent from FY22–FY25 because participation was below funding levels

Low grant rate discourages facility participation, but increasing it to levels deemed sufficient by administrators would be costly

- Rate paid to assisted living facilities is $2,130 per month ($2,450 in Northern Virginia), compared to median private-pay charges of ~$7,000
- Insufficient grant rate is the top reason facilities do not accept the grant, cited nearly 3 times as often as the next most common factor
- Facilities cite rates of $3,300 (residential level of care) and $4,400 (assisted living level of care) as sufficient, which would require $38M to $79M in additional state funding at current participation
- These rates are facilities' own estimates; state has limited insight into actual costs of serving recipients

Structuring auxiliary grant program to allow direct cash assistance could serve more adults

- Eligible adults could use direct cash assistance for in-home care, housing, food, clothing, and other expenses
  - Older adults often prefer care at home and have advocated for in-home options
- Eligible adults would not need to obtain a scarce auxiliary grant bed in an assisted living facility to receive the direct cash assistance benefit
- Existing auxiliary grant could still be used for assisted living
- Could use the auxiliary grant's current functional criteria to determine eligibility for direct cash assistance
- To manage costs, the state would likely need to cap the number of people receiving direct cash assistance

Policy option #2

The General Assembly could allow individuals meeting the auxiliary grant's eligibility criteria to receive it as direct cash assistance to be spent on in-home care services as well as general expenses, and cap participation to control costs.

Finding – Medicaid waiver for assisted living care

A Medicaid waiver could be used to improve assisted living affordability, especially after federal rules change in 2028.

Virginia could soon use Medicaid for assisted living under new federal rules

- States can use Medicaid waivers to pay for services for low-income assisted living facility residents
  - 28 states use a Medicaid waiver for assisted living
- Existing Medicaid waiver rules require nursing-facility-level care, disqualifying most Virginia assisted living residents
- However, in 2028, states can apply for a Medicaid waiver to cover services for people with less acute needs, potentially assisted living residents
- Cost-effective way to improve assisted living affordability due to the 50% federal match; facilities could receive more revenue per participant compared to a program funded with only state and local funds

Policy option #3

The General Assembly could consider directing DMAS, in coordination with DARS and VDSS, to complete the research and administrative steps to apply for an assisted living waiver in 2028.

Section 4

Oversight of in-home care

Virginia Department of Health's Office of Licensure and Certification (OLC) licenses and inspects home care organizations (HCOs)

- HCOs provide non-skilled in-home care services (i.e., non-medical)
- OLC reviews HCO license applications, inspects new HCOs, and is required to inspect each HCO every two years
- Strong HCO oversight is critical to protect vulnerable individuals who are often receiving unsupervised care in their homes
- OLC also oversees other providers, such as hospitals, nursing facilities, and home health and hospice agencies

Finding – Initial licensure process

OLC's weak initial licensure process lets unprepared HCOs enter the market.

OLC's weak initial licensure process allows ill-prepared home care organizations to enter the market

- Many applicants are unprepared to complete the application or pass an on-site inspection
  - OLC staff provide prolonged assistance even though some applicants fail to improve or understand the nature of the work
- Statute and regulations lack explicit criteria for denying licensure, and staff believe they lack authority to deny a license application
  - "We don't deny licenses…We just work with them to get it." – OLC staff
- Process eventually licenses HCOs not prepared for operations

Recommendation #15

The General Assembly may wish to consider granting OLC explicit authority to deny HCO licensure applications.

Findings – Oversight of HCOs

State HCO ongoing oversight is weak, with rare in-home visits and a large inspection backlog.

OLC does not have enough inspectors to meet workload demands.

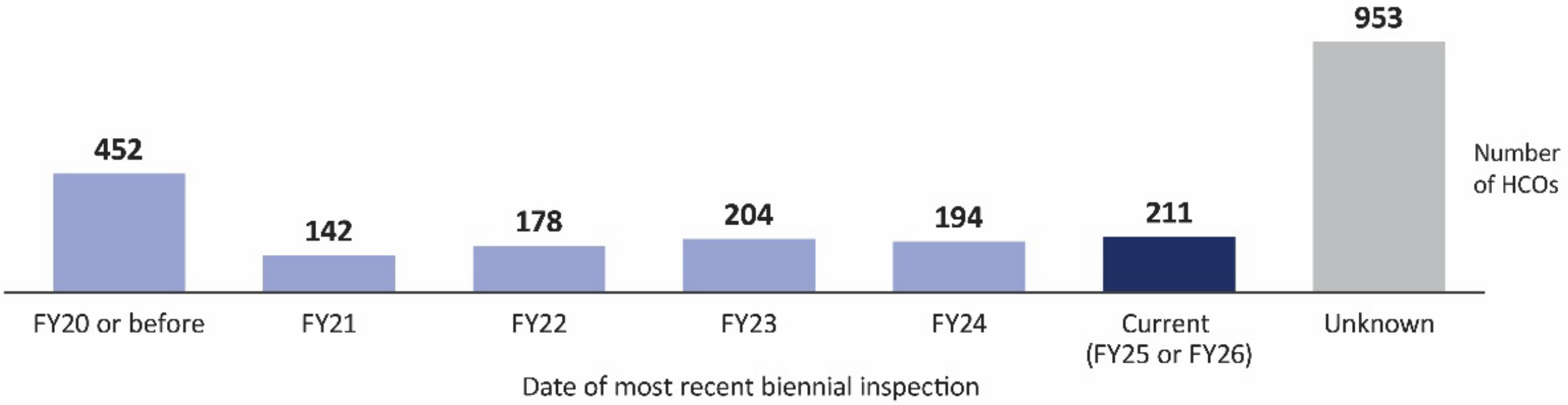
Lack of client contact is a major shortcoming in OLC's oversight

- Care is unsupervised, and clients may be alone when staff visit, making them especially vulnerable
- Inspections rely on in-office file reviews; home visits not required since 2012
- Without actual client contact, inspectors have no firsthand information on the quality of services
- Regulations already allow home visits; potential for visits would give HCOs an incentive to maintain or improve quality of services

Recommendation #18

OLC should immediately make in-home client visits and client interviews components of the biennial inspection for a sample of HCOs and protect clients' anonymity if desired.

About 90% of HCOs have not been inspected in the last two years; some have not been inspected in more than a decade



Note: OLC reported 2,123 of 2,334 active HCOs were not inspected in the last two years.

OLC could not conduct timely inspections even if fully staffed

- OLC HCO division has just 4 of 10 inspector positions filled and completes about 150 of 1,000 inspections due each year
- 96% of inspections that do occur find deficiencies; without inspections, noncompliant HCOs can operate without oversight or enforcement
  - Inspectors report increasingly serious complaints, such as falls, hospital trips, and mistreatment
- Even fully staffed, OLC could not keep up; JLARC estimates OLC needs about 10 more inspectors
  - Could take several years to clear the backlog even with additional inspectors

OLC could complete more inspections by addressing operational inefficiencies

- OLC does not use a regional approach to inspections: inspectors travel 5 to 10 hours in a typical week, resulting in lost work time
- HCO offices are frequently closed when inspectors arrive, causing inspector downtime and repeat visits, with no effective enforcement tools to compel compliance
- OLC could be more strategic and maximize limited staff time by prioritizing which HCOs to inspect:
  - A sample of overdue providers to maintain inspection unpredictability
  - HCOs that pose greater risk of noncompliance or have among the largest caseloads

Recommendations #22, #23, & #24

The Office of Licensure and Certification should:

- implement a regional approach for conducting its inspections of home care organizations.
- maximize existing inspection resources by selecting a random sample of home care organizations (HCOs) with overdue biennial inspections for inspection and prioritizing HCOs that pose greater risk of noncompliance or have a large caseload.

The General Assembly may wish to amend Code to authorize the Office of Licensure and Certification to levy administrative fines on home care organizations that are unavailable for an unannounced inspection during posted business hours.

Section 5

Quality and oversight of assisted living facilities

VDSS's Division of Licensing Programs (DOLP) oversees assisted living facilities

- DOLP issues licenses and monitors assisted living facilities' compliance with licensing requirements through annual inspections and complaint investigations
  - Inspections involve a tour of the facility, interviews with residents and staff, observing medication administration, and reviewing records
- JLARC staff used licensing violation and complaint data, as well as survey responses from key stakeholders*, to assess assisted living facility quality

*JLARC staff surveyed VDSS licensing inspectors, AAA staff, and LDSS staff for their perspectives on the quality of the assisted living facilities on their caseloads or in their service areas

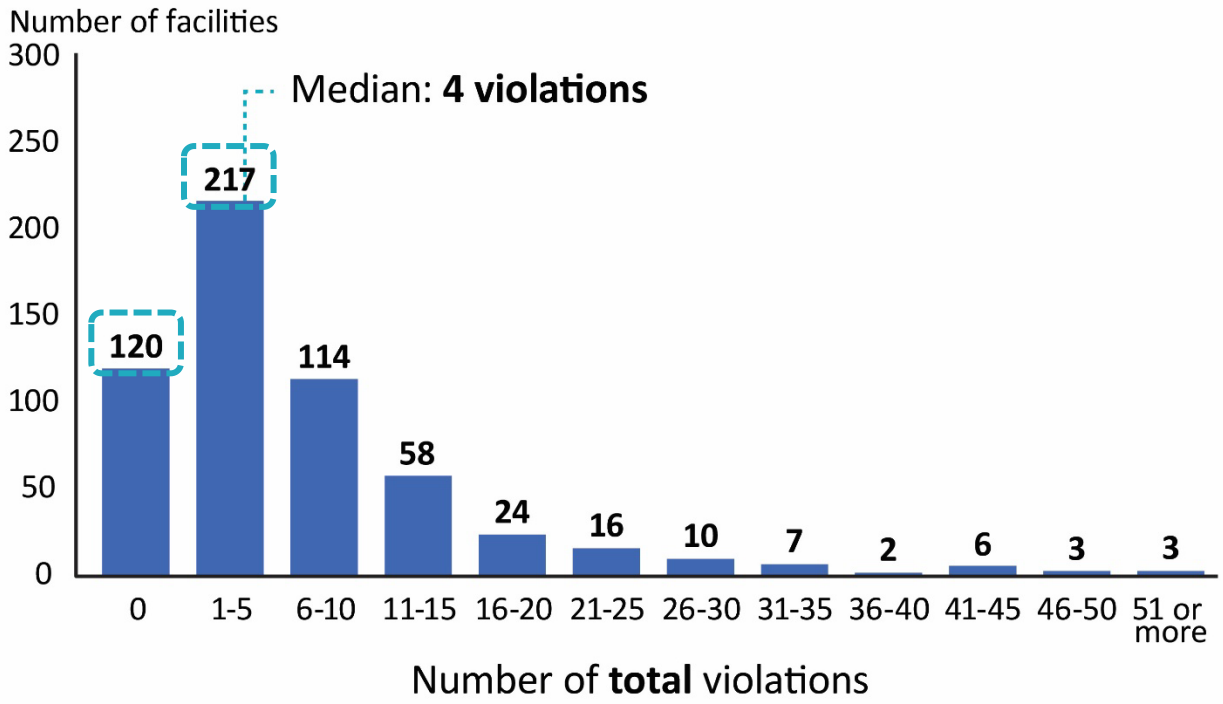
Finding – Assisted living facility quality

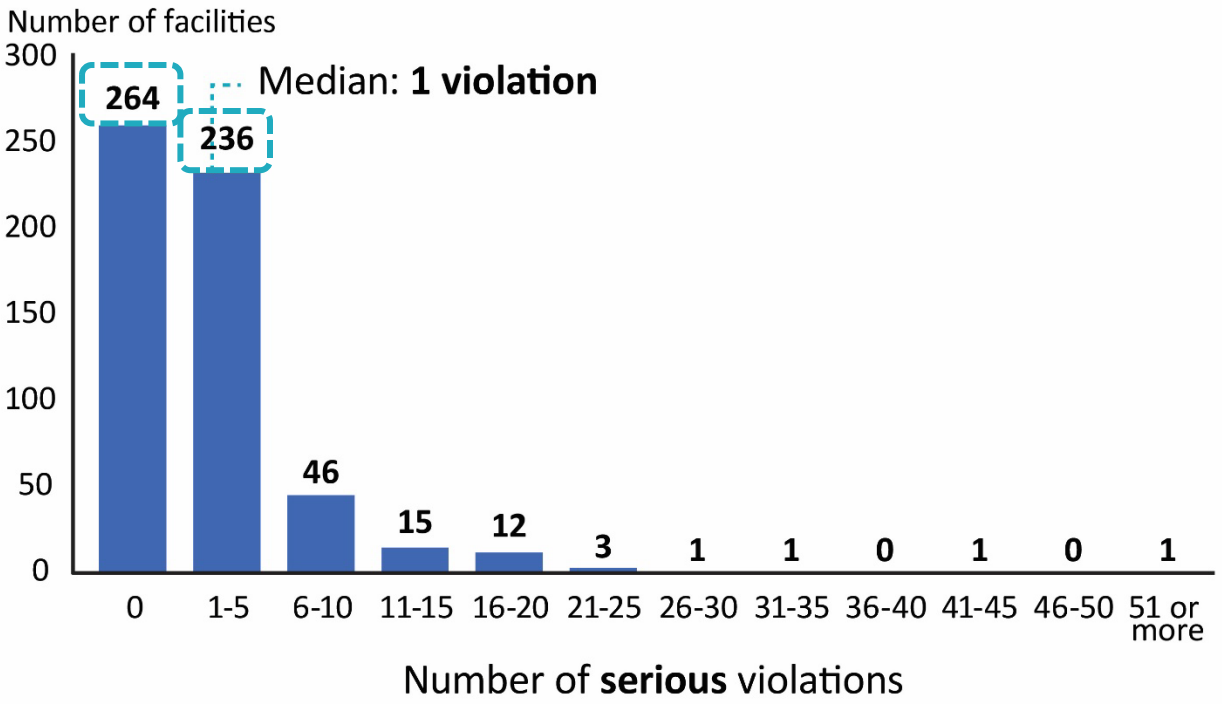
About 21% of assisted living facilities have indicators of a quality problem.

Public cannot easily evaluate and compare assisted living facility quality using the limited information available on VDSS's website.

Most facilities had few violations, though some were for critical issues

- Violations were concentrated in consequential areas related to resident care, including medication administration and individualized service plans





Assisted living facilities where quality is a cause for concern account for a disproportionate share of violations

- 122 assisted living facilities (21%) were identified as having a quality problem
- These facilities accounted for
  - 51% of *all* violations,
  - 65% of *serious* violations, and
  - 75% of substantiated incidents
- Facilities where quality is a cause for concern are disproportionately located in the Piedmont & Western VDSS licensing region [a]

[a] Regions are VDSS licensing regions, which are shown on slide 73. Quality problem indicators: total violations outlier, serious violations outlier, any C-3 violation (i.e., most serious type), substantiated VDSS/APS complaint outlier, or unanimous stakeholder concern. (See Chapter 3.)

17 facilities accounted for a disproportionately large share of violations and complaints

- These make up just 3% of all facilities, but account for
  - ~1,450 licensed beds
  - 17% of total violations and 26% of serious violations
  - 36% of C-3* violations
  - 20% of substantiated incidents
- Facilities are across VDSS licensing regions: Piedmont & Western (9 facilities), Fairfax (3), Northern & Valley (3), and Eastern & Peninsula (2) [a]
- Additional facilities had similarly concerning performance, but did not rank among the worst in their size tier or statewide

*C-3 violations represent VDSS's most serious violation risk rating indicating harm of extreme severity occurred or was imminent. [a] Regions are shown on slide 73.

Inspectors shared examples of poor resident care at facilities with quality problems

"There are prolonged periods without toileting, unanswered medical needs, pressure sores, and inadequate feeding assistance. Medications not received on time or [not] being re-ordered. Residents needing assistance with bathing/showering are not receiving it consistently. Residents that are incontinent are being left unattended in wet pads and clothing for long periods of time." – VDSS licensing inspector

"The residents are often unkempt with outdated, soiled clothing and body odor. There is a lack of attention to residents' individual needs…No one maintains their hair and they are not assisted with showers." – VDSS licensing inspector

VDSS's assisted living facility search tool omits available information that would help the public

- Current web-based search tool shows license type (e.g., residential only, assisted living, memory care), total capacity, and inspection results
- However, search tool omits some information
  - useful facility information (e.g., room types, typical charges, and auxiliary grant participation)
  - detail about the seriousness and consequences of violations, and instances of abuse, neglect, or exploitation by staff
- Reporting this information would require no new data collection, only modifications to how VDSS presents existing data

Scan for VDSS search tool

Recommendation #3

VDSS should publish on its public-facing assisted living facility search tool, by January 1, 2028:

- additional facility characteristics, such as room types, typical charges and fees, admissions criteria, and facility's auxiliary grant participation;
- the severity rating assigned to each violation;
- substantiated Adult Protective Services investigations against facility employees; and
- VDSS sanctions imposed on the facility.

Inspections assess compliance, which does not fully reflect quality of care

- Compliance is only one component of assisted living facility quality
  - Indicates whether a facility met requirements, not how well it performed
- Other pertinent quality measures are not tracked by VDSS
  - health and safety outcomes, such as ER visits and hospitalizations, fall rates, and elopements
  - resident and family satisfaction
  - staffing, such as turnover and care hours per resident

Publishing additional quality information would improve accountability and help families choose care

- Decisions to place someone in assisted living are often made quickly and under stress, such as after a hospitalization
- Collecting and publishing additional quality information could
  - help the public differentiate among facilities offering similar services
  - promote accountability by drawing attention to quality deficiencies
- At least 24 states collect more assisted living quality information than Virginia; Minnesota, Ohio, and Oregon publish it in easily accessible formats

Scan for MN

Scan for OH

Scan for OR

Policy option #1

The General Assembly could direct VDSS to:

- plan for a quality reporting system that would include resident satisfaction and health outcomes, and facility staffing information;
- pilot test the system; and
- make the system available to the public via the VDSS website.

The General Assembly could direct the Board of Social Services to require assisted living facilities to collect and report this information to VDSS as a condition of licensure.

Findings – Assisted living facility staffing and resident acuity

Insufficient staffing is a main contributor to assisted living quality issues.

Virginia's staffing standards are too general to ensure facilities are adequately staffed or to hold facilities accountable when they are understaffed.

Stakeholders identify staffing as the best predictor of assisted living facility quality

- Inspectors, AAAs, and LDSSs ranked insufficient staffing as the top factor affecting quality
  - Emphasized the need to have the right ***number*** of staff, as well as staff with the right ***qualifications and training***
- *"Residents pay their entire life savings to these facilities for bare minimum care or no care at all due to the lack of staff available to tend to residents in a timely manner."* – AAA staff
- *"Facility staffing is inadequate to meet the needs of residents in care, leading to increased serious neglect and [hurting] the quality of care."* – VDSS licensing inspector
- Research shows specific staffing requirements can reduce hospitalizations

Virginia's "sufficiency" standard does not ensure appropriate staffing

- Regulations require facilities to have "staff in sufficient numbers" to meet residents' needs
  - Require only one awake staff member per building; set no additional minimum staffing requirements, regardless of census or care needs
  - Memory care units ("safe, secure environments") are subject to additional staffing requirements (2 awake staff, increases with census)
- Inspectors often find facilities understaffed but cannot cite them because the facilities meet their own staffing plans and the minimal state requirements
  - *"Since there are no mandatory ratios…the facilities staff to the bare minimum."* – VDSS inspector

Key stakeholders support stronger assisted living facility staffing requirements

- Majority of VDSS inspectors said staffing regulations are too lenient
- All five VDSS regional licensing administrators support strengthening staffing regulations
- AAA and local social services staff, several administrators, and some providers also support explicit requirements
- Legislative reports dating back to 1979 identified Virginia's standard as inadequate

Staffing levels should be dictated by residents' needs

- Resident census and care needs vary substantially across assisted living facilities
  - Residents with complex care needs require significantly more staff time
- Insufficient staff to care for residents' needs can contribute to more falls, medication errors, and avoidable hospitalizations
- Experts report tying staffing to residents' care needs is most effective for ensuring quality of care

Recommendation #4

The General Assembly may wish to consider amending § 63.2-1803 of the Code of Virginia to:

- replace the current "sufficiency standard" for assisted living facility staffing with requirements that the number and types of direct care staff be determined by resident census and residents' care needs; and
- require the Board of Social Services to establish specific, detailed staffing standards for assisted living facilities.

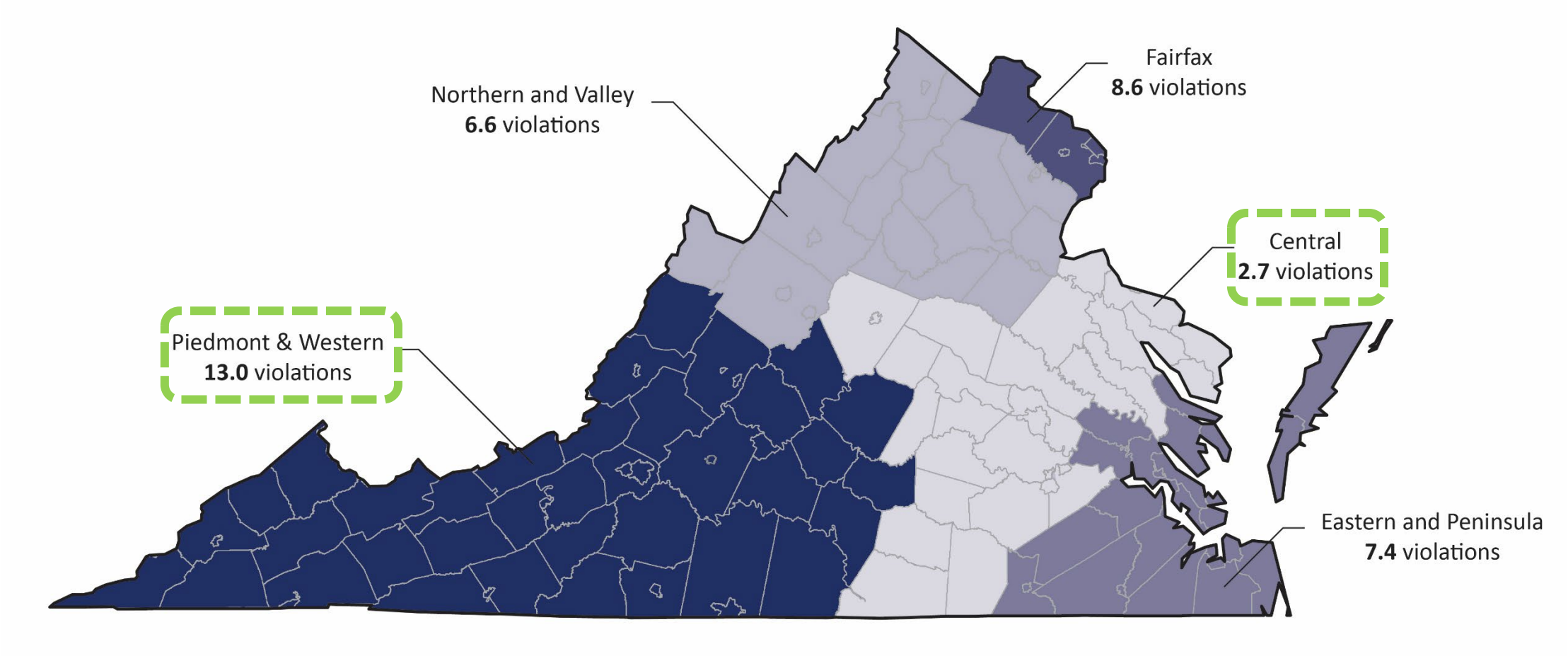
Finding – VDSS oversight

Stakeholders generally view VDSS oversight positively, but there are concerns about inspector inconsistency.

Stakeholders were generally positive but reported concerns about inconsistent inspection and licensing practices

- Most facility administrators say VDSS inspectors are knowledgeable, communicate clearly and in a timely manner
  - VDSS completed all mandated annual inspections on time in FY26
- However, some administrators reported concerns about inconsistency across licensing inspectors and licensing regions
  - *"Communities often experience variations in how requirements are applied, with similar situations receiving different responses depending on the inspector conducting the review."* – Assisted living facility administrator
- VDSS inspectors observed that they or their fellow inspectors followed inconsistent inspection and sanction practices
  - Inspectors reported that they would like additional training on carrying out inspections and determining violations

Variance in average number of violations across VDSS licensing regions suggests inconsistent inspector practices



Violations per facility in the region (2025). Variation exists within every facility size category.

Recommendation #5

VDSS should:

- identify the causes of regional variation in assisted living facility violation citations;
- develop clear guidance for inspectors on the agency's regulatory philosophy and expectations for inspection consistency; and
- provide additional training to inspectors on core inspection functions.

Finding – Assisted living facility oversight shortcomings

Complaints about assisted living facilities have been increasing, and VDSS inspectors are unable to respond to all complaints in a timely manner.

One annual inspection is insufficient to effectively oversee worst-performing assisted living facilities.

More complaints are straining licensing inspectors

- Complaints about assisted living facilities rose 21% between FY25 & FY26; now account for ~40 percent of inspector workload
- Inspectors prioritize mandated annual inspections, so some complaints go unaddressed for months
- Most inspectors reported that they are unable to investigate complaints in a timely manner
- Delays can leave residents exposed to unsafe or harmful conditions

VDSS inspects most assisted living facilities once per year, regardless of compliance history

- Facilities most likely to have recurring problems are not subject to any more mandated inspections than better-performing ones
  - Prior to 2010, facilities with weaker compliance histories were inspected up to three times per year
- VDSS has discretion to inspect facilities more than once per year, but does not regularly do so because of limited inspector capacity
- Other entities licensed by the state receive inspections more frequently than once per year (e.g., adult day centers, childcare centers)

Recommendations #7 & #8

VDSS should establish a special investigations unit, staffed by experienced licensing inspectors, to exclusively investigate complaints about assisted living facilities involving the greatest risk of harm to residents.

The General Assembly may wish to consider requiring VDSS to conduct an additional unannounced inspection each year of a randomly selected subset of assisted living facilities in each region that demonstrate indicators of poor performance or are otherwise high risk.

JLARC staff for this report

Tracey Smith, Associate Director

Joe McMahon, Chief Legislative Analyst

Dillon Wild, Senior Legislative Analyst

Mitch Parry, Senior Legislative Analyst

Hannah Garfinkel, Senior Associate Legislative Analyst

Parker Sims, Assistant Legislative Analyst