JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

THE VIRGINIA GENERAL ASSEMBLY

HOMES FOR ADULTS IN VIRGINIA

A report in a series focusing on individual and family services programs in the Commonwealth
December 10, 1979

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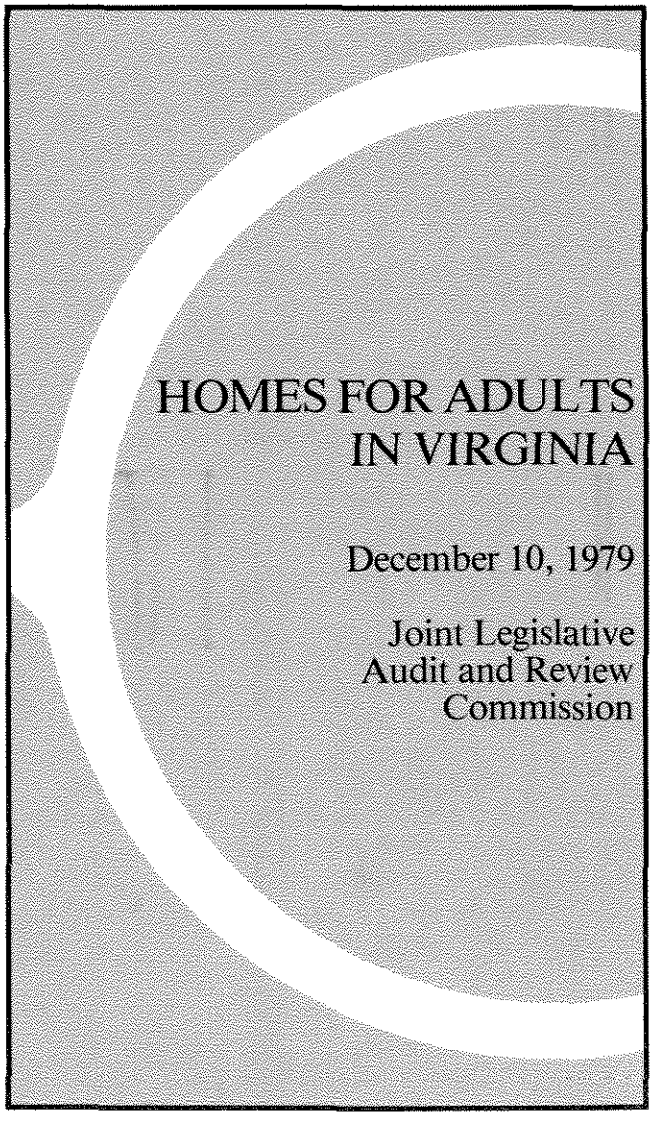


Homes for adults provide a basic level of domiciliary care services (room, board, and discernible supervision) to four or more aged, infirm, or disabled persons. In recent years, increasing demand for domiciliary care has reflected State efforts to (1) reduce inappropriate use of nursing homes, and (2) provide supervised housing for persons discharged from State mental institutions. As of July 1979, approximately 8,800 people were housed in 314 homes for adults located throughout the State.

Virginia has made a major commitment to ensuring adequate living arrangements in homes for adults. The State Department of Welfare (SDW) is responsible through its licensure and inspection functions for protecting the health, welfare, and well-being of residents. SDW also administers the auxiliary grant program which provides financial assistance to needy residents. Such assistance amounted to $3.7 million in general fund appropriations in FY 1978 for 2,500 recipients.

A JLARC REPORT SUMMARY

A total of 48 licensed adult homes were visited during the course of this evaluation. Many of these homes were found to provide a satisfactory level of care and owners appeared to be concerned about the mental and physical well-being of their residents. But on-site assessments also revealed that some licensed homes operate with significant violations of licensure standards. Current problems stem from both the failure of some operators to comply with minimum licensure requirements and from administrative weaknesses in the licensure and auxiliary grant programs.

QUALITY OF RESIDENT LIFE

Significant violations appeared to be prevalent in homes which primarily accept mental aftercare patients and auxiliary grant recipients. Furthermore, owners of these homes are not always subjected to routine fire safety inspections and are frequently unprepared to deal with the special needs of mental aftercare patients.

Food Service, Nutrition, and Sanitation (pp. 14-23)

SDW has developed explicit standards for adult homes concerning food supply, nutrition, and sanitation. Major violations of food service standards were found in 15 homes visited by a professional nutritionist employed by the State Department of Health. These findings, combined with the observations of JLARC staff visits, resulted in a special report to the Commission and a subsequent investigation of adult homes by the Department of Welfare.

Special JLARC Report. Serious problems were found in nutritional inspections regarding inadequate food supplies and low nutritional content. Some homes did not plan nutritious

meals and, at times, meals inferior to those reported on daily menus were actually served to residents. Therapeutic diets were not routinely provided, although physical ailments of residents required them.

Violations of sanitation standards ranged from inadequate refrigeration temperatures to filthy conditions. Some homes visited did not have a routine maintenance program for the control and prevention of flies, roaches, or vermin; and food was often improperly stored.

At some homes, violations appeared so serious in terms of compliance with rudimentary standards related to food service and sanitation, that immediate remedial action was deemed necessary. Therefore, preliminary findings were discussed at an August 1979 JLARC meeting and shared with the Commissioner of Welfare.

SDW Investigation. As a result of the special report, the Commissioner undertook a crash investigation program consisting of team inspections of 144 licensed adult homes throughout the State. These inspections confirmed many of the violations found during the course of the earlier visits, and provided the Department of Welfare a formal basis for corrective action and official sanctions.

As part of an ongoing corrective effort, JLARC recommended that SDW emphasize compliance with standards for food service and sanitation during regular licensure inspections. Homes with auxiliary grant or aftercare residents and low food costs should receive priority attention. SDW was also asked to arrange for training for licensees and licensing inspectors, and for a professional nutritionist to supplement some inspections.

Fire Safety (pp. 23-24)

Fire safety is of primary importance in physical facilities that house elderly and disabled individuals. Despite the responsibility of State government for licensing adult homes, the State Fire Marshall lacks inspection authority for over one-third of the homes — the 114 homes with fewer than ten residents. These facilities house a high proportion of auxiliary grant recipients and individuals discharged from State mental institutions and may not be regularly inspected. The General Assembly may wish to consider amending the *Code of Virginia* to provide the State Fire Marshall with authority to inspect all licensed homes for adults.

Aftercare Services (pp. 24-27)

Homes for adults are required to provide for the supervision of residents who are mentally ill. However, licensure standards in use during the course of this evaluation did not adequately address the service needs of aftercare residents.

As many as 2,000 residents of adult homes have been discharged from State institutions for the mentally ill and mentally retarded. Licensees have generally been unprepared to deal with the unique behavioral and medical needs of these residents. Moreover, the mental health system has not developed adequate procedures to discharge, place, and follow up former patients in the community (these issues are addressed in the JLARC report *Deinstitutionalization and Community Services*).

New licensing standards are intended to increase access to community mental health services by aftercare residents in adult homes. However, the cooperation of the Department of Mental Health and Mental Retardation (DMHMR) is necessary to provide training to adult home staff and improve the outreach capability of mental health and mental retardation Community Service Boards. DMHMR should also require State hospitals to place aftercare clients only in adult homes which are in substantial compliance with licensing standards.

LICENSURE AND MANAGEMENT

The purpose of the licensure program for adult homes is to protect the health, safety, and welfare of residents. The State Board of Welfare has adopted explicit standards to ensure at least a minimum quality of resident life. However, weaknesses in the licensure and enforcement process have resulted in failure to correct significant violations of standards by home operators and to detect the operation of illegal homes.

Inspection and Supervision (pp. 33-38)

Compliance inspections conducted by SDW's licensing specialists are of limited effectiveness. Licensing specialists routinely provide home operators with advance notice which may allow the licensee to hide or temporarily correct deficiencies. Violations of standards are not routinely followed up by specialists to ensure correction.

There is reason to question whether some licensing staff adequately inspect, observe, or report violations which exist in homes, particularly in the areas of food service and sanitation. Violations in these areas are infrequently cited although significant violations were found by the health department nutritionist and by SDW special inspection teams.

The Commission recommended that SDW take steps to correct weaknesses in the inspection process. For example, all compliance inspections should be conducted without advance notice to licensees. The General Assembly may wish to specify this requirement by amending Section 63.1-177 of the *Code of Virginia*. Follow-up inspections should take place with specified frequency and within time periods determined by the seriousness of the violations cited. Violations which relate to residents' health and safety should be aggressively followed up.

Sanctions (pp. 38-41)

Existing sanctions do not appear to be effective in enforcing correction of licensing violations, and there are no intermediate sanctions between a warning, and revocation or denial of a license.

SDW has tried to use provisional licensing as an enforcement sanction. However, as presently administered the provisional license has little effect in inducing compliance. Approximately one-third of all homes operate with provisional licenses (renewable for six-month periods up to two years). These homes receive full benefits of licensure; and once a home has operated for an extended period with a provisional license, it is difficult to deny or revoke a license. In effect homes "wait out" the provisional licensing period.

Effective licensing sanctions need to be developed. Administrative or legislative action could restrict the use of the provisional license to short periods of time. Issuance of an annual license should only be done if it is contingent upon correction of the violations which required granting the provisional license in the first place. SDW was also asked to identify new intermediate sanctions for legislative consideration.

Illegal Activities (pp. 41-45)

Under State law, a license is required for any facility which provides room, board, and discernible supervision for four or more aged, infirm, or disabled adults. State law also requires that the maximum number of persons for whom an adult home may care be stipulated in the home's license. Despite these statutory requirements, homes operating with excess capacity or without a license appear to exist throughout Virginia.

SDW should develop an active program to seek out illegally operating adult homes. This effort should include the use of specialized staff and procedures to identify illegal homes and ways to bring them into compliance with licensing standards.

Central Office Role (pp. 45-50)

Significant variations in implementation of licensure requirements indicate there are, in effect, seven adult home licensing programs, one in each region. Active monitoring of adult home licensing decisions and inspections can enhance the quality of decisions and uniformity of enforcement among regions.

The licensing division's central office staff should be given responsibility to ensure greater uniformity in the enforcement of standards. The director of the licensing division should review in advance the issuance of each provisional adult home license as well as the revocation of licenses as is now done. Central office monitoring of routine regional licensing decisions should include case audits of licensure procedures by on-site verification.

AUXILIARY GRANT PROGRAM

The auxiliary grant program represents a growing source of income for many adult homes, and in some cases it is the only source of income for residents other than federal supplemental income (SSI) payments. SDW needs to develop a more systematic approach to rate setting based on reliable cost data. In addition, improved coordination is needed between the auxiliary grant program and licensure. Gaps in coordination have led to auxiliary grant abuse in some cases.

Rate Setting (pp. 51-58)

Auxiliary grant rates have more than doubled over the last five years despite the absence of data that accurately reflect the cost of operating an adult home. The maximum monthly grant as of July 1979 was $372. Licensees annually

submit cost reports to SDW, but the department has not regularly audited or verified these reports.

The need for audited data was illustrated in mid-1979, when SDW began an audit program which focused on one "typical" home from each of its seven regions. According to these audits, monthly rates set for four of the seven adult homes were inaccurate.

CONTRAST BETWEEN REPORTED AND AUDITED COSTS, SEVEN HOMES FOR ADULTS

	Per Resident		
Licensed Bed Capacity Range	Reported Monthly Costs	Audited Monthly Costs	Error in Home Monthly Rate
20-49	$338	$268	$ 68
20-49	336+	321	15
50+	365	175	161
50+	339	319	17
20-49	336+	336+	Error[1]
20-49	336+	336+	Error[1]
20-49	336+	336+	Accurate

[1]Data for these homes were mis-reported and in error; however, actual costs exceeded maximum allowed rate.

SDW should take steps to improve the basis for setting monthly adult home rates. Guidelines should be established for a monthly rate which includes allowable costs and an equitable rate of return. Cost data audited by SDW or certified by an independent auditor retained by the home should be used when setting monthly rates for individual homes.

Monitoring Eligibility and Payments (pp. 58-64)

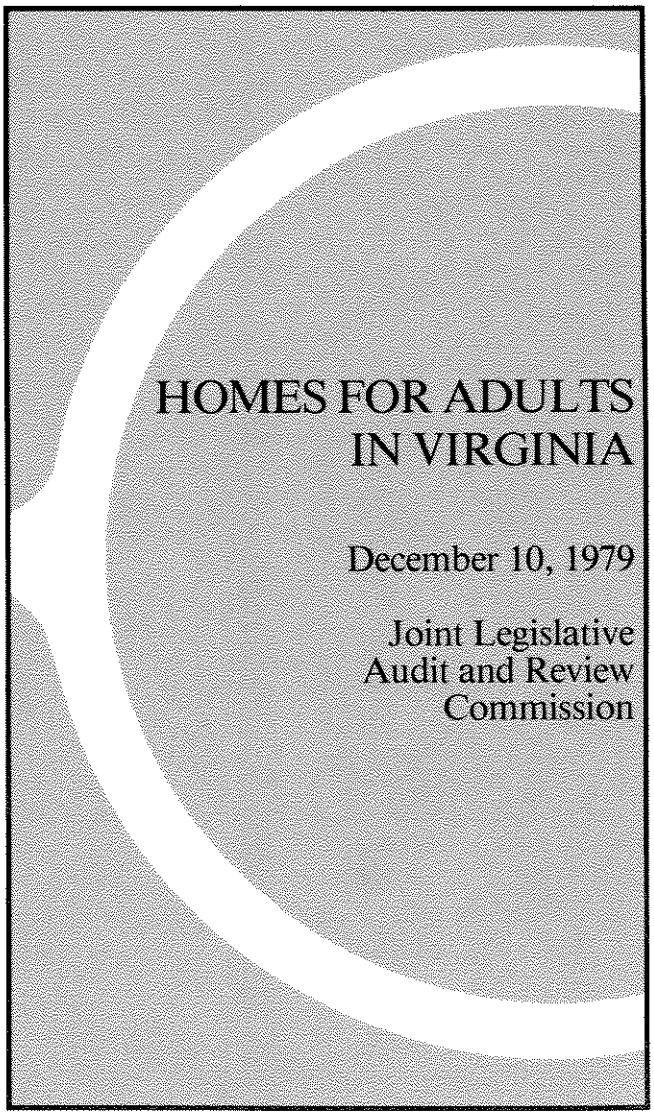
Neither SDW nor local welfare agencies effectively monitor the continued eligibility of auxiliary grant recipients. Some persons who did not meet the program requirement of residence in a licensed home have nevertheless received auxiliary grant payments. Currently, monitoring is the responsibility of local welfare agencies who may make payments to recipients in distant parts of the State where on-site verification is difficult.

SDW needs to establish improved fraud and abuse controls over auxiliary grant payments. This can be accomplished through the identification of homes and recipients on auxiliary grant checks and check registers, and acknowledgment of receipt of payments by residents. Additionally, adult home licensing personnel should be trained in the requirements of the auxiliary grant program and have routine access to grant information for residents of homes they inspect.

CONCLUSION

Homes for adults are becoming an increasingly important housing option for the aged, infirm, and disabled. The Commonwealth plays a key role in regulating homes and in providing financial assistance to impoverished residents. Despite this role, there is no clear focus of responsibility in the Department of Welfare for planning, coordination, and implementation of adult home activities.

SDW needs to develop a programmatic approach to managing its adult home activities. This approach should specify the methods and staffing needed to achieve the goals and objectives of the adult home program, and appropriate ways of coordinating adult home activities with other State agencies.



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I. Introduction

Homes for adults provide housing options for aged, infirm, and disabled people. There are 314 licensed adult homes in Virginia. These homes, which range in size from four to 502 beds, provide domiciliary care for their residents. The demand for this type of care has increased dramatically in recent years as a result of State policies designed to (1) reduce inappropriate use of nursing homes, and (2) provide supervised housing alternatives for people discharged from State facilities for the mentally ill and mentally retarded.

Over 8,800 people live in adult homes. Many of these residents are unable to protect their own interests and must rely on others for essential services. The State Department of Welfare (SDW) is responsible through its licensure and inspection functions for ensuring that residents receive an adequate level of care. The State's involvement with adult homes, however, extends beyond regulating their operation. Approximately 2,500 residents currently receive financial assistance for housing through the auxiliary grant program. Such assistance amounted to $3.7 million in general fund appropriations during FY 1978-79.

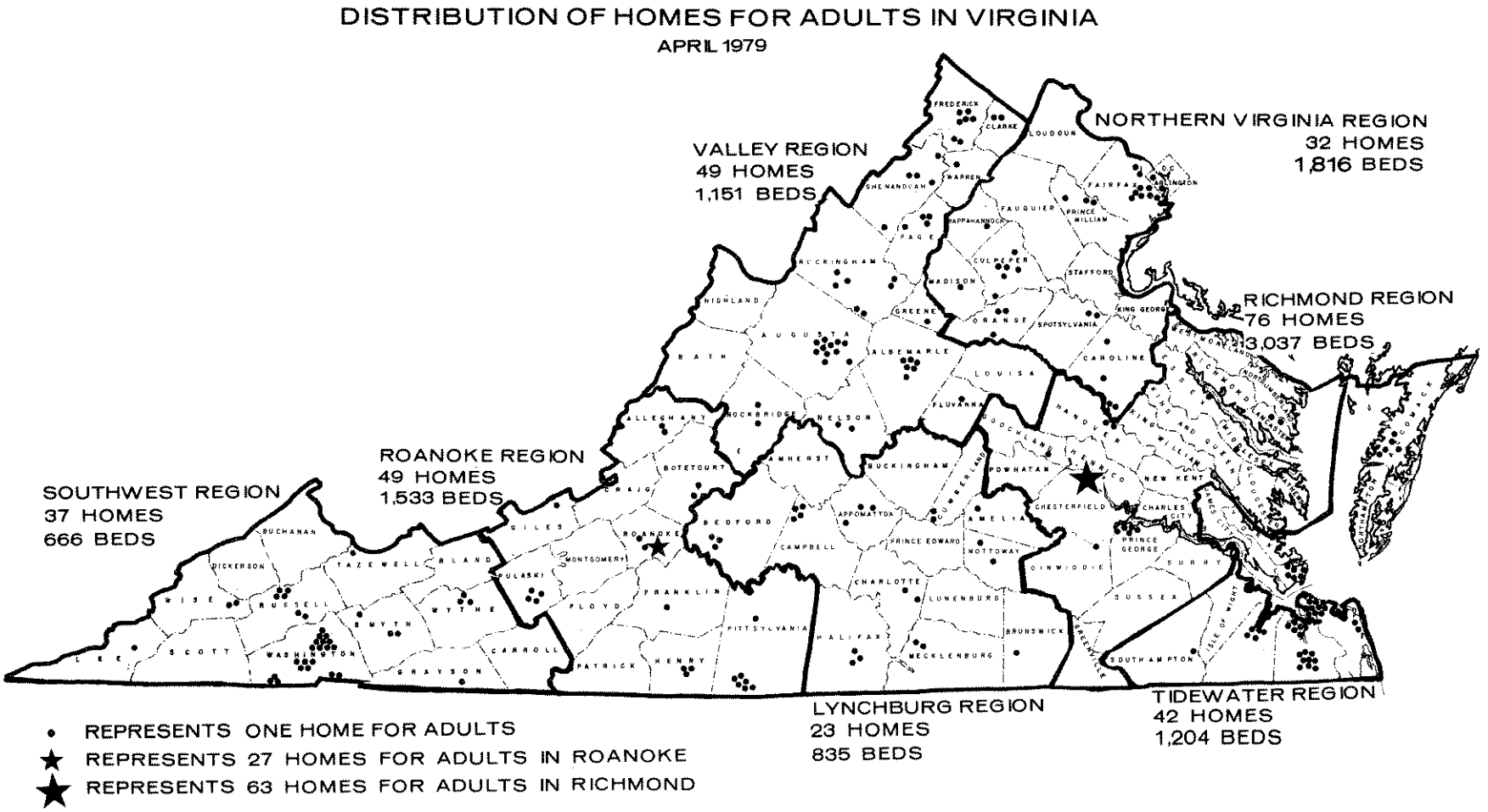
A total of 48 licensed adult homes were visited during the course of this study. Many of these homes were found to provide a satisfactory level of domiciliary care and appeared to be concerned about the mental and physical well-being of their residents. But on-site assessments also revealed that some licensed homes were operating with significant violations of licensing standards. In these instances, the Commonwealth could be giving financial assistance for an expected standard of care which the residents are not receiving.

Current problems stem from both the failure of home operators to comply with standards and from weaknesses in the licensure, inspection, and auxiliary grant programs. SDW needs to give priority to a vigorous program of supervisory and compliance inspections and appropriate enforcement actions, in order to bring all adult homes up to minimum standards.

PUBLIC SECTOR INFLUENCES

The General Assembly recorded its intent in Section 63.1-174 of the *Code of Virginia* when it required the State Board of Welfare to adopt "reasonable regulations governing the construction, maintenance, and operation of homes for adults." These regulations, which have been revised twice since 1974, apply to any home providing room, board, and discernible supervision to four or more aged, infirm, or disabled adults.

Figure 1



Source: JLARC representation of data from SDW's April 1979 Directory of Licensed Homes for Adults and Adult Day Care Centers.

SDW has reorganized and expanded its licensure activities in the past few years. The licensure program was decentralized into seven regions in 1975. Increases in staffing accompanied this regionalization, and the department now has 32 licensing specialists in the regional offices who license homes for adults and six other types of facilities.

Licensed homes for adults are distributed throughout the seven State regions (Figure 1). The Richmond region has the largest number of homes (76), while the Lynchburg region has the smallest number (23). The largest number of licensed adult home beds (3,037) is also in the Richmond region, while the Southwest region has the smallest number (666). A profile of Virginia's adult homes and their residents is shown in Figure 2.

Expansion in the number of beds in licensed adult homes has been a long-term growth characteristic of the industry. Between 1970 and 1979, the licensed bed capacity in homes increased by 72 percent. The number of licensed adult homes grew by 26 percent during the same period. Recent federal and State actions have contributed to this growth.

Federal Actions

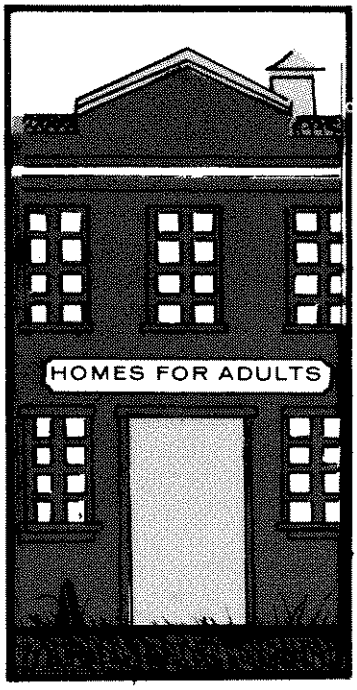
Expansion in the area of adult homes accelerated after two actions by the federal government. One action increased the clientele able to pay for care in adult homes, and the other action indirectly served to increase the supply of beds available in homes for adults. Both actions have had marked effects on the demand for and supply of homes for adults in the Commonwealth.

Financial assistance supplied by federal and State governments has resulted in growth in the number of beds in licensed homes. In 1973, Congress created the Supplemental Security Income (SSI) program. To be eligible for SSI, a person must be aged, blind, or disabled, and meet certain low-income and financial resource guidelines set by the Social Security Administration. States were required to provide financial supplements to those new SSI recipients transferred from other existing financial programs who would have lost benefits as a result of the transfer. The states were also given the option of expanding the covered group.

Federal certification standards for intermediate-care nursing homes also caused growth in the number of adult homes. Rather than meet structural, record-keeping, and other requirements under these standards, some nursing homes "downgraded" their status to homes for adults. Thus, additional beds were made available to serve a clientele which did not require nursing care.

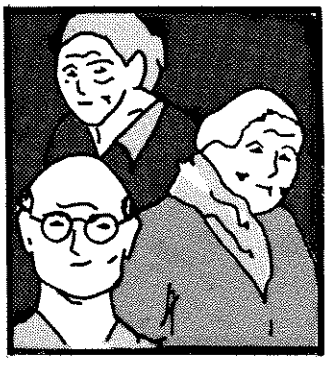
Figure 2

PROFILE OF HOMES FOR ADULTS



- 314 homes Statewide
- Average size is 31 beds
- Range in size from 4 to 502 beds
- Total licensed bed capacity Statewide is 10,420
- Occupancy rate is 85%
- Minimum monthly charge is about $175 per resident
- Maximum monthly charge exceeds $1,000 per resident
- Approximately 278 homes are proprietary, 30 homes are affiliated with non-profit organizations, and 6 are jointly funded by localities
- At least 22 homes, with 3,278 beds, are attached to intermediate-care facilities

PROFILE OF RESIDENTS OF HOMES FOR ADULTS



- 8,800 residents Statewide
- Median age is 76 years
- 82.5% are over 65 years of age
- 8.9% are under 55 years of age
- Women outnumber men 2.2-to-1
- 1,500 to 2,000 residents are deinstitutionalized mental patients

Source: JLARC representation of Department of Health and SDW data, July 1979.

State Auxiliary Grant Program

Virginia opted to expand State-covered financial assistance by creating the auxiliary grant program in 1974. The purpose of this optional program was to make additional payments to SSI recipients and other needy State residents who live in licensed adult homes.

The number of auxiliary grant recipients in homes for adults has surged upward since 1976. The current annual rate of growth is 15 percent. This growth has occurred in the State's optional group (Table 1).

Table 1

AVERAGE MONTHLY AGED AND DISABLED
AUXILIARY GRANT RECIPIENTS

	Federally Mandated Recipients		State Option Recipients	
FY 1975	2,742	(92%)	229	(8%)
FY 1976	1,375	(64%)	760	(36%)
FY 1977	815	(43%)	1,102	(57%)
FY 1978	568	(29%)	1,389	(71%)
FY 1979 (10 mos.)	432	(19%)	1,815	(81%)

Source: SDW data.

Deinstitutionalization

Adult homes have become a de facto component of the State's mental aftercare program. This is because an estimated 1,500 to 2,000 people, or 17 to 23 percent of all current adult home residents, are deinstitutionalized mental patients.

State mental hospitals began a policy of reducing their inpatient populations in 1972. Many of these patients were placed in homes for adults by hospital personnel and social service agencies, and others found their own way into such homes. Findings from a JLARC staff report, "Deinstitutionalization and Community Services," indicated that adult homes are about the only supervised housing alternative for discharged patients in many parts of the State. In six areas selected for case study analysis, there were 937 beds in homes for adults, compared to only 30 beds in specially-staffed facilities for the mentally ill and mentally retarded. Throughout the Commonwealth, there are 226 beds in supervised facilities provided by mental health agencies for discharged mentally ill clients, and 320 such beds for discharged mentally retarded clients.

Many deinstitutionalized clients living in adult homes depend on the auxiliary grant for financial assistance. Once

released from a State mental hospital or retardation facility, clients must often not only find housing, but also find a way to pay for it. The auxiliary grant program enables low-income clients to receive domiciliary care in a licensed home.

Medicaid Screening Program

Medicaid's preadmission screening program for nursing homes has provided another impetus for growth in the adult home industry. This program, which is administered by the State Department of Health, reviews the medical needs of medicaid-eligible people seeking admission to a nursing home.

In its first two years of operation, the screening program recommended over 300 individuals for placement in adult homes rather than nursing homes. This represents almost ten average-size homes for adults, and signifies substantial savings over more costly care provided in intermediate-care facilities. As of July 1979, the average monthly State medicaid payment for intermediate care was $842, while the maximum monthly auxiliary grant rate for an adult home was $372.

In summary, homes for adults have filled a gap in long-term care housing needs in the State. They represent about the only major source of supervised housing available for deinstitutionalized mental patients. In addition, adult homes are a low-cost alternative to what could be inappropriate placement for long-term care in nursing homes. Therefore, the demand for such housing can be expected to continue increasing in the foreseeable future.

JLARC REVIEW

The 1978 Legislative Program Review and Evaluation Act provides for JLARC to review selected programs, agencies, and activities of State government, according to a specific schedule. Senate Joint Resolution 133, enacted during the 1979 legislative session, implemented the provisions of the Evaluation Act. During FY 1979-80, SJR 133 directs JLARC to evaluate programs and agencies in the Standards of Living Subfunction of the Individual and Family Services budget function. This review of homes for adults is the first study prepared by JLARC under the joint resolution. Study efforts are being coordinated with the House Committee on Health, Welfare and Institutions and the Senate Committee on Rehabilitation and Social Services.

Scope

This review's primary focus is the administration of the adult homes licensing function, and the auxiliary grant program.

As the direct providers of care, the homes were an additional focus of the study. This review has three concerns:

- The extent to which regulation and licensing by SDW ensures compliance with minimum standards and, therefore, ensures a minimum quality of life in licensed homes for adults.
- The adequacy of SDW's policies and procedures for licensing adult homes and enforcement of licensing standards.
- The impact and administration of the auxiliary grant program.

Methods

To carry out this review, JLARC staff gathered data from a number of sources. Interviews were conducted with personnel involved in the regulation of homes for adults and in the administration of auxiliary grant funding at both the State and local levels. Visits were made to 48 licensed adult homes throughout the State. This included a random sample of 29 licensed adult homes which were representative of all homes for adults in the State in terms of key demographic characteristics. In addition, staff visited six unlicensed homes which were alleged to have been operating illegally. A technical appendix describes sample selection and other methodological procedures.

The review of the quality of resident life in licensed adult homes utilized expert opinions from five State agencies: State Fire Marshall, State Board of Pharmacy, Bureau of Medical and Nursing Facilities Services of the State Department of Health, Office of Health Protection and Environmental Management of the State Department of Health, and State Department of Mental Health and Mental Retardation.

Additional information was gathered from the written licensing records and operating cost reports on file with SDW, and interviews with licensees, residents of adult homes, and various State and local agency personnel.

Report Organization

The report consists of four chapters. The first chapter has presented an overview of the growth and development of adult homes in Virginia. Chapter II addresses the quality of resident life in the homes, measured by the extent to which homes meet minimum compliance standards in certain key areas. Chapter III addresses the licensure and enforcement functions administered by SDW. Finally, Chapter IV reviews the auxiliary grant program.

II. Quality of Resident Life

Many of Virginia's homes for adults have been responsive to the special residential needs of the aged, infirm, and disabled, and have provided adequate levels of domiciliary care. These homes offer residents a good quality living environment at varying costs. The following homes, visited during the course of this study, illustrate the diversity and quality which may be found in adult homes.

Home A

A home licensed for 12 residents is located in a remote rural area. At the time of the JLARC staff visit, 11 of the residents were deinstitutionalized mental patients, and ten of the residents were receiving financial assistance from the auxiliary grant program.

The home was described as a "super" placement for aftercare patients because of the owner's involvement with the Community Service Board. Group therapy is held in the home weekly, and the licensee has completed special training in caring for the mentally ill. The monthly charge at this home was $336. The home was clean and a "homelike" atmosphere was observable.

Home B

A high-rise home for adults in a metropolitan area has over 400 residents. The support system for residents includes a wide range of health, recreational, and social services. The home offers physical therapy, a cafeteria, full-time activities and social work staff, an in-house newspaper, and classes conducted in the facility by a local community college. The monthly charge ranged from about $450 to over $1,000, as well as an initial admission fee.

Homes for adults, however, vary widely in the level of services provided to residents. Although many homes visited by JLARC staff and by other inspectors during the course of this study offered the quality of life described above, other homes were observed operating with significant violations of minimum standards regulating room and board services. Violations appeared to be especially prevalent in homes which accept predominantly mental aftercare patients and auxiliary grant recipients.

The following significant violations in basic services of licensed adult homes were observed:

- inadequate food supply and nutrition content;
- faulty meal planning;
- unsatisfactory sanitation and preventive health measures;
- lack of fire safety inspections; and
- inadequate control of residents' medications.

At some homes visited by JLARC staff, violations appeared so serious, in terms of compliance with rudimentary standards related to food service and sanitation, that immediate remedial action was deemed necessary. Therefore, preliminary findings were discussed at the August 1979 JLARC meeting and shared with the Commissioner of Welfare. As a result of this special report, the commissioner announced an investigation consisting of inspections at 144 licensed adult homes throughout the State. These inspections identified many of the same violations found during the course of the earlier visits and provided a formal basis for corrective action and official sanctions. The findings of SDW's special investigation are cited in various parts of this report.

Assessing the Quality of Resident Life

To assess the quality of resident life in adult homes, the JLARC review focused on compliance with existing SDW licensing standards concerning room and board. Experts from State agencies were asked to inspect a sample of licensed homes for compliance with standards pertaining to food service, food supply and nutrition, sanitation, and fire safety. Other components of resident life examined in the homes included the availability of aftercare services and recreational activities, the handling of drugs, and the training and qualifications of staff. The overall quality of resident life in the 29 sample homes was subjectively rated by JLARC staff and by SDW's licensing specialists, who are required to annually inspect all licensed adult homes.

Section 63.1-174 of the *Code of Virginia* requires the State Board of Welfare to adopt standards that will " . . . protect the health, safety and welfare . . ." of residents of licensed homes for adults. Pursuant to this charge, minimum standards have been adopted with which adult homes are required to comply. These standards cover many aspects of the construction, maintenance, and operation of adult homes, but do not require licensing specialists to rate the overall quality of a home.

There is clear intent, however, that residents in licensed homes for adults be assured a satisfactory quality of life. In fact, the prologue to SDW's licensing standards recognizes the necessity for inspectors to be aware of important but difficult-to-measure factors that contribute to the quality of resident life, and against which homes are to be tested. The prologue states:

> By the act of licensing an adult home for aged, infirm, and/or disabled persons, the Commonwealth of Virginia places responsibility upon the operator through these standards and regulations to insure the physical and emotional health and safety of the residents. However, it should be understood that a positive philosophy which stresses the individuality and self-esteem of each resident undergirds these standards and regulations.
>
> Some of the elements of good care are:
>
> A cheerful, homelike environment, which demonstrates thoughtful planning for the physical safety of persons with disabling conditions or lessened mobility.
>
> Nutritious meals, carefully prepared and attractively served in a pleasant dining area, with consideration shown for the resident's special dietary needs for reason of health, religious practice or personal preference.
>
> Sensitive and caring employees, who are well trained in their needed functions in the home, are aware of the resident's individual needs, and are able to communicate their personal concern for the resident.
>
> Encouragement of group activities and relationships among the residents, and with their family and friends in the community which stimulates interest and participation in daily life.
>
> An awareness of the resident's possible loss of some personal independence of action by reason of a changed physical, emotional, mental or financial situation, and creative measures taken to prevent further dependence and decline.

> These elements of a positive philosophy of care are the touchstones against which every home for adults should be tested, to help insure that the well-being of every resident is preserved with dignity and respect.

In addition, the licensing manual used by SDW licensing personnel requires that quality of resident life be recognized, stating in part:

> While the home should be in reasonable order, it is more important that there be an atmosphere of warmth and provision for the comfort and convenience of the occupants.

Thus, SDW acknowledges the need for an overall assessment of the "welfare" of residents and the quality of their lives.

Overall Rating of Quality

The quality of resident life in 12 of the 29 sample homes was rated marginal at best by two independent sources: SDW licensing specialists and JLARC staff. The other homes were rated satisfactory or better.

For purposes of rating the quality of resident life in the homes, three categories were used:

1. Satisfactory - The home regularly meets all licensing standards and, in addition, provides a "homelike" atmosphere.

2. Marginal - The home has difficulty maintaining compliance with minimum licensing standards on a routine basis. It makes little if any effort to go beyond these standards and provide a "homelike" atmosphere.

3. Unsatisfactory - The home is frequently or always out of compliance with licensing standards. Furthermore, there is no attempt at care or providing for a "homelike" atmosphere.

Based upon site visits and knowledge about the homes, SDW licensing specialists and JLARC staff classified the sample homes into one of these three categories. The specialists, rating the homes they routinely inspect, indicated that 11 of the sample homes were marginal and one was unsatisfactory. Almost identical ratings were given to the same homes by JLARC staff. Using the three quality categories, but lacking the specialists' day-to-day familiarity with the homes, JLARC staff rated all but four of the homes the same as the licensing specialists (Figure 3).

Figure 3

RATINGS FOR SAMPLE HOMES

REGION	HOME	SDW LICENSING SPECIALIST	JLARC STAFF
A	1	○	○
	2	○	○
	3	○	○
B	4	○	○
	5	◒	◒
C	6	○	○
	7	◒	●
	8	◒	◒
	9	◒	◒
	10	○	○
	11	◒	○
D	12	○	○
	13	●	◒
	14	○	◒
	15	○	○
E	16	○	○
	17	◒	◒
	18	◒	◒
F	19	NR	○
	20	○	○
	21	NR	◒
	22	NR	○
	23	◒	◒
G	24	○	○
	25	◒	◒
	26	○	○
	27	○	○
	28	◒	◒
	29	◒	◒

○ SATISFACTORY
◒ MARGINAL
● UNSATISFACTORY
NR NOT REPORTING

Source: SDW licensing specialists and JLARC staff site visits.

The less than satisfactory ratings given to almost half of the sample homes indicate the quality range among adult homes. Many homes are satisfactory and comply with the letter and spirit of the standards. Other homes are marginal at best and contain violations of standards that are detailed in following sections of this report.

FOOD SUPPLY AND NUTRITIONAL CONTENT

To sustain life and strength, nutritious food in an adequate quantity must be served to residents of adult homes. SDW has developed explicit standards for adult homes concerning food supply and nutritional content. However, significant violations of food service standards were found in 15 of 17 homes visited by a Health Department nutritionist. Various food service violations may exist in as many as one-third of all licensed homes. These violations are often found in homes with auxiliary grant recipients or aftercare residents.

Food Service and Nutrition

Analysis of unaudited meal costs at 141 adult homes which accept auxiliary grant recipients revealed that a significant number spend very little on meals. As a result, some homes were suspected of not meeting basic food service standards. The average meal cost per resident for all homes submitting data to SDW was $1.20 (Table 2). Forty-six homes (33%) reported costs per meal of less than $.75. Reported meal costs ranged from $.15 to more than $7.

Table 2

INDIVIDUAL MEAL COSTS PER RESIDENT

Cost Range	Number of Homes	Percent
Less than $.75	46	33%
$.75-1.19	49	35
$1.20-1.75	32	22
Over $1.75	14	10
Total	141	100%

Average meal cost per resident = $1.20

Source: JLARC analysis of SDW cost data.

Because of this finding, JLARC asked a licensed nutritionist from the State Department of Health to inspect a group of homes and determine the adequacy of diets and compliance with food service and nutrition standards. As required in SDW licensing standards, the nutritionist utilized minimum daily nutritional requirements established by the National Academy of Sciences, a recognized authority, and, where relevant, determined compliance with physician-prescribed diets. Target homes were first identified using cost data. Additional visits were requested from the sample of 29 homes.

The nutritionist summarized her findings in the basic food service and nutrition areas by stating:

> There appears to be little or no understanding of minimum daily dietary requirements necessary for sustaining good health. . . (In addition to) the overall lack of nutritional content, both the quality and quantity of food served is of questionable adequacy.

Nutritional Standards. Licensing standards are explicit about how homes are to provide for the nutritional needs of residents. Among the standards governing food service in licensed adult homes, the following establish fundamental requirements:

1. Food and nutritional needs of the residents must meet dietary allowances prescribed by a recognized authority specified in the SDW regulations or an attending physician's orders.

2. At least a week's supply of staple foods must be on hand.

3. Homes must serve three meals each day.

4. Bedtime snacks are to be available.

Inadequate food supplies and low nutritional content were observed at 15 of the 17 homes visited by the nutritionist. The following homes illustrate two of the more serious food service and nutrition problems uncovered by the nutritionist.

Home A

A home with 12 residents and reported meal costs of $.21 per resident did not have enough food in the house for one meal. The entire evening meal consisted of two boxes of tuna helper with no tuna, a can of greens, crackers, and Kool-Aid. This was all the food on hand. The owner reported that only two meals per day were served on weekends.

The nutritionist stated in her report: "My most immediate concern is for the lack of food to maintain the health of the residents. This facility is basically out of compliance with all regulations applied."

Home B

At a home with 68 residents and meal costs of $.26 per resident, the food was found to be low in protein, vitamin content, and quantity. "On the day of my visit," reported the nutritionist, "lunch was to be served 'after 3 P.M.' according to the owner. This meal, to feed 68 patients and eight staff, consisted of four or five pounds of pork to be made into a casserole. This amount of meat should serve 18-20 people a standard four-ounce portion. I strongly suspect that only two meals a day are served routinely."

Meal Planning

The nutritionist also found problems in the meal planning function of licensed adult homes. Many homes failed to plan nutritious meals for their residents, and in some cases the meals that are planned are not actually served to residents. The nutritionist observed these conditions in 15 of the 17 adult homes she visited.

Meal Planning Standards. SDW's licensing standards are explicit in requiring meals to be planned. They state in part:

> A menu for meals shall be planned for at least two weeks at a time and posted and any changes shall be noted. A record of menus actually served shall be retained for six months.

Planning helps ensure that meals are nutritionally balanced and facilitates food purchasing. A written record of meals served also documents the nutritional intake of residents.

Licensing specialists are directed by the Licensing Manual to do more than merely note the presence of a posted menu. According to the manual:

> Emphasis shall be placed on evaluating the nutritional value and balance of diet; consideration should be given to variety and interest in the meals served . . . The primary concern is that meals be well balanced and nutritious.

Nutritionist's Findings. Menus were requested during unannounced visits to the sample homes. Of the 29 homes in the sample, only 16 could provide menus. Five homes had no menus at all. The remaining eight homes refused to supply copies of menus, or could not find them. Nine homes did not have menus posted. Frequently, menus provided by homes were a year or more old.

These findings are supported by those of the nutritionist, who summarized visits to 17 homes by stating:

> There is little or no relationship between the menus and the actual food served. There seems to be no appreciation of the necessity or value of planned menus, either from the point of view of food purchasing or providing adequate diet. The facilities appear to do this task only for the purpose of satisfying a paper requirement.

The nutritionist's comments on the 16 menus she reviewed highlight the seriousness of this failure to comply with licensing standards. Concerning the adequacy and appropriateness of the menus, the nutritionist made the following observations:

- The overall quantity of food available to residents was inadequate to supply the 1800 to 2400 calories needed to maintain good health.

- The quality of food planned for meals was generally poor. Nutrient content was less than adequate as evidenced by inadequate protein, vitamin, and milk content, and by inadequate amounts of fruits and vegetables.

- Planned beverages and snacks were of little or no nutritional value, generally consisting of empty calories.

- Menus consisted primarily of starchy foods, and exhibited extreme repetition of foods.

These problems are illustrated by the menus shown in Figure 4. In both examples, the written menus contain insufficient calories, nutritional imbalance, primarily starchy foods, and nutritionless beverages. More important, however, the meals actually served deviated from the menus almost totally, and contained even less adequate nutrition. At one home, no evening meal was served at all, despite the fact that one had appeared on the menu.

Therapeutic Diets. Some residents, especially those who are diabetic, have special nutritional needs. Standards require homes to meet the dietary needs of residents as prescribed by an

Figure 4

CONTRAST BETWEEN MENUS AND MEALS
SERVED AT TWO ADULT HOMES

Home No. 1
(More than 50 residents)

MENU

Breakfast	Lunch	Dinner
Grits	Soup	Cheese Sandwich
Toast	Meat	Kool-Aid
Coffee	Greens	
Milk	Bread	
	Kool-Aid	

MEAL SERVED

Breakfast	Lunch	Dinner
Grits	Pork Casserole	No meal was served
Toast	Kool-Aid	
Coffee		

Home No. 2
(Less than 10 residents)

MENU

Breakfast	Lunch	Dinner
Eggs	Fish	Soup
Oatmeal	French Fries	Crackers
Milk	Cornbread	Milk or Tea
Coffee	Tea	

MEAL SERVED

Breakfast	Lunch	Dinner
Hot cereal	Pork Patties	Unknown
Coffee	Bread	(No decision had
	Kool-Aid	been made about
		what to serve
		at the time of
		nutritionist's visit)

Source: Review of 16 adult home menus by State Department of Health nutritionist.

attending physician. Nevertheless, the nutritionist found serious breaches of this requirement to be common. From visits to the 17 targeted homes, the nutritionist concluded:

> There is real concern for the inadequate provisions for handling, planning, and serving meals to residents who may require controlled diets (diabetics, etc.).

This failure to comply with residents' therapeutic diets was noted at a home with eight residents. Concerning this home, the nutritionist said:

> There are no provisions made for the management of therapeutic diets, although at the time of my survey there were three diabetic diets, one low-calorie, and one low-salt diet ordered for residents.

SDW Special Investigation. SDW found similar nutritional conditions in its special inspections of 144 adult homes. In SDW's report on the inspections, 11 percent of the 144 homes were judged to serve an inadequate quantity of food to residents. Thirteen percent of the homes were determined to provide food that was not nutritionally adequate to meet residents' needs. At 41 percent of the homes, the food actually served did not reflect meals planned in the menus. In 37 percent of the homes surveyed, meals were not planned two weeks in advance, and in 38 percent of the homes, menus were not kept on file. Three percent of the homes did not serve the required three meals per day. The following examples are drawn from the special inspection reports.

Food Supply

A home for 20 residents did not have on hand all the food items planned for the noon meal. The inspection team questioned the nutritional value of the food served and the food on hand.

Meal Planning

A home for seven residents had no current menus available and no meals had been planned in advance. Menus posted were six weeks old, and many of the meals listed on the menu were identical.

Therapeutic Diets

At one home, two residents had been prescribed diabetic diets and one resident was on a post-operative diet. SDW's inspection team noted that, because the residents didn't want to follow the diets, the home did little to encourage them.

Improving Food Services in Homes for Adults

Serious problems in food supply, nutrition, and the provision of therapeutic diets were found in licensed homes. These deficiencies occurred predominantly in homes with aftercare residents and auxiliary grant recipients, for whom the State bears a special responsibility.

In some cases, the State has paid for care which did not meet minimum standards. Moreover, significant food service violations have been found in homes which are routinely inspected for compliance with explicit standards.

Recommendation (1). SDW needs to take several steps to strengthen the food service activity in licensed adult homes:

1. During unannounced inspections of adult homes, greater attention should be given to compliance with food service standards. Homes with auxiliary grant recipients, mental aftercare residents, or low food costs should be given priority by SDW.

2. Licensing specialists should receive training in areas related to food service and nutrition and some inspections should be supplemented by a professional nutritionist or dietician.

3. Licensees should be offered special training by SDW in meal planning, food service, nutrition, and therapeutic diet preparation.

SANITATION AND HOUSING

A clean, safe physical facility is an important component of the room and board mission of adult homes. Most homes appear to be physically sound structures, although the type of structure varies considerably. However, sanitary violations were found to exist in half of the licensed adult homes in the sample. Aged and infirm residents are particularly vulnerable to diseases which are promoted by unclean surroundings. They are also in special need of protection from fire hazards, although over one-third of all homes are not subject to inspection by State fire officials.

Sanitation and Preventive Health

Sanitary conditions in adult homes were reviewed for compliance with State standards as reported by licensing specialists, local health department sanitarians, and the State Department of Health nutritionist.

Sanitation Standards. SDW's adult home licensing standards focus on sanitation in food service and storage areas. Sanitary conditions in these areas are essential to prevent the spread of disease to residents. Cleanliness in other areas of the home is also required by the following standards:

- The home shall be kept safe, neat, clean, and free of dirt, rubbish and foul odors.
- The home shall be kept free of flies, roaches, rats, and other vermin.
- Animals shall not be in rooms where food is stored, prepared, or served.
- Refrigerators, eating and cooking utensils, sinks, and other equipment shall be kept clean.
- Food, cleaning supplies, and prescription medicine shall be separately stored.

These and additional standards provide for sanitation in adult homes. Key provisions of the Virginia restaurant law are also applicable in homes with ten or more residents.

Findings. Of the 29 homes in the sample, 17 (59%) were found by local sanitarians in their most recent inspection to contain some violation of standards. Sanitarians frequently found refrigerator temperatures too high and improper disposal of trash. Each licensed home for adults is inspected without prior notice at least annually by local health department sanitarians.

Violations found by local sanitarians were also observed in separate visits by the nutritionist. Additionally, violations more serious than those reported by the sanitarians were uncovered, sometimes within days of the sanitarians' inspection.

The nutritionist summarized her comments by stating:

- There appears to be no routine maintenance program for the control and prevention of flies, roaches, and vermin.
- There appears to be no understanding of the necessity for practicing adequate sanitation for the prevention of food-born illness.
- There appears to be no awareness of the potential health and safety hazards resulting from storing food with cleaning materials and for storing prescription medications in food storage areas.

The extent of sanitation problems in some licensed homes is illustrated below.

> *A licensed home with six residents contained extremely unsanitary conditions. The dining room, kitchen, and storage areas were filthy and overrun with roaches. A basement storage area was flooded with dirty rainwater. The owner kept dogs in the dining room and a litter box was under the dining table. The odor of the dogs was overwhelming.*
>
> *"It is difficult to believe that anyone lives in such a level of filth, and unbelievable that residents pay for such conditions," the nutritionist reported.*

In six of the homes found by the nutritionist to be out of compliance with SDW's minimum standards, the local sanitarians reported either no violations of standards or only minor discrepancies. Some of the nutritionist's visits occurred within days of the local sanitarian's inspection, so the question arises as to why the nutritionist found more severe sanitation problems than the local sanitarians. This finding also raises a concern that, by relying upon local sanitarians to determine compliance with sanitation standards, the SDW licensing specialist remains unaware of these violations.

SDW Special Investigation. The findings reported above were also contained in SDW's special investigation. Fifty-six percent of the 144 homes examined were out of compliance with sanitation standards relating to food storage and/or food preparation areas. Twenty-eight percent had "dirty premises," and 27 percent were found to contain flies, roaches, or other vermin. The following examples were drawn from SDW reports.

Home A

> *At a home for 24 residents, a dog was being kept in a basement food storage area near the laundry facilities. Fleas were found in a stairway carpet, and stagnant water was standing in sinks and on the floor.*

Home B

> *At a home with six residents, raw food was found stored directly on the floor, and the food storage cabinet was dirty.*

Recommendation (2). SDW licensing inspectors should supplement the inspections of local sanitarians to ensure that homes comply with standards. In addition, SDW should request the

State Department of Health to ensure that violations of sanitation standards are accurately detected and reported.

Fire Safety

Fire safety is of primary importance in physical facilities that house elderly and disabled individuals. Despite the responsibility of State government for licensing adult homes, the State Fire Marshall lacks inspection authority for over one-third of all these facilities. As a result, some homes are not regularly inspected. Failure to inspect for hazards is compounded when residents who are not ambulatory are placed in rooms without easy emergency exits.

Fire Inspections. The State Fire Marshall does not have authority to inspect licensed adult homes with fewer than ten residents. More than one-third (114) of all homes are in this category. These facilities house a high proportion of auxiliary grant recipients and individuals discharged from State mental institutions.

According to SDW licensing specialists, inspections of these homes by local fire officials are often delayed. They are also subject to variations in the training and background of part-time staff, particularly in rural areas. Additionally, the inspection form provided to local fire officials by SDW has been described by licensing specialists as confusing and poorly designed.

Because no single agency has the responsibility for inspecting all adult homes, some "fall through cracks" and may not be inspected at all, as happened in the following illustration.

> *A home for adults in a southwestern county fell under the inspection authority of local fire officials, since none of the buildings making up the home had a capacity of ten or more residents. This home was over 20 miles from the nearest fire department in the county. Therefore, the home owner requested a fire inspection from a closer fire department, even though this department was in another county.*
>
> *Because it was inconvenient for one local department, and out of another department's jurisdiction, there was no fire inspection of the home between October 1975 and March 1979.*

Non-ambulatory Residents. People who have difficulty walking or who need assistance walking should reside in rooms where quick and safe exits could be made in case of an emergency.

Licensing standards for adult homes require that non-ambulatory residents may not be placed in rooms above the facility's ground floor without the approval of SDW. However, in visits to homes, residents with severe physical disabilities were frequently found in rooms on upper floors. These people could easily become victims in case of fire. The following case illustrates the problem.

> *In a visit to a home with 14 residents, an aged blind man was found alone in the back room of the second floor. The room had two doors. One led to a small porch with delapidated stairs leading to the ground. The other door led to a hallway with several other doors, one of which opened onto stairs leading to the ground floor. The operator of the home indicated that the blind man was over 100 years old and normally slept in the upstairs room.*

In case of emergency, this resident would not be able to exit quickly or safely. Such conditions are in clear violation of safety standards in licensed adult homes.

Recommendation (3). The General Assembly may wish to consider amending the *Code of Virginia* to provide the State Fire Marshall with the authority to inspect all State-licensed homes for adults. In addition, SDW should strictly enforce requirements that non-ambulatory residents not be placed in upper floors.

ADDITIONAL RESIDENT NEEDS

Homes for adults provide residents with supervision in addition to room and board. Supervision includes a limited amount of health care. SDW has recently promulgated health-related standards which, for the first time, provide for the supervision of residents who are mentally ill, bedfast, or who require physical restraints. However, these standards do not adequately address the full range of mental health needs or the proper handling of medications. Additionally, these standards do not fully incorporate provisions for other resident needs such as recreational and social activities or the protection of personal finances.

Aftercare Services

As many as 2,000 current residents of homes for adults have been discharged from State institutions for the mentally ill and mentally retarded. Since the beginning of the State's deinstitutionalization effort in 1972, homes for adults have represented a primary source of housing for aftercare clients. SDW has not until recently incorporated standards regarding the service needs of

aftercare clients into regulations. Moreover, the new standards may not require the same services for aftercare residents already in the homes as for aftercare residents who enter homes after the new standards take effect.

Because there are so many deinstitutionalized mental patients now residing in licensed homes for adults, the Department of Mental Health and Mental Retardation (DMHMR) was asked to conduct a separate inspection of a sample of homes with aftercare residents. In addition, JLARC staff examined facets of aftercare services in adult homes.

Aftercare Problems. Licensees have had to cope with a wide range of needs and problems involving aftercare residents, despite a lack of standards to guide them. These needs and problems include:

- managing large dosages of psychotropic medication;
- providing activities appropriate for aftercare residents;
- dealing with assaultive behavior; and
- ensuring the availability of community mental health clinic and emergency services.

The following case study illustrates the unique and serious problems presented to licensees by discharged mental patients.

> *A resident who had spent 19 years in State mental hospitals (Southwestern and Catawba) was placed in a home for adults as part of the aftercare program. The patient had a recurring history of suicide attempts. In fact, the release documents noted that appropriate agency follow-up was needed and that caution should be exercised against further suicide attempts.*
>
> *While a resident at the home, the individual made repeated statements about commiting suicide. On a cold, snowy winter night, the resident left the home. The resident was later found a short distance from the home, dead from overexposure to cold weather.*

Licensees of homes for adults have generally been unprepared to deal with special mental health needs of aftercare residents. In addition, the mental health system has not been consistent in developing appropriate discharge plans, selecting suitable residential placements, and providing follow-up care to former patients. (These issues are addressed in the JLARC study, Deinstitutionalization and Community Services.)

New Standards. New licensing standards are intended to increase access to community mental health services by aftercare residents in adult homes. Licensees are required to enter into written agreements with Community Service Boards to arrange for clinic services. The clinics are to provide emergency, outpatient, diagnostic, evaluation, and referral mental health services.

While these services have generally been available in communities, DMHMR and JLARC staff found differences in utilization. This point was made by DMHMR in its review of homes for adults:

> There was great variation in the amount of consultation from qualified mental health professionals that was received by the staff in Homes for Adults. Some homes received regular visits from local mental health clinic staff, especially social workers, while other homes received few visits.

The new standards do not make clear whether the estimated 1,500 to 2,000 aftercare residents who will be residing in adult homes when the standards take effect (January 1980) will receive the same services as aftercare residents who enter homes after that date.

Moreover, access to mental health professionals will not relieve adult home operators from dealing with the day-to-day problems created by some aftercare residents. Home operators need to constantly monitor the behavior of these residents, even when they routinely visit mental health clinics, since problems may result from changes in medication, as happened in the following case.

> *When responsibility for treatment of aftercare residents was shifted in July 1978 from a county health department to a new mental health clinic, a new psychiatrist began treating the aftercare residents of several homes for adults. The doctor's approach to medication was to keep the administration of these drugs as simple as possible. In addition, he felt that aftercare residents should be taken off psychotropic sedatives. Thus, this new doctor quickly changed many of the medications taken by residents.*
>
> *Licensees noticed immediate effects on their residents, including going into deep depressions, becoming hyper-active, fighting among themselves, experiencing weight loss, and becoming generally more difficult to deal with.*

The licensees determined that they were all having the same problem with their aftercare residents. In conjunction with the regional office of SDW, they met with the psychiatrist. It was finally agreed that another psychiatrist would work with the aftercare residents, since the current doctor did not see the need to change the medications.

The staff of adult homes must be prepared to identify behavior of deinstitutionalized residents which requires immediate or professional attention.

Improving Aftercare Services. It is clear that present as well as future aftercare clients would benefit from increased coordination between homes for adults and community mental health clinics. Moreover, DMHMR and JLARC staff have identified the need for home operators to have more detailed information regarding the condition of aftercare residents as well as additional training in caring for such clients.

Recommendation (4). Licensing standards requiring specific aftercare services should apply to all facilities housing deinstitutionalized clients who can be identified by adult home operators.

Recommendation (5). The State mental health system needs to take the lead in providing services to deinstitutionalized mental patients who reside in adult homes. DMHMR should:

- Assist Community Service Boards in developing outreach capabilities.
- Encourage Community Service Boards to provide consultation and training for operators and staff of adult homes in the handling of psychiatric and medical emergencies, and the management of assaultive and disoriented residents.
- Require State hospital staff to prepare a discharge summary of the client's medical and social history in clear and simple language, and send the summary to the adult home, contingent upon the client's consent, prior to the client's placement in the home.
- Require State institutions to place mental aftercare clients only in adult homes which are in substantial compliance with licensing standards.

Drug Procedures

Many residents of homes for adults require one or more types of medication, and aftercare residents often take multiple

medications. Therefore, it is essential that operators document dispensing of medications and maintain prescribed dosages.

The State Board of Pharmacy, the agency responsible for enforcing Virginia's Drug Control Act, was requested to conduct an independent inspection of homes. Drug inspectors in each region of the State made unannounced visits to JLARC's 29 sample homes. These inspections were based on SDW's licensing standards and on appropriate requirements of the Drug Control Act.

Standards. SDW standards primarily address the storage, security, and administering of medications. The standards require that each home:

- have a locked cabinet for prescription medications;
- separate medications from cleaning supplies;
- not start or continue a medical program without the written authority of a physician;
- allow residents to keep their own medications if their physician so authorizes; and
- allow only responsible and authorized personnel to dispense and administer medications.

Principal violations of these standards included storing medications with food or cleaning supplies and not keeping medications secure.

Gaps in Standards. Neither current nor new standards address the hazards associated with possible misuse or abuse of controlled substances. Documentation of the dispensing of medications is not required. In addition, standards are not explicit concerning unauthorized changes in the dosage of prescribed medication or the use of a controlled substance by a person other than the one for whom it was prescribed.

A State Board of Pharmacy investigator summarized the lack of accountability for controlled substances:

> The majority of these homes maintained a relatively large stock of controlled substances with no accountability for these drugs. Therefore, this investigator recommends that the requirement of records for receipt, administration, and destruction for the individual prescriptions maintained at homes for adults should be considered.

It is not possible to tell if medications are dispensed in a timely, appropriate manner unless records are kept which indicate how,

when, to whom, and by whom medicine was dispensed or administered. In at least three instances, operators were found to be keeping old medicines for use by future residents.

One licensee was found to have changed dosages on his own authority, as illustrated below.

> *When JLARC staff visited a home for about 20 residents, it was determined that most of the residents had been discharged from the mental ward of a nearby hospital. Most of the residents were using high levels of psychotropic medications. The licensee said that he changed medication levels for residents when they became assaultive or "began acting a little funny." Sometimes the licensee telephoned a local doctor, who would approve such dosage changes without seeing the patients. But sometimes, the licensee just changed the medication on his own.*

There is a definite need to fill drug-related gaps in current standards and to provide operators with necessary training.

Recommendation (6). With the assistance of the Board of Pharmacy, SDW should develop explicit requirements and simple forms for operators to (1) document the medications prescribed for residents, (2) note the amount, time, and dispensor of each dose, (3) note physician-approved changes in dosage, and (4) record observed reactions of the patient. In addition, SDW should ensure that licensees receive special training concerning laws and regulations governing prescription medication, the effects of medications and drug interaction, and the proper storage of medications.

Recreational Activities

An observation frequently made by the various inspectors who cooperated in this JLARC review was that most residents do little or nothing all day. The only activities observed in most homes were sitting, sleeping, and watching television. This was especially true in smaller homes with auxiliary grant or aftercare residents.

The current standard requires that each licensee "be responsible for making available programs within the home that will be appropriate to the needs, interests, and abilities of the residents." Thus, licensees can justify residents sitting or watching television because residents are "interested" in doing these things.

New licensing standards will require one hour of organized activity each day. One expert who consulted with SDW in developing this new standard felt that lack of activities leads to boredom, which often results in apathy and behavior or medical problems. He felt that one hour of organized activity each day was inadequate and that more time should be allocated for this area.

Recommendation (8). SDW should take the lead in assisting the licensee to develop organized activities for residents. Licensing specialists should refer licensees to agencies which could assist in developing activities, such as local mental health clinics and centers, area offices on aging, and other community service agencies.

Residents' Personal Finances

The personal finances of aged, infirm, and disabled residents are of special concern because such residents often are unable to look after their own interests. Of particular concern are residents' personal monthly allowance. For auxiliary grant recipients, these allowances are required under State policy and amount to $25 per month. In addition, people who receive general relief for domiciliary care receive a $25 per month personal allowance. Licensing standards and enforcement are not explicit enough to protect residents' allowances and personal finances.

Personal Allowance. Auxiliary grant and general relief recipients in adult homes do not always receive the full allowance to which they are entitled for the purchase of clothing and other personal items. In part, this is because there is no standard concerning how the allowance should be handled by licensees.

The personal allowance comes as a portion of the monthly financial assistance check. Many recipients simply endorse this check and give it to the home's licensee.

Before the allowance is dispensed to the recipient, some licensees deduct a fee for laundry services or for snacks, both of which are required by licensing standards. Other licensees sell personal and food items to residents. Because of the vulnerability of aged, blind, and disabled auxiliary grant recipients, this practice could be abusive.

Recommendation (9). SDW should specify that services required by licensing standards, such as laundry and snacks, are purchased by monthly financial assistance payments. Recipients should not be required to spend their personal allowances for these basic services. In addition, SDW should investigate the practice of selling items and services to residents, and develop appropriate regulations.

Personal Financial Affairs. The potential for abuse of residents' personal finances exists in those homes where the licensee manages the resident's total personal finances. In contrast to the personal allowance, which is only received by auxiliary grant and general relief recipients, any resident of a licensed adult home may delegate this management responsibility to the licensee. Current licensing standards require the home in these cases to provide residents with a quarterly accounting of financial transactions made on their behalf.

The regional licensing staffs' enforcement of this standard varies considerably among regions. In one region, licensing specialists require homes to document only the monthly personal allowances received by auxiliary grant recipients. In another region, licensing specialists require homes to document all financial transactions between home and resident. Such variable enforcement practices create an opportunity for the abuse of residents' personal finances.

Recommendation (10). SDW should require a uniform method of providing the quarterly accounting of transactions on residents' behalf. This would help to ensure that residents' personal financial affairs are satisfactorily managed by licensees.

III. Licensure and Management

The purpose of the licensure program for adult homes is to protect the health, safety, and welfare of residents. In many instances, SDW has established relevant and explicit standards to ensure a minimum quality of resident life. However, weaknesses in the licensure and enforcement process have resulted in failure to correct significant violations of standards by home operators and to detect the operation of illegal homes. On-site enforcement problems are compounded by the absence of effective central department monitoring of regional licensure staff.

ENFORCEMENT

Key components of a licensure program are procedures to ensure compliance with standards, such as inspections, application of sanctions, and investigation of illegal operations.

Regional licensing staffs issue licenses to homes that provide supervisory care to four or more aged, infirm, or disabled residents. Applications are approved or licenses renewed on the basis of comprehensive annual compliance inspections. Interim supervisory inspections are conducted to ensure continued compliance with licensing standards. Regular licenses are issued for one year. Homes temporarily unable to comply with standards may receive a provisional license for up to six months, renewable for up to two years.

SDW enforcement mechanisms are weak in several respects: (1) inspections for compliance with licensing standards are usually announced to the licensee in advance; (2) the range of sanctions is inadequate; (3) provisional licenses are used inappropriately; and (4) processes for dealing with illegal or overcrowded homes are passive.

Inspection and Supervision

The effectiveness of compliance inspections appears to be limited, in part because (1) inspectors routinely provide operators with advance notice; (2) substantial differences were found to exist in some instances between violations reported by licensing specialists and those found by other inspectors, raising questions of the thoroughness of inspections; and (3) violations that are reported are not regularly followed up to ensure that remedial action takes place.

Announced Inspections. Announced visits allow the licensee to orchestrate the visit and to hide or temporarily correct discrepancies. The following cases illustrate how a significant violation of standards may not be detected by specialists who give prior notice to operators.

Home A

JLARC staff made an unannounced visit to a home in Eastern Virginia. The facility was actually two separate buildings, about 25 feet apart, each housing residents. At the time of this visit, six elderly residents were found unattended in one of the buildings, with no evidence of a call system between the buildings. This situation constituted a violation of Section 63.1-172 of the Code of Virginia, which explicitly requires general supervision in licensed adult homes.

The licensing specialist responsible for this home was asked about the situation. He stated that every time he had visited the facility there had been adequate supervision in both of the buildings. However, he stated that he always called the home in advance and announced his visit.

Home B

JLARC staff made an unannounced visit to a rural home licensed for 24 adults. The visit occurred at about 10 a.m. on a weekday. Unattended residents were found working in the laundry, kitchen, and yard, creating all kinds of possibilities for emergency situations. The licensing specialist who carried this home in his caseload confirmed that he had received other reports of lack of supervision at this facility, but had not been able to verify them. He also said he always called before visiting the facility.

The routine practice by SDW's licensing specialists of notifying licensees of inspections renders the compliance aspect of inspections largely ineffective.

Objections raised by licensing staff to making unannounced or surprise inspections of adult homes do not appear valid. Because licensing specialists must interview licensees during the compliance inspection, the specialists said that they must be sure the licensee is present during the inspection. However, making

unannounced visits does not necessarily mean missing the licensee. In unannounced visits to 27 adult homes, JLARC staff found licensees to be at the home or easily contacted in all but two cases. And in those two cases, lack of supervision, a significant violation of standards, was found at the facilities. Other inspectors cooperating in this review also reported no difficulty gaining access to licensees during unannounced visits.

A second reason reported by licensing staff for announcing inspections was to avoid inconveniencing the adult home licensee. This reasoning places a higher priority on the licensee's convenience than on enforcement of standards, and clearly conflicts with SDW's mission of ensuring compliance with standards. The purpose of adult home inspections is to ensure compliance with standards, not to accommodate licensees.

Finally, the decision to issue an annual or a provisional license can be made only as a consequence of a compliance study. Thus, it is important for the licensing specialist to observe conditions in the home as they normally exist. Giving the licensee advance notice of the compliance study may mean the licensing decision is based on observed conditions not normally present in the home.

Violations Detected. There is a reason to question whether some SDW licensing specialists adequately inspect, observe, or report violations which exist in homes, particularly in the areas of food service and nutrition. Homes in the JLARC sample were mainly cited by licensing specialists for violations in easily documented record-keeping or physical facility categories, such as failure to record resident physical examinations or to repair broken furniture (Table 3).

Table 3

VIOLATIONS AT SAMPLE HOMES CITED BY SDW INSPECTORS

Type of Violation	Number of Violations	Percent
Records	93	55%
Buildings	39	23
Management	20	12
Sanitation	7	4
Fire Protection	3	2
Activities	3	2
General Regulations	2	1
Food Service	2	1
Total	169	100%

Source: Most recent compliance studies by SDW licensing specialists for the 29 sample homes for adults.

In their most recent inspections of the 29 sample homes in this study, licensing specialists cited only two violations in the area of food service and seven in the area of sanitation. However, numerous significant deficiencies in these areas were noted by the Health Department nutritionist when she visited ten of the same homes, at times within days of the licensing inspection. SDW's special investigation of 144 homes also found a significant number of violations in food service and sanitation categories.

The difference in violations reported by licensing specialists and by other inspectors in similar time periods is illustrated below.

Home A

One morning, a licensing specialist conducted a compliance inspection of a home for 13 adults. No violations were reported, and the home was subsequently issued an annual license.

That afternoon, the Health Department nutritionist made an unannounced visit of the home. The following violations were noted:

-poor sanitation in kitchen, dining room, and food service areas;
-cleaning supplies and prescription medicine stored with food;
-unsanitary and cracked dishes used to serve food;
-dirty refrigerator and freezer;
-food served was inadequate; and
-menus did not reflect food actually served.

Three months later, the SDW special investigation team inspected this home. Many of the same violations were noted at that time, including:

-food served was inadequate;
-refrigerator dirty and too warm;
-improper storage of cleaning supplies;
-flies and roaches in kitchen;
-two blind, non-ambulatory residents in upstairs rooms; and
-no staff on night duty.

Home B

A licensing specialist made a supervisory visit to a home for nine adults. The following violations of licensing standards were noted:

-loose carpeting on stairway;
-no railing on front porch; and
-broken sofa in living room.

This same home was visited five days later by the nutritionist. She noted the following violations of the licensing standards:

-no menus posted;
-food served was inadequate;
-kitchen, storage, and dining areas extremely dirty;
-abundant roaches and flies;
-sanitation poor;
-drugs and cleaning supplies stored with food; and
-kitchen equipment dirty and in disrepair.

During this general period, the SDW regional office received complaints about this home from a community health clinic, a local welfare agency, and a State hospital. The complaints alleged that sanitation and medication problems existed in the home.

Four months later, after the SDW special inspections had occurred, this same home failed its annual compliance inspection. At that time, the following violations were found:

-the owner was mentally incapable of running a home and not of good moral character;
-dirty, cluttered, and hazardous conditions;
-no lighting;
-lack of activities:
-odors;
-roaches in kitchen;
-dirty refrigerator; and
-resident medical records missing.

These cases give reason to question whether the licensing specialists adequately inspected, observed, and reported conditions in the two homes.

Inadequate Follow-up. Licensing inspectors do not regularly follow up to make certain that violations are corrected. Sometimes violations cited during annual compliance visits are not reviewed until the home's license is once again up for renewal. Thus, compliance in the interim is not determined, as illustrated in the following case:

> *A licensing specialist made an unannounced supervisory visit to a home with 12 residents. The licensee later told JLARC staff that the specialist found virtually no food in the facility and very dirty conditions. The licensee said she was directed to clean up and to purchase an adequate supply of food for the residents, although the specialist did not record any problem with the food supply.*
>
> *Two months later, JLARC staff visited the home. The licensing specialist had not returned to the home. Although there appeared to be an adequate supply of food on hand, the home was still extremely dirty.*

If correction of standards violations is not determined after breaches are detected, then licensees may see no need to remedy the violations. The potential consequences of not determining subsequent compliance were illustrated at an administrative hearing, where one licensee stated that food had been purchased and stored, but not used, because it was "for the inspector to see." Licensing specialists should routinely follow up the correction of violations.

Recommendation (11). All compliance inspections should be conducted without advance notice to licensees. The General Assembly may wish to specify this requirement by amending Section 63.1-177 of the *Code of Virginia*. Moreover, follow-up inspections should take place with specified frequency and within time periods determined by the seriousness of the violations cited. Violations which relate to residents' health and safety should be aggressively followed up.

Provisional License

There are no sanctions that licensing specialists can use effectively to enforce correction of licensing violations. Specialists have only two options: revocation or denial of a license. Because of this, the department has tried to use provisional licensing as an enforcement sanction. This practice has not proven adequate.

Many homes for adults have received a license without meeting minimum licensing standards. This has occurred because Section 63.1-178 of the *Code of Virginia* authorizes a provisional license to be issued when a home is temporarily unable to comply with the minimum standards. Under the statute, a provisional license may be issued for up to six months, and may be renewed for up to two years.

Although SDW licensing staff consider that the provisional license carries a stigma which will induce licensees to comply with standards, it appears to have little, if any, such effect. Homes with a provisional license may still open for business, receive such benefits of licensure as income from State-funded auxiliary grant recipients, and are not identified in any substantial way as operating under a provisional rather than regular license.

Use of Provisional License. Legislation explicitly provides that the provisional license should be issued to adult homes temporarily unable to meet minimum standards. It is left to administrative discretion as to how long the home should be licensed while unable to comply with standards.

SDW has used the provisional license in such a way that adult homes with long-standing violations have been able to continue in business and eventually obtain a full annual license without complying. The following illustrates how this has occurred.

> *An adult home licensed for 54 residents operated with a provisional license from October 1976 to October 1978. The major reason for the provisional license was the lack of a waste disposal system approved by the local health department. This created a potentially serious sanitation problem and is not permitted under local ordinance.*
>
> *When interviewed by JLARC, the licensing specialist said he told the owners not to get upset because they had 24 months to correct the problem.*
>
> *The owners spent 18 of those months trying to legally overturn the provisional license. During the last six months of the provisional license, the owners entered into negotiations with the surrounding local authorities to try to work out a solution. At the end of the 24 months, the discrepancy still had not been corrected.*
>
> *At that time, the licensing specialist said he believed that the owners had made a "good faith" effort to comply with standards, so he granted the facility an annual license.*

When JLARC staff visited the home seven months after issuance of the annual license, the home had still not corrected the violation.

There is little incentive for a home with a provisional license to comply with standards if the licensee can merely "wait out" the licensing specialist. Yet the specialist has only one other option--to revoke the home's license. This is particularly difficult if the home has been permitted to operate for two years with a provisional license.

A high proportion of all adult homes receiving licenses have received provisional licenses. In five of the last seven years, over 50 percent of all licensed homes had a provisional license. The overall downward trend may indicate improvement in conditions at adult homes; however, it is just as likely that homes formerly on a provisional license reached the two-year statutory limit and were granted an annual license.

Table 4

ADULT HOMES WITH PROVISIONAL LICENSES
1972-1978

Year	New Homes with Provisional as First License	Homes Receiving Provisional as Renewal	Total Homes with Provisional	Percent of All Licensed Homes on Provisional
1972	31	211	242	89%
1973	42	166	208	69
1974	40	139	179	60
1975	41	107	148	46
1976	22	141	163	52
1977	32	172	204	65
1978	27	89	116	37

Source: SDW, JLARC.

Recommendation (12). The sanctioning effect of the provisional license should be strengthened. Alternatives are:

1. The provisional license could be issued for relatively short periods of time. If the violations were not found to be corrected at the end of this period, then SDW should not renew the provisional license.

2. The General Assembly may wish to consider amending Section 63.1-178 of the *Code of Virginia* to specify more specific parameters for the use of the provi-

sional license. For example, the provisional license might be limited to one-time use for a six-month or one-year nonrenewable period in existing licensed homes.

3. SDW could issue provisional licenses printed on specially-colored paper, and require them to be prominently displayed at the home. Violations of standards should be described on the license in simple language.

4. A provisional license should not be granted to a new facility not previously licensed.

Revocations. Because revocation of a license usually involves meeting requirements of the administrative process law as well as considerable time and expense, SDW reports that revocation is used infrequently. In the 18 months between January 1978 and August 1979, SDW revoked four adult home licenses. During that period, SDW also denied license renewals to five homes.

Although revocation and denial could be an effective enforcement tool, these sanctions appear to be difficult to use. Several licensing specialists reported that the time-consuming nature of revoking or denying a license tended to discourage use of these enforcement tools.

Recommendation (13). SDW should develop and propose to the General Assembly intermediate sanctions to enforce compliance with State standards. Such sanctions could include the authority to prohibit a home's acceptance of new residents, new auxiliary grant recipients, or new aftercare residents until violations were corrected. In addition, SDW could strengthen the sanctioning effect of the provisional license, as discussed above, by using it sparingly.

Illegal Activities

Under State law, a license is required for any facility which provides room, board, and discernible supervision to four or more aged, infirm, or disabled adults. Despite this statutory requirement, homes which provide such services without the necessary license appear to exist throughout Virginia.

Identification of Illegal Homes. While the Commissioner of Welfare has acknowledged that illegal adult homes exist, the magnitude of the problem is unknown. During the course of this study, several members of SDW's licensing staff and local agency staff reported that illegal homes are a perennial problem.

At least one state has attempted to identify potentially illegal adult homes. The Maryland Department of Human Resources

issued a draft report through its Project HOME in June 1979 concerning domiciliary care homes. Using a definition similar to Virginia's definition of a home for adults, the report estimated that as many as 100 illegal domiciliary care homes may exist in Maryland. This estimate was based on inspections of a sample of addresses where three or more SSI checks were sent. Data concerning SSI checks are routinely sent to the states by the Social Security Administration.

At the August 1979 JLARC meeting, the Commissioner of Welfare announced similar plans to utilize SSI data to assist in identifying potentially illegal adult homes. According to the commissioner, a special computer program is being prepared to aid in this process.

When an allegedly illegal home is identified, an SDW licensing specialist conducts an investigation to determine whether the facility is operating as a home for adults. When an illegal home is identified, SDW gives the operator the choice of applying for a license or halting operations. If the operator refuses to do either, SDW may commence legal proceedings to halt the home's operation. Over the 18-month period from January 1978 to July 1979, SDW obtained 12 injunctions against illegal homes.

Licensing specialists have been hampered in dealing with potentially illegal adult homes because, until very recently, no guidelines existed to help define the supervisory activities in which a facility must engage in order to require licensure. Lacking such guidelines, SDW's licensing specialists were not adequately equipped to determine whether a facility required a license. In addition, licensing specialists have had to deal with illegal homes in addition to their regular caseload. In some instances, regular caseloads were reported to have become secondary to investigations of potentially illegal homes. There may be a need for specialized staff trained in identifying illegal homes and in enforcement techniques.

When the operator of an illegal adult home applies for a license, SDW normally gives the operator time to bring the facility into compliance with licensing standards. In some cases, homes with pending applications may continue to operate for long periods of time without a license, as illustrated below.

Home A

A facility providing room, board, custodial care, and supervision for five aged adults opened for business in August 1977. It was not licensed as a home for adults and was thus an illegal home.

The regional licensing staff first learned of the home's existence in October 1977 through a

local health department employee. The regional licensing specialist subsequently contacted the owner and informed her of her options: either halt operations or apply for a license. In late 1977, the owner applied for a license. During the next eight months, the facility continued to operate illegally while its application was pending.

The regional licensing staff conducted a compliance inspection in the summer of 1978 and found 11 violations of licensing standards. These violations included numerous safety hazards, roaches in food service areas, odors, and incomplete records. Nevertheless, the regional licensing staff issued a provisional license to the home.

Home B

A facility with more than 100 beds began providing room, board, and supervision to 20 to 30 residents in early 1979. Although the operator applied for a license, local officials had not issued a certificate of occupancy for the facility so no license was issued. Thus the home was operating illegally.

Six months after the operator began accepting residents, the occupancy certificate was issued to the facility. SDW subsequently issued an adult home license to the facility.

In these cases, the homes operated without a license for several months after SDW learned of their existence. At no time during this period did Home A meet standards for licensure; however, it was ultimately approved for licensure.

Exceeding Licensed Capacity. State law requires that the maximum number of residents for whom an adult home may care must be stipulated in the home's license. Additional residents may strain the capability of the home to provide adequate services. Licensees who care for more people than allowed by their license commit a misdemeanor under the law.

In visits to the 29 sample homes, JLARC staff identified four homes with more residents than allowed by their license. In each of these cases, the "extra" residents also received State-funded auxiliary grant payments. Several additional adult homes had more beds than their licenses allowed, raising the question as to whether these facilities also cared for too many residents. All of these homes had been routinely inspected by licensing specialists. In two of the four cases, specialists had found the extra residents

and corrected the situation. In the other two cases, however, licensing specialists had either missed or not reported the extra residents.

SDW's special investigation of adult homes found five homes which were exceeding licensed capacity. Two of these homes were keeping the "extra" residents in the licensed facility, and three facilities were using non-licensed buildings to house the additional residents.

Recommendation (14). SDW should develop an active program to deal with illegally operating adult homes. This program could:

1. Compel illegal homes to comply with licensing standards within specified time periods or seek appropriate legal action against the homes.

2. Utilize "enforcement specialists" trained in detecting illegal homes and in compliance techniques.

3. Use SSI data routinely supplied to SDW by the Social Security Administration to locate potentially illegal adult homes.

4. Maintain a regularly updated count of the number of beds actually in facilities, in addition to the licensed capacity of facilities, in order to identify homes with the potential for exceeding licensed capacity.

Inappropriate Placements. There is evidence that local welfare agencies and State mental hospitals have placed residents in unlicensed adult homes and have encouraged licensed homes to accept more residents than their licensed capacity. These placement practices have led to violations of licensing standards and promoted auxiliary grant abuse.

Residents found in unlicensed and potentially illegal adult homes are often deinstitutionalized mental patients. These patients frequently require services in addition to room and board, and placement in an unlicensed facility may deprive them of these needed services.

During the course of this study, it was reported to JLARC staff that State mental hospitals had made placements in unlicensed facilities in the Tidewater and Valley regions, Richmond, and Danville. In addition, it was reported that local agencies had also made such placements, as illustrated in the following case.

In 1973, an Eastern Virginia city began to assist community integration of former

institutionalized mental patients. Many of these individuals were placed by the city in "boarding homes" housing more than four residents.

A 1978 study by city staff of these placements found that these facilities were often illegal adult homes. Although the residents frequently required supervision and other services, very poor care was provided. Compounding this situation was the failure of State institutions to notify the local welfare agency in advance of individuals returning to the community.

According to the director of the local agency, in April 1979 an estimated 20 percent of the agency's placements resided in unlicensed and potentially illegal facilities.

With the assistance of local agencies in Richmond and in the Tidewater region, JLARC staff visited six unlicensed and potentially illegal adult homes. The residents were primarily deinstitutionalized mental patients. Conditions in these homes were deplorable and characterized by filth, unsanitary food service and storage areas, inoperable plumbing facilities, and inadequate supervision. These facilities were subsequently reported to SDW.

While deinstitutionalization does not always lead to an illegal, poor, or inappropriate placement, the possibility of such a consequence does exist.

Recommendation (15). In order to effectively coordinate the placement of individuals in appropriate facilities, communication should be improved between State mental hospitals, local welfare agencies, and other placement agencies. Information on placement of mental patients in licensed or unlicensed adult homes should be routinely shared with SDW to facilitate the monitoring of potentially illegal homes.

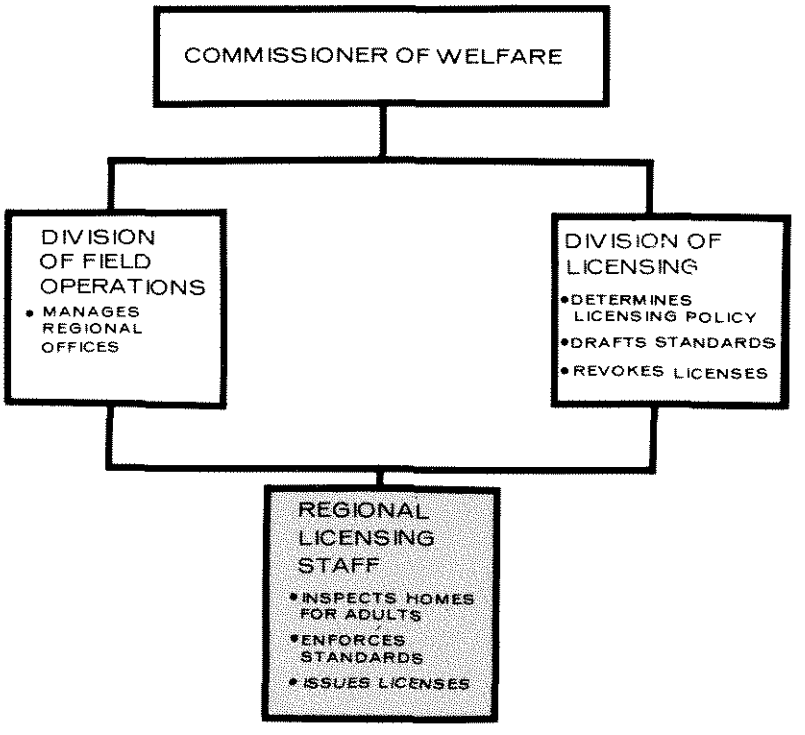
MANAGEMENT OF THE LICENSURE PROGRAM

The licensure program is one of the few SDW activities that is directly operated rather than supervised by the department. During the course of this review, JLARC staff found that management of adult home licensing activities is split between two SDW administrative divisions and, to a degree, among the seven regional offices. Significant regional variation in implementation of licensure requirements exists. In effect, there are seven adult home licensing programs, one in each region.

Within the central office, responsibility for policy-making is assigned to the Division of Licensing. Administration of regional office activity is the responsibility of the Division of Field Operations. The functional responsibilities of both central office divisions are shown in Figure 5. Also shown are the responsibilities carried out on a regular basis by licensing supervisors and inspectors housed in each of the seven regional offices.

Figure 5

ORGANIZATION OF HOMES FOR ADULTS LICENSURE PROGRAM



Source: SDW, JLARC.

Regional Variations in Procedures

The Division of Licensing attempts to establish Statewide procedures through preparation of the Licensing Manual and periodic directives to and training of regional staff. However, it is clear that regional licensing staff take different approaches to inspections and the use of provisional licenses.

Three different regional patterns in the type of violations noted by SDW licensing specialists are shown in Table 5.

Licensing specialists in Region 1 stated during interviews that they emphasized compliance with record-keeping standards. Violations cited by specialists in that region did, in fact, reflect this emphasis. This general pattern was observed in Regions 1, 2, 3, and 4. Regions 5 and 6 displayed a different pattern. Specialists in Region 5 told JLARC they emphasized the safety and security of the physical facility, and cited those violations most frequently. None of the regions noted many violations in food service or sanitation standards, although, as reported in Chapter II, the Health Department nutritionist and SDW's own special investigation reported a substantial number of violations in these areas.

Table 5

VIOLATIONS CITED ON PROVISIONAL LICENSES
1978

	Region						
	1	2	3	4	5	6	7
Records	40%	35%	32%	39%	24%	29%	*
Physical Structure	18	25	22	21	41	36	*
General Standards	9	9	15	9	10	8	*
Fire Safety	7	9	10	13	2	14	*
Sanitation	1	3	7	9	6	6	*
Food Service	14	13	10	5	10	8	*
No. Provisional Licenses Issued	33	51	22	22	17	24	2

*Insufficient data.

Source: SDW, JLARC.

Licensing specialists in Region 1 told JLARC they thought that issuing a high number of provisional licenses indicated they were doing a good job. During 1978, Region 1 licensing specialists issued provisional licenses to 78 percent of all homes in that region. In contrast, the licensing specialist in Region 7 told JLARC he did not believe in issuing provisional licenses, as he preferred to work with licensees to bring facilities into compliance. Only two (9%) of the homes in that region received provisional licenses in 1978.

Regional variation in these key activities indicates that regional licensing staffs have considerable autonomy in deciding programmatic emphases. Regional variation also seems to indicate that a home in one part of the State could be cited for a violation that might not be cited in another region. In addition, the consequences of such variation in licensing and enforcement practices can have important effects on licensees and residents of

adult homes. Emphasizing some licensing standards over others can be especially troublesome, because it suggests to owners that some standards may be only weakly enforced.

Established working hours and caseload can affect the efficiency and effectiveness of licensing staff. In one region, staff activity was limited by the regional director's decision not to permit overtime past 5 p.m. As a result, staff could not determine compliance with the licensing standard requiring 24-hour supervision in certain homes, or make visits during the evening meal.

Three regions appeared to be routinely three to six months behind in processing adult home renewals. Because of these backlogs, all homes in these regions are not inspected each year. Among the seven regions, adult home caseload assignments reported for 15 licensing specialists varied from four to 40 homes (Table 6).

Table 6

ADULT HOME CASELOAD OF SDW LICENSING SPECIALISTS
August 1979

Region	Specialist	Adult Homes	Other Facilities*
A	1	23	4
B	1	31	10
C	1	28	2
	2	26	2
	3	25	7
D	1	22	1
	2	25	0
E	1	10	16
	2	29	4
F	1	4	23
	2	5	14
	3	21	14
	4	12	23
G	1	40	2
	2	10	27

*Includes adult daycare centers and child caring facilities.

Source: SDW.

These variations in workload and procedures resulted from decisions being made on a regional level. The central office of the licensing division appeared to have little part in decisions that affected regional consistency in the administration of the adult home licensure program.

Monitoring Process

The central office of the Licensing Division does not participate in regional decisions to issue licenses or independently evaluate conditions in adult homes. All routine decisions for issuance and renewal of adult home licenses are made at the regional level.

Decisions on denials and revocations are made centrally within the division. Thus, the central office of the division gets a predominantly one-sided view of the adult homes licensing program. As the former director of the Licensing Division stated: "It is difficult to take a 'negative action' when you have not been involved in the positive actions."

Limited File Review. Accurate, relevant, and timely monitoring of adult home licensure can greatly enhance the quality of decisions and uniformity of enforcement among regions. However, SDW currently has a very limited monitoring system. Under present procedures, the department examines only one component of licensing decisions--the compliance document prepared by licensing specialists. The appropriateness and sense of judgment that go into licensing decisions are not evaluated.

Twice a year, ten percent of the compliance studies from the active adult homes caseload are pulled from licenses issued in each region during a three-month period. For some regions, this may mean that only one or two case files a year are reviewed. The case files are forwarded to the central office of the Division of Licensing, where they are reviewed for procedural and technical accuracy, as well as timeliness.

Lack of Site Visits. No attempt is made during central office review to make a "case audit" (verifying whether conditions reported in the document accurately reflect conditions in the particular home). Site visits of homes are not routinely conducted by the central office for any purpose and licensure reports are not monitored on a continuing basis.

The following case illustrates one instance where the Director of Licensing would have overruled the decision of the regional staff. In this case, the central office did not learn of the serious nature of violations until procedures were initiated to revoke a recently-issued provisional license.

The regional licensing staff conducted a compliance inspection of a new adult home in August 1978 and found 11 violations of licensing standards. Nevertheless, the regional licensing staff issued a provisional license for a six-month period ending in early 1979.

A compliance study conducted in February 1979 found three of the original violations corrected, but five new violations were observed for a total of 13. At this point, the regional licensing staff decided to recommend to the central office that the provisional license be revoked and that the facility cease to operate.

The Director of the Licensing Division stated in an interview that this home should never have received a license in the first place.

Recommendation (16). The role of the licensing division's central office should be modified to ensure greater uniformity in the enforcement of standards. The director of the licensing division should review in advance the issuance of each provisional adult home license as well as the revocation of licenses. Central office monitoring of routine regional licensing decisions should include case audits of licensure procedures by on-site verification of conditions reported by licensing specialists.

IV. Auxiliary Grant Program

The auxiliary grant program pays for the care received by 2,500 residents of licensed homes for adults. Because SDW's licensing specialists routinely inspect every adult home, an important link exists between the auxiliary grant program and licensure. However, sufficient coordination between the grant program and licensure has not been achieved. This coordination problem has led in some cases to people receiving grant payments without receiving the intended domiciliary care.

Additional weaknesses exist within the auxiliary grant program. Monthly grant payments have been increased without adequate justification. Eligibility monitoring for the program has been weak. Adult homes have been awarded monthly grant rates based on unreliable and unaudited cost reports.

RATE-SETTING

Payments through the auxiliary grant program for care in licensed adult homes have increased rapidly. This escalation has occurred despite the absence of data accurately reflecting the cost of operating an adult home. Although adult home licensees have routinely submitted reports to SDW detailing the cost of care, SDW did not audit or verify any of the cost reports until mid-1979. Thus, SDW has not been in a position to establish a monthly rate that reflects actual costs.

In 1974, the General Assembly authorized the State Board of Welfare to implement a State and local funded auxiliary grant program to provide financial assistance to people unable to meet minimum standards of need. The State Board of Welfare subsequently linked the recipients' minimum need to the cost of providing domiciliary care in licensed adult homes. Thus, a low-income aged, blind, or disabled person could only be eligible for the auxiliary grant program by receiving care in a licensed adult home. The monthly adult home rate was set equal to the cost of operating the licensed home in which the grant recipient lived, up to a maximum amount set by the General Assembly.

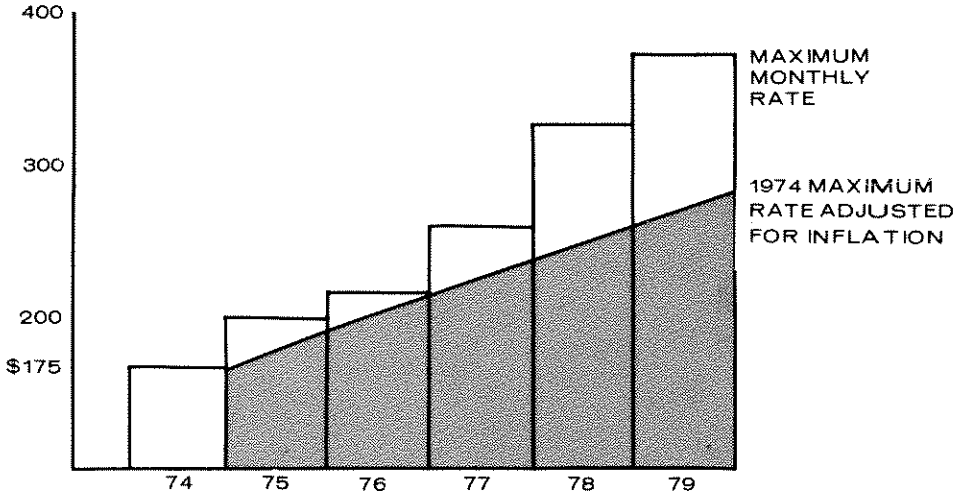
Local welfare agencies play an important role in the auxiliary grant program. The local agencies determine whether an individual is eligible for auxiliary grant payments. In addition, the local agencies make the monthly payments to recipients. SDW reimburses local welfare agencies for 62.5 percent of their auxiliary grant expenditures.

Growth in Auxiliary Grant Rate

The maximum monthly financial assistance under the auxiliary grant program has more than doubled over the last five years. This increase has exceeded the rate of inflation (Figure 6) and represents a real increase in the State's support for needy residents of licensed homes.

Figure 6

MAXIMUM HOME FOR ADULTS RATE AND INFLATION
1974-79



Source: JLARC representation of SDW data.

Table 7

MAXIMUM MONTHLY PAYMENT TO AN INDIVIDUAL
UNDER SSI AND AUXILIARY GRANT PROGRAMS

	Maximum SSI Payment	Maximum Auxiliary Grant*	Maximum Home for Adults Rate
July 1974	$146.00	$ 29.00	$175.00
Oct. 1974	146.00	54.00	200.00
July 1975	157.70	42.30	200.00
July 1976	167.80	47.20	215.00
July 1977	177.80	52.20	230.00
Jan. 1978	177.80	82.20	260.00
July 1978	189.40	146.60	336.00
July 1979	208.20	163.80	372.00

*Assumes individual is receiving maximum SSI payment. Includes both State share (62.5%) and local share (37.5%). Does not include personal allowance to each recipient.

Source: Social Security Administration, SDW, and JLARC.

Auxiliary grant recipients generally receive both an auxiliary grant payment from the State and a federal SSI payment. Federal law requires SSI to increase annually at a rate tied to the cost of living. However, the auxiliary grant has escalated much more rapidly than SSI (Table 7). Total State general fund appropriations for the grant program have also increased. The growth in State appropriations for the auxiliary grant program is shown in Table 8.

Table 8

STATE APPROPRIATIONS FOR THE AUXILIARY GRANT PROGRAM, AGED AND DISABLED RECIPIENTS

Fiscal Year	Appropriation
1976-77	$ 903,385
1977-78	1,106,400
1978-79	3,715,400
1979-80	4,372,500

Source: JLARC.

Rate-Setting

Because SDW has never fully audited cost reports submitted by adult homes, the cost of providing care in those homes remains unknown. Despite SDW's lack of reliable data on the cost of care in homes for adults, the following appeared in SDW's budget exhibit for 1980-82:

> Funding of supplemental income assistance to recipients in domiciliary care currently permits payment of $336 per month, far below the cost of such care. (emphasis added)

Audits. Preliminary evidence indicates that licensees have, in fact, supplied SDW with faulty cost data which was then used to set monthly rates. Thus, monthly rates for some homes have been equally faulty.

In mid-1979, SDW conducted audits of seven adult homes (one "typical" home was selected from each region). According to these audits, monthly rates set for four of the seven adult homes were inaccurate. In addition, major discrepancies were found in the cost reports submitted by six of the seven homes (Figure 7). These discrepancies had the effect of overstating the cost of providing care at these six homes.

These findings suggest that substantial overpayments may have been made through the auxiliary grant program. Although the

Figure 7

CONTRAST IN OPERATING COSTS AT ADULT HOMES

SDW requires operators of adult homes who wish to receive a monthly rate of over $175 to submit a report detailing the costs of operating the home. These cost reports have never been audited, yet SDW has used them as a basis for setting adult home rates. Data based on these unaudited cost reports follows.

Table A

REPORTED OPERATING COSTS,
*ALL HOMES FOR ADULTS REPORTING**

Licensed Bed Capacity Range	Average Monthly Operating Cost Per Resident	Minimum - Maximum Monthly Operating Cost Range
4-9	$382	$ 37 - $2,346
10-19	458	261 - 1,295
20-49	471	282 - 1,592
50+	532	339 - 819
All reporting homes	$466	$ 37 - $2,346

**Based on 171 operating cost reports submitted to SDW as of January, 1979, by adult homes applying for more than the minimum monthly rate. These cost reports are not audited and may contain errors.*

In mid-1979, SDW audited seven adult homes. These audits revealed major errors in cost reporting at six of the seven homes. At four of the homes, monthly rates were determined to be higher than justified by the home's actual cost experience. The magnitude of error uncovered in the audits is shown below.

Table B

CONTRAST BETWEEN REPORTED AND AUDITED COSTS,
SEVEN HOMES FOR ADULTS

Home	Licensed Bed Capacity Range	Per Resident: Reported Monthly Costs	Per Resident: Audited Monthly Costs	Error in Monthly Rate
1	20-49	$337	$268	$ 68
2	20-49	336+	321	15
3	50+	365	175	161
4	50+	339	319	17
5	20-49	336+	336+	Error[1]
6	20-49	336+	336+	Error[1]
7	20-49	336+	336+	Accurate

[1]*Data mis-reported and in error; however, actual costs exceeded maximum allowed rate.*

Thus, monthly adult home rates at six of these seven homes have been based on erroneous cost data. Errors in data appear to have operated in the homes' favor, resulting in some homes receiving excessive payments from the auxiliary grant program.

Source: JLARC representation of data from SDW's Bureau of Fiscal Management and Office of Internal Audit.

audit findings suggest that not all homes can justify the maximum rate, it is received by most adult homes which apply for a monthly rate. As of January 1979, 171 licensed homes had filed operating cost statements with SDW, and 149 (87%) of these homes received the maximum rate.

The actual cost of providing care in licensed adult homes must be established before SDW can adequately justify any further increases in the monthly rate under the auxiliary grant program.

Recommendation (17). SDW should take steps to improve the basis for setting monthly adult home rates. Guidelines should be established for a monthly rate which includes allowable costs and an equitable rate of return. Cost data audited by SDW or certified by an independent auditor retained by the home should be used when setting monthly rates for individual adult homes. The maximum monthly rate should not be increased above an adjustment for inflation unless clearly justified on the basis of reliable data concerning the cost of operating adult homes.

Cost Reporting

Cost reporting policies and procedures developed for the auxiliary grant program are inadequate. Under these policies, some homes have received rates based on artificially inflated data, or on no data at all. In addition, the cost reporting form seems to hinder accurate reporting of costs, and some licensing and rate-setting employees have assisted adult home licensees in obtaining higher monthly rates.

Misreported Costs. Misreporting of income and expenditures by licensees may be widespread. Six of the seven adult homes audited by SDW had misreported cost data so that their expenditures appeared to be higher than could be justified.

JLARC staff found additional evidence that misreporting may be widespread. In visits to 29 sample homes, licensees who had submitted cost reports were queried about certain cost-related categories. The following examples show how misreporting of costs occurred.

Case A

JLARC staff visited a home which had listed $1,800 in licensed nursing services in its latest cost report. When questioned in person, the licensee stated he had never paid for any nursing services. By reporting expenses which had not in fact been paid, the licensee artificially increased his cost of operation.

Case B

The income earned from vending machines is supposed to be reported as part of the home's total income. Of the 29 homes in JLARC's sample which had filed cost reports, nine had vending machines on the premises. Eight of the nine did not report any income from this source. Only one home listed any vending machine income in its most recent cost report.

Case C

The licensee of one home in JLARC's sample stated that he had submitted projected costs instead of actual costs. He said he didn't know that only actual costs should be reported.

Cost Reporting Policy. Poorly developed cost reporting policies have enabled some homes to receive a rate based on distorted costs. Follow-up and adjustment of negotiated rates for new homes has been inconsistent.

According to SDW policy, monthly rates for new homes without previous cost experience are supposed to be based on negotiation until the home has 90 days of cost experience. At that time, a monthly rate should be set on the basis of the 90 days of cost experience. The following case illustrates that this process is not always followed.

One licensee received the maximum monthly rate without submitting any cost data. When this licensee first obtained his license he was told that, because he was a new licensee and had no previous cost history, his rate would be the minimum, $175 per month.

"Send over the buses so we can move the people out," he told SDW officials. "I can't keep them for $175." The licensee subsequently negotiated with SDW and received the then-maximum rate, $336 per month.

In this case, the negotiated rate had not been reviewed or adjusted, although it had been in effect for over eight months when JLARC staff interviewed the licensee.

Licensees who operate several separately licensed homes have received rates based on the cost of operating all their facilities. This method tends to distort the costs of operating, and thus affects the home's monthly rate, as this example shows:

A licensee operates four licensed homes. One home has a capacity of 39 residents and is some distance from the other three facilities, which are on the same street and have capacities of five to seven residents. The cost of operating the homes varies due to differences such as size, staffing, and taxes.

This licensee submits one cost report with information on the cost of running all four homes, thereby distorting the actual cost of operating each home. Using the single cost report, SDW personnel set the monthly rate for all four homes at this distorted level.

Of the cost reports filed with SDW in January 1979, ten licensees were identified who operated more than one licensed home. Seven of these ten licensees submitted only one cost report, with combined cost data from several homes. As a result, a monthly rate which distorted actual costs was generated for each home.

One SDW employee responsible for rate-setting explained this policy to JLARC staff by saying, "One cost form is better than a whole bunch of forms." However, SDW policy also permits one cost report to be submitted for each home.

Recommendation (18). SDW needs to strengthen cost reporting policies. A separate cost report should be required for each separately licensed home. In addition, SDW should establish a policy which precludes negotiations and cost projections for rate-setting, except that projected rates for newly licensed homes should be established and routinely reviewed and adjusted when the home has accumulated 90 days of cost experience.

Cost Reporting Form. The cost reporting form developed by SDW hinders the accurate reporting of cost information and contains ambiguous categories. Only a few of the many items specified on the form are actually used in rate-setting, and the instructions for detailing these items are not clear. The form contains the following problems:

1. Several cost categories are not explained at all in the instructions. Such items as "nonallowable expenses" and "restricted contributions" appear to require further description, which is not on the form.

2. According to instructions for the cost reporting form, depreciation of the physical structure could be allowed although the licensee is only renting the facility. Licensees could, therefore, claim as expenses both rent payments and depreciation.

3. Instructions on the form do not specify how mortgage payments should be listed. Presently such payments may be counted in at least two separate categories.

4. The use of projected costs in the form cannot be distinguished from the use of actual costs. One licensee submitted projections and received a monthly rate on that basis, as SDW employees could not ascertain from the form that projected costs were used instead of actual costs.

Recommendation (19). The cost reporting form should be redesigned. It should contain clear instructions and unambiguous categories. In addition, policies should be established as to which costs may be claimed and which costs will be disallowed. These policies should be clearly stated on the form or in accompanying instructions.

Employees' Role. SDW currently has no policy on the extent to which employees may assist licensees. As a result, several SDW employees--including central office and regional personnel--have filled out cost reports for licensees. These employees acted outside of their regulatory roles and could have become advocates for specific homes.

One employee told JLARC staff that he "knew the home could get more" than its current rate, so he assisted the licensee in applying for a higher rate. Other employees appear to ignore licensees' legitimate requests for information about the auxiliary grant program. A licensee told JLARC staff that a SDW employee with a key role in rate-setting never returns phone calls, ignores letters, and "is never available when questions arise."

Recommendation (20). SDW should identify the proper role of licensing staff in the auxiliary grant program. Licensing staff should provide general information about the grant program and refer requests for assistance to appropriate auxiliary grant staff. All requests for information and assistance should be promptly answered.

MONITORING THE AUXILIARY GRANT PROGRAM

A key eligibility requirement for the auxiliary grant program is residence in a licensed adult home. This is intended to ensure that the care provided through State-funded financial assistance meets minimum standards. Licensure thus plays an important role for the auxiliary grant program.

Despite licensure's role, some people not residing in a licensed adult home have received auxiliary grant payments. Such

abuse of the auxiliary grant program has occurred in part because monitoring of grant payments has been ineffective, and because SDW has not enforced policies and procedures for grant eligibility.

The Payment Process

Accountability for the expenditure of State funds in the auxiliary grant program is diffuse. Local welfare agencies, not SDW, determine client eligibility and make payments. SDW's role is confined to setting the monthly rate for individual homes and to reimbursing the local agencies for auxiliary grant expenditures. However, neither SDW nor the local agencies effectively monitor continued eligibility of clients.

Local Role. To make the initial eligibility determination and the annual re-determination, local welfare agencies must keep track of many auxiliary grant recipients who move around the State. Under State law, which welfare agency makes grant payments for a deinstitutionalized mental patient depends on where the patient lived prior to being placed in an institution.

Because the local welfare agencies which make eligibility determinations can be miles away from the recipient, the recipient's place of residence often cannot be monitored or verified by the responsible agency. Consequently, ineligible persons may receive grant payments, as shown in the following examples.

Home A

Licensing staff in one region received a complaint in early 1979 on a home in JLARC's sample. According to the complaint, the licensee was keeping residents in a trailer on the same property as the licensed home.

Licensing staff investigated the complaint and found it to be valid. Because the practice violates licensing standards, the licensee was told to remove the residents from the trailer.

Subsequently, it was learned that the three residents in the trailer had been receiving auxiliary grant payments for approximately one year. These people were not eligible for the auxiliary grant program because they did not reside in a licensed home for adults.

The people received the grant from separate local welfare agencies, the closest of which was 40 miles from the home. The amount of payments made to these ineligible people was approximately $5,500.

Home B

The licensee of an adult home rented a cottage near the licensed facility and kept boarders in this cottage. In mid-1978, the licensee received a provisional license with the stipulation that no more than three boarders be housed in the cottage.

The cottage was not part of the licensed facility, yet one boarder, who was ineligible for the grant, in fact received auxiliary grant payments.

This practice continued for over a year, during which time the boarder received more than $1,500 in auxiliary grant payments. The local welfare agency which made the payments was 25 miles from the home.

In both of these cases, auxiliary grant payments were made to people living in facilities not licensed by SDW. In addition, the responsible local welfare agencies had not effectively determined the continued eligibility of these people for the grant.

Reporting Requirements. State law requires individual auxiliary grant recipients, under threat of a misdemeanor, to report changes in circumstances that may affect their continued eligibility for the grant. Compliance with this statutory requirement may be difficult because auxiliary grant recipients are aged, blind, or disabled. Although recipients technically receive the monthly grant payments, the money ultimately passes to the licensee as the provider of domiciliary care. Many licensees are, in fact, the payee for auxiliary grant checks.

It is not clear under State law whether licensees carry an obligation to report changes in circumstances which affect their residents' eligibility for auxiliary grant payments. As the licensed provider of domiciliary care and the ultimate beneficiary of the auxiliary grant payment, the licensee plays a special role in the grant process. Clearly, the licensee is better able to note potential changes in client eligibility than the aged, blind, or disabled client.

Licensees have a clear financial incentive not to report changes in residents' continued eligibility. The following example illustrates what can happen if statutory reqirements are not followed.

Southwestern State Hospital placed a patient at a licensed home for adults in mid-December 1976. The patient was determined to be eligible for the auxiliary grant and stayed

at the home about two weeks before she was recommitted to Southwestern State.

Auxiliary grant checks were subsequently sent to the home, even though the patient no longer resided at the home. Neither patient, home, nor hospital notified the responsible county for several months after the patient was recommitted.

In this case, the recipient was unable to report on changes in eligibility status. While it may have been more suitable for the licensee to notify the local welfare agency, he had little incentive to do so.

Because the licensees are responsible for providing care to auxiliary grant recipients, their responsibilities in the grant program should be clarified.

Recommendation (21). SDW should establish fraud and abuse controls over auxiliary grant payments. At a minimum, each auxiliary grant check should carry both the recipient's name and an identifier of the home in which the recipient lives. A mechanism should also be considered whereby the recipient would regularly confirm continued eligibility for grant payments. Such confirmation could be obtained on a form routinely mailed with the payment or printed on the reverse side of the monthly check. Another control mechanism would be for the licensee to confirm regularly that specific grant recipients continue to reside in the licensed home. Unless this confirmation were received for each recipient, subsequent grant payments could be questioned or not be made until verified.

SDW Role

SDW is the only agency with staff which routinely visit and inspect all licensed adult homes. However, communication and coordination between this staff and the auxiliary grant administration have been lacking. SDW's licensing specialists routinely inspect adult homes, yet some were found who knew little about the auxiliary grant program. While licensing specialists could use information already collected by SDW to monitor the grant program, they have never been assigned this role.

These deficiencies have hindered SDW in fulfilling a priority identified by the State Board of Welfare in its statement of mission:

> All efforts will be guided to assure that only those persons eligible for assistance and/or services should receive them and that those not

eligible for them or abusing the program, whether a client or provider of service, shall be dealt with according to law.

SDW must be more active in ensuring that State funds provide care only to eligible persons in licensed adult homes.

Licensing's Role. Auxiliary grant abuse has gone undetected by SDW's licensing staff. To some extent this is due to a lack of awareness about the requirements of the auxiliary grant program, as illustrated in the following example.

> *JLARC staff and an SDW licensing specialist visited a sample home. In the course of the visit, the licensing specialist reviewed the residents' records and noticed that the home had files on three residents living in a nearby house. The financial statements included in these records showed that the three residents in the nearby house were receiving auxiliary grant payments in addition to SSI.*
>
> *The specialist did not know whether it was correct for people who did not reside in a licensed home for adults to receive auxiliary grant payments. While these people had been receiving the grant for some time, the specialist had not previously noticed this fact. The specialist finally turned to the JLARC staff member and asked whether it was appropriate.*
>
> *(Although the "neighbors" sometimes participated in the licensed home, they did not reside in the licensed home. Thus, they were ineligible for the grants.)*

In this case, a licensing specialist was not aware of the residency requirement and, as a result, did not know whether the neighbors were eligible for auxiliary grant payments.

Recommendation (22). SDW licensing personnel who routinely inspect adult homes should be trained in the requirements of the auxiliary grant program. In addition, licensing staff should closely monitor homes which have the potential for auxiliary grant abuse, such as homes with trailers or other out-buildings on the premises, or with more beds than allowed by the terms of their license.

Warrant Registers. SDW routinely collects information about all auxiliary grant recipients in Virginia, but has made little use of it. By utilizing this information to monitor the auxiliary grant program, SDW could improve the administration of the program.

Every month local welfare agencies submit registers of all auxiliary grant warrants to SDW. SDW currently uses data from these warrant registers to reimburse the local agencies for a portion of their total auxiliary grant payments during the month. Data from the warrant registers could also be used to identify potentially ineligible recipients, as the following case illustrates.

> *JLARC staff visited a home for adults licensed for seven residents. Several trailers and a small house were on the same property as the licensed facility. The licensee refused to let staff inspect these dwellings.*
>
> *In checking warrant registers from the appropriate localities, two people were identified as receiving auxiliary grant payments at the home's address, although the licensee had not identified these people as residents of the home. The local welfare agency making payments to these people confirmed that they were living at the home. Thus, it appeared that the licensee was keeping at least two extra residents, possibly in the trailers or small house, who were receiving auxiliary grant payments.*
>
> *Although the local welfare agency confirmed that these people were living at the home and receiving grant payments, SDW's regional licensing staff investigated and concluded the two extra residents were not living in the licensed home. The matter had not been satisfactorily resolved at the time this report was written.*

In this case, the presence of habitable out-buildings on the same premises as a licensed adult home suggested that the licensee might have "extra" residents. Information from the local agency and from the warrant registers tended to confirm this possibility, and the SDW investigation did not rule out this possibility.

Warrant registers provide a centralized source of information on auxiliary grant recipients that SDW could use to improve monitoring of the auxiliary grant program.

Recommendation (23). SDW should monitor local determinations of eligibility for the auxiliary grant program. Information currently collected by SDW concerning auxiliary grant recipients could be used for such monitoring. A list of recipients in each

licensed adult home could be assembled by computer from warrant registers if the registers included the name of the recipient and identification of the home. These lists could then be used routinely by licensing specialists to verify residency during inspections of homes.

SUMMARY AND CONCLUSION

The State Department of Welfare needs a fully conceptualized program for adult homes. Currently, there is no clear focus of responsibility for planning, coordination, and implementation of adult home activities. Close coordination between auxiliary grant administration and licensure would facilitate addressing such problems as over-capacity, quality control, and auxiliary grant abuse.

Recommendation (24). SDW should develop a programmatic approach to managing its adult home activities. This approach should include the development and implementation of an annual program plan which:

1. Defines goals and objectives, identifies ways to achieve them, and assigns specific staff responsibility.

2. Defines the role of adult homes in meeting long-term care housing needs of the aged, infirm, and disabled.

3. Describes appropriate ways of coordinating SDW adult home activities with other State agencies, such as the Office on Aging and DMHMR.

4. Identifies specific ways to closely link auxiliary grant administration with the licensure program.

5. Lists various training activities scheduled for licensing specialists.

Future demand for domiciliary care in adult homes for the aged, infirm, and disabled can be expected to increase. The priority assigned to homes for adults regulation should be consistent with the important role of these homes.

Appendices

Agency Response

JLARC policy provides that each State agency involved in a program review be given the opportunity to comment on an exposure draft. This process is one part of an extensive data validation process. Appropriate corrections resulting from the written comments have been made in the final report.

TECHNICAL APPENDIX

JLARC policy and sound research practice require a technical explanation of research methodology. A technical appendix was prepared for this report and was part of the exposure draft. The technical appendix is available on request from JLARC, 910 Capitol Street, Richmond, Virginia 23219.

The technical appendix includes a detailed explanation of the methods and research employed in the development of this study. The following areas are covered:

1. Random Sample of Homes. Visits were made to a randomly selected sample of licensed adult homes. The sample was drawn from the 258 licensed homes open for business during all of 1978. The sample of 29 homes was judged representative of the 258 homes on six measures, which are included.

2. Inspections by Experts. Expert opinion was requested from five State agencies concerning nutrition, sanitation, fire safety, and the provision for certain personal needs of residents. These experts utilized applicable standards when inspecting homes, and provided written reports of their findings. A copy of the form used by the nutritionist during on-site inspections is included. State agencies which provided expert opinion included the State Department of Health, State Department of Mental Health and Mental Retardation, State Department of Welfare, State Fire Marshall, and State Pharmacy Board.

3. Operating Cost Analysis. Operating cost data supplied to SDW by 171 homes were analyzed to determine several indicators. Included is a description of how cost per meal per resident was calculated.

4. Estimated Aftercare Population. The number of deinstitutionalized clients residing in licensed homes was estimated from a 1979 survey of homes conducted by SDW. Based on data from 180 responding homes, it was estimated that 1,500-2,000 current residents of homes may be deinstitutionalized.

5. Interviews. Many State and local agencies were consulted during the course of this review, as were various interested groups and individuals. An important part of the review involved on-site visits by JLARC staff to a total of 48 licensed homes located throughout the State. Interviews were conducted with licensees and staff of each home. Many residents of homes were also interviewed.

COMMONWEALTH of VIRGINIA
Department of Welfare
Office of the Commissioner

Blair Building
8007 Discovery Drive
Richmond, Virginia 23288

William L. Lukhard
Commissioner

November 30, 1979

Mr. Ray D. Pethtel, Director
Joint Legislative Audit and
Review Commission
823 East Main Street, Suite 200
Richmond, VA 23219

Dear Ray:

The Department of Welfare has reviewed the draft report on the homes for adults and wishes to make the following comments.

First, the Department expresses appreciation to the Commission and its staff for the work that it has done in processing the audit in homes for adults. We were particularly pleased that the Commission and staff had shared with the Department throughout its study certain information which enabled the Department to follow up on certain complaints relative to some licensed homes. The follow up of these complaints and further unannounced visits to other homes for adults have been done by the Department and a report on these activities has been provided to the Commission.

In general, the Department has reviewed the report and its 24 recommendations and wishes to assure the Commission that each of the recommendations will be given serious consideration by the Department as to the future operations of both licensing of homes for adults and the auxiliary grant program which provides for supplemental payments to SSI recipients who are found eligible for such payments by local departments of public welfare. The Department concurs in most of the recommendations of the report but does have several comments as will be stated below on specific recommendations. To implement some of the recommendations will obviously require additional staff and in these times of limited resources it may not be possible to implement all recommendations within the next biennium. As an example, to effect some of the audit recommendations with which the Department does concur, it would take about 50% of our current internal audit resources in effect to audit a program of auxiliary grants which represents approximately 1% of the Department's total budget.

In general, the report throughout cites certain examples of homes and their operations. The report first refers to its random sample of 29 homes and to the other 19 homes visited. In its findings, the report does not distinguish numerically whether the results cited are from the random sample and therefore

presumably valid or whether the findings resulted from the other visits which would not have the same validity in terms of applying the example to the entire home for adults industry. This particular point is pertinent when the examples used for the most part are in the small operated homes between 4 and 25 beds. This group of homes, though representing about two-thirds of the licensed facilities in the State, only represents approximately 24% of the licensed bed capacity. In the Department's August, 1979, study of 144 of the smaller homes, the findings indicated that serious deficiencies, i.e., relative to health and safety of clients, affected approximately 1.8% of licensed beds in the home for adults industry. Whereas the Department is concerned for those particular facilities and the patients therein, we do not believe it is appropriate that examples be cited and then left to the imagination of the reader that this is reflective of a substantial number of licensed beds and facilities licensed as homes for adults. Another point in this area is that in the recording, both by JLARC staff and by the Department's staff in its follow up study of violation of standards, there is no grading of such violations in the sense that there are serious violations of health and safety which result in a stronger enforcement activity such as revocation of the license or court suit to enjoin operation. These are the less serious violations such as a given record not being up to date or a menu not being posted which though actually violations of standards, do not impact critically the care of the patients in the facility in most instances. It is the Department's position that where it is factually correct that there are deficiencies of standards and that the licensee should meet all standards it should not be implied that the level of care of the patient may be substantially adversely affected as a result of less serious deficiencies in meeting standards.

With reference to many of the recommendations, the Department had already begun prior to the initiation of the study by the JLARC staff and during the study to improve the operation of the program. For example, a whole new set of standards for homes for adults was being developed with input from providers and has been approved by the State Board of Welfare to become effective January 1, 1980. Other activities will be cited below as comments to several of the specific recommendations.

With regard to Recommendation 1, the Department concurs in these recommendations and, from its findings of the 144 homes, is in the process of developing a training plan for licensees. Training for licensing specialists began in October, 1979.

With reference to the report's discussion of fire safety, the State Fire Marshal has no authority to inspect homes with fewer than ten residents, as is stated in the report, and has no authority to inspect those homes constructed after September 1, 1973. The State Fire Marshal inspects for structural fire safety while local fire officials inspect for fire hazards. Both are important. In a number of localities in the State, particularly in rural areas, the Department of Welare is dependent upon the fire inspection being done by staff of local volunteer fire departments. Whereas most local officials are cooperative and provide annual inspections to homes for adults, in some communities with the dependence on the volunteer effort at times it is slow and on rare occasions, as cited in the case on page 29, results in no local fire inspection. The Department does strongly endorse Recommendation 3.

After-care services to current residents and recommendation for, we believe, has been addressed in the new standards approved by State Board of Welfare effective January 1, 1980. It is the intent of these standards to require after-care or any mental health services to any resident who requires them. This standard addresses the need for current residents and has the support of both the Department of Welfare and the Department of Mental Health and Mental Retardation. In an attempt to improve after-care services, we believe that Recommendation 5 has been addressed in the new standards also. The standards here will require that the licensee obtain a discharge summary before accepting a patient from a State hospital and must have community service support from the local community service mental health board. This standard is supported strongly by the Department of Mental Health and Mental Retardation and we have been assured by that Department that should such local community service boards refuse to provide such service to the licensed home for adults and the patient needing such service that we should contact the State Department of Mental Health and Mental Retardation so that they can work closely with that local community service board to provide such services as needed.

Recommendation dealing with drugs and the administration thereof has also been addressed. Those standards as they relate to drugs were developed with the assistance of the Board of Pharmacy. The Department of Welfare has been working and continues to work with the Board of Pharmacy and the Virginia Pharmaceutical Society to develop a training package for licensees.

Recommendation 10 deals with a single method of accounting for patients' funds which should be established by the Department of Welfare. We disagree that standards should require a single method of accounting due to the wide variety of types of accounting systems that may exist and the varying capabilities of staff that may exist among the varying size homes. The licensing standards do specify that an acceptable accounting procedure be provided for handling patient funds which should accomplish the basic intent of this recommendation. However, the Department believes that if it tries to specify one single type of accounting system or method that many of the providers would say that we are trying to over-regulate their facility.

In the general area of enforcement, we believe that the report does not provide a balanced review as to the Department's efforts in the past. As I had stated before the Commission earlier, in the past two years there had been a number of revocations and denials totaling approximately 10 for the two-year period and that approximately 8 injunctive relief suits had been sought as well as much effort in the area of assisting providers to come into compliance with the standards. The case example given on page 47 of the report does not mention that a Department's investigation had started on May 15, 1979, and that subsequently thereto there were 5 additional visits, unannounced, to the facility with follow up written documentation as to expectations of the provider which resulted in a recommendation for denial in October, 1979. This points out in general a very difficult job of enforcement which I also brought to the attention of the Commission in terms that the documentation for revocation and denial requires a lot of work on the part of the specialist and other staff and once a denial or revocation is made, the provider has access to the Administrative Procedures Act which requires that an administrative hearing be provided and that after the findings of the administrative hearing officer with a final decision being reached by the Commissioner of Welfare that the provider can appeal that decision into court for a decision. While all of this is going on, the provider or

licensee can continue to operate and because of adversary position between the licensee and the Department, it is very difficult for the Department to monitor the operations of the facility during that period. At times, the Department has attempted to enjoin facilities from operating, but then the standard for obtaining such an injunction in court is rather stringent in terms of the immediate danger to life and health of the patient. The Department would welcome a streamlined approach to enforcement and desires to work with the Commission to effect appropriate legal changes to the Code of Virginia to provide for such a streamlined system.

With reference to Recommendation 11, the Department does not agree that all visits should be unannounced but that a reasonable balance between announced and unannounced visits is the best means of achieving compliance with standards and the Department would not be supportive of a legislative mandate that all compliance inspections be unannounced. We do believe that the inspection at the time of annual licensing renewal should be an announced visit so that the owner and/or operator of the home has an opportunity to discuss any deficiency in standards that are found with the licensing specialist so that an effort can be made for compliance to be obtained in the quickest time possible.

With reference to Recommendation 12, we would concur with the first three sections of this recommendation, with some slight modifications to permit reasonable judements to be made in individual instances. However, we would not wish to be prohibited from issuing a provisional license to an initial applicant because oftentimes compliance with standards cannot be fully established until residents are actually in care.

We agree with Recommendation 13 that sanctions are needed. However, we believe that placement sanctions are more readily enforceable by placing agencies than by licensing staff. A sanction more readily enforceable for licensing would be fines, should the Legislature be interested in authorizing such sanctions.

Again I would like to state that because a recommendation was not addressed by number in the above comments does not mean that the Department has not reviewed them or does it mean that the Deparment will not act upon them. Except for the qualifications stated above, the Department supports the recommendations of the report and to the extent that it has authority to do so, and the resources with which to implement such recommendations, will move in that direction.

I thank you and your staff for the work that has gone into this report and for the considerations which you have given the staff of our Department and sharing with us as you were involved in the study with information that could help us to improve the licensing program in the homes for adults.

Very truly yours,

Bill

William L. Lukhard

/pjs

LEO E. KIRVEN, JR., M.D.
COMMISSIONER

COMMONWEALTH of VIRGINIA

Department of
Mental Health and Mental Retardation

MAILING ADDRESS
P. O. BOX 1797
RICHMOND, VA. 23214

November 9, 1979

Mr. Ray D. Pethtel, Director
Joint Legislative Audit
& Review Commission
Suite 1000
910 Capitol Street
Richmond, Virginia 23219

RE: Exposure Draft on Homes for Adults in Virginia

Dear Mr. Pethtel:

I have received and reviewed the October 29, 1979, draft of the Joint Legislative Audit and Review Commission's report on "Homes for Adults in Virginia." This report outlines the current state of homes for adults in Virginia while delineating specific problem areas found in a random sample of these homes throughout the Commonwealth.

Although the licensing of these facilities is not directly supervised by the Virginia Department of Mental Health and Mental Retardation, it was pointed out in the report that approximately 17 to 23% of the residents presently living in Virginia's Homes for Adults have at one time been patients in mental health facilities. The report points out problems which have developed in providing these individuals with aftercare services, particularly medication services after they leave the hospital and begin residing in a home for adults. It is with this population in mind that the enclosed comments on this report are made. I am supportive of the recommendations that the JLARC staff have made regarding this population group. My staff and I will work closely with the Virginia Department of Welfare, Community Mental Health and Mental Retardation Services Board's staff, State mental health and mental retardation facilities, and local welfare agencies to assure a higher quality of life for the residents of these homes.

Thank you for the opportunity to comment on this report.

Yours very truly,

Leo E. Kirven, Jr., M.D.
Commissioner

LEKjr/hr

Enclosure: Comments

cc: The Honorable Jean L. Harris
Mrs. Elsie R. Chittum
Ms. Margaret L. Cavey, R.N.
Dan Payne, Ph.D.
Ms. Mary N. Blackwood, M.H.A.

COMMONWEALTH of VIRGINIA

Department of Health
Richmond, Va. 23219

JAMES B. KENLEY, M.D.
COMMISSIONER

November 13, 1979

Mr. Ray D. Pethtel, Director
Joint Legislative Audit
and Review Commission
Suite 1100
910 Capitol Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

Selected staff of this Department have reviewed the exposure draft of the study of homes for adults. We concur in the findings and recommendations which relate to the Health Department.

The attached Policy and Procedure Instruction was sent to all local health departments in August 1979 as a result of findings made during the course of studying conditions in homes for adults.

Sincerely,

for James B. Kenley, M. D.
State Health Commissioner

Attachment

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