

State of Nevada

Performance Audit LA18-04

Department of Health and Human Services Aging and Disability Services Division

2016

<https://www.leg.state.nv.us/Division/Audit/Full/BE2018/LA18-04%20Aging%20&%20Disability%20Services%20Report.pdf>

Audit Highlights



Highlights of performance audit report on the Aging and Disability Services Division issued January 18, 2017. Legislative Auditor report # LA18-04.

Background

The Division develops, coordinates, and delivers a comprehensive support system of services for Nevada residents aged 60 and over, and children and adults with disabilities or special health care needs. Most of the Division's expenditures relate to services for intellectually disabled persons, which are primarily funded through state appropriations and Medicaid funds. Expenditures for these services totaled about \$160 million in fiscal year 2016, mostly for payments to SLA and JDT providers.

SLA providers offer residential support services to individuals who require assistance to live in the least restrictive community setting possible. SLA services were provided to about 1,900 persons per month in fiscal year 2016. JDT providers assist individuals in obtaining meaningful employment and living skills to help them achieve community inclusion, independence, and productivity. JDT services were provided to about 2,400 persons per month in fiscal year 2016.

Purpose of Audit

The purpose of this audit was to determine whether the Division has: (1) adequate controls over payments to providers of Supported Living Arrangement services and Jobs and Day Training services, and (2) effectively monitored these providers to ensure the safety and welfare of individuals with intellectual disabilities. The scope of our audit was calendar year 2015, although we included some activities in 2016.

Audit Recommendations

This audit report contains 10 recommendations to improve the Division's oversight of providers of services to intellectually disabled persons. Six recommendations improve controls to ensure the Division only pays providers for services performed. Four recommendations help ensure the Division effectively monitors providers to ensure the safety and welfare of individuals with intellectual disabilities.

The Division accepted the 10 recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 13, 2017. In addition, the six-month report on the status of audit recommendations is due on October 13, 2017.

Aging and Disability Services

Department of Health and Human Services

Summary

The Division needs additional controls to prevent overpayments to providers of services to individuals with intellectual disabilities. Based on our test results, we estimate the Division overpaid providers a combined total between \$3.5 million and \$4.3 million in 2015. Overpayments to providers included those providing 24-hour care, as well as those providing jobs and day training to the Division's clients. The combined total is based on overpayments identified in three areas: (1) overbilling issues for 24-hour care homes (\$2.2 million to \$3.0 million); (2) billing for more supported living arrangement (SLA) services than were agreed upon (\$504,000); and (3) billing for more jobs and day training (JDT) services than were provided (\$766,000). Improved controls would help ensure the Division receives the services it pays for and intellectually disabled individuals receive the services they need. Furthermore, by eliminating overpayments to providers, the Division can serve more clients. The Division paid a total of \$106 million in calendar year 2015 to providers serving clients of the Desert Regional Center (DRC) and Sierra Regional Center (SRC).

Some of the overbilling problems described in this report may be the result of provider fraud, while others may be unintentional errors. Therefore, as required by NRS 218G.140(2), we reported this information to the Governor, each Legislator, and the Attorney General.

Although the Division has a thorough process for certifying SLA providers, the timeliness of certifying these providers needs to be improved. In addition, the Division has not yet developed a rigorous process for certifying JDT providers, several years after legislation was passed requiring them to do so. A well-developed certification process will include standards for the provision of quality care and training by JDT providers to the Division's intellectually disabled clients. Finally, the Division did not always have documentation showing that deficiencies noted during home inspections were corrected.

Key Findings

We estimate the Division overpaid providers of 24-hour SLA services between \$2.2 million and \$3.0 million in 2015. Our estimate is based on a detailed review of about \$550,000 in payments for about 1,800 days of service, which found overbillings of between 3.1% and 4.3% of the total billed. (page 7)

The level of SLA services provided to the Division's clients often varied from the level agreed upon. In about one-fourth of the days tested, the number of staff hours provided were less than the number established when the contract was developed. On days that clients are underserved, it can affect their health and welfare, as well as the safety of provider staff. Conversely, in about one-fourth of the days tested, the number of hours provided was greater than the number agreed upon. We estimate the Division overpaid providers of SLA services an additional \$504,000 in 2015 for days when more hours were provided than were agreed upon. (page 10)

For 27 of 150 (18%) JDT billings tested, the number of days billed was more than the number shown on providers' logs of staff and client daily attendance or other records. We estimate the Division overpaid providers of JDT services about \$766,000 in calendar year 2015. Based on the average cost of providing JDT services for a year, eliminating overpayments to JDT providers could have paid for JDT services to about 50 more clients for one year. (page 13)

Our testing of the 29 largest SLA providers found 27 were not certified timely. Certification reviews include inspections and testing to help ensure that clients' living conditions are safe and provider staff are properly trained and have cleared criminal background checks. (page 16)

The Division's certification process for JDT providers is limited to administrative requirements, such as verifying the provider has a Nevada business license. The process excludes criminal background checks, documentation of employee licensure, and proof of staff training. The Division has not yet adopted regulations with more rigorous certification requirements, as required by legislation passed in 2009. In addition, the Division has not documented that additional certification requirements from legislation passed in 2011 have been met. (page 18)

Although the Division inspected homes timely, it did not have an effective process to ensure deficiencies identified during home inspections were corrected. In 14 of the 29 homes we tested that were inspected, corrective action was required to address deficiencies found in the home. However, for 6 of the 14 (43%) homes with deficiencies, the Division did not have documentation showing that corrective action was completed. (page 21)

State of Nevada

Performance Audit LA18-13

Department of Health and Human Services
Division of Public and Behavioral Health

Adult Mental Health Services
Community-Based Living Arrangement Homes

2017

<https://www.leg.state.nv.us/Division/Audit/Full/BE2018/LA18-13%20AMHS%20Community-Based%20Living%20Arrangement%20Homes.pdf>

Audit Highlights



Highlights of performance audit report on Adult Mental Health Services, Community-Based Living Arrangement Homes issued on January 17, 2018. Legislative Auditor report # LA18-13.

Background

Within the Division of Public and Behavioral Health (Division), the Clinical Services Branch provides adult mental health services, primarily through NNAMHS, SNAMHS, and Rural Counseling and Supportive Services. The primary clients of these agencies are Nevadans with mental illness who are underinsured, uninsured, and those whose conditions have resulted in interaction with law enforcement. Expenditures for adult mental health services totaled about \$134 million in fiscal year 2017.

The CBLA living arrangement pays a provider the rent, utilities, and staff service hours up to a predetermined number of hours per month, per client, for supervision and assistance with activities of daily living. According to payment information provided by the Division, the State pays an average of \$1,450 per month, per CBLA client. This amount does not include client payments to CBLA providers from social security or other income. For the homes we inspected, the average number of clients in each home was four.

Purpose of Audit

The purpose of this audit was to determine if controls for monitoring providers of CBLA services are adequate to ensure the safety and welfare of adult mental health clients at NNAMHS and SNAMHS.

Audit Recommendations

This audit report contains seven recommendations to improve oversight of providers of CBLA services. Six of these recommendations relate to improving controls to ensure the Division effectively inspects CBLA homes. The other recommendation helps ensure the Division properly certifies CBLA providers.

The Division accepted the seven recommendations.

Recommendation Status

The Division's 60-day plan for corrective action is due on April 12, 2018. In addition, the six-month report on the status of audit recommendations is due on October 12, 2018.

Adult Mental Health Services Community-Based Living Arrangement Homes

Division of Public and Behavioral Health

Summary

Adults in need of mental health care live in dismal conditions at many community-based living arrangement (CBLA) provider homes. During our inspections of provider homes, we identified serious, deficient conditions prevalent at most of the homes. This includes unsanitary and unsafe conditions, and poor medication management practices. In addition, we identified numerous conditions that could negatively affect the quality of life for mentally ill clients. Furthermore, we observed children living at risk at two homes. We inspected CBLA homes that serve clients of Northern Nevada Adult Mental Health Services (NNAMHS) and Southern Nevada Adult Mental Health Services (SNAMHS). Although the Division developed policies and procedures to inspect provider homes, staff implementation of procedures is inadequate. When home inspections are not performed properly, deficiencies go undocumented, corrective action is not taken, and unsafe and unhealthy conditions may continue and proliferate.

Although the Division is responsible for certifying providers of CBLA homes, certification activities performed by the Division are inadequate. Specifically, reviews and assessments required for certifying providers were not performed for most of the 20 CBLA providers we tested, and were untimely for others. Although NNAMHS and SNAMHS performed some steps, such as obtaining business licenses and proof of insurance coverages, other key activities important for determining whether the providers met the Division's 2014 standards for certification were often omitted. When CBLA providers do not undergo complete or timely certification reviews, there is increased risk that unqualified providers may operate unchecked, needlessly exposing clients to adverse conditions.

Without strong inspection and certification processes, we have serious concerns with the current model for funding CBLA provider homes. Providers operate a business that inherently is driven by a profit motive. In the absence of adequate inspection and certification activities, providers may limit their level of care to maximize profits at the detriment of client services.

Key Findings

During our inspections of CBLA homes, we observed serious, deficient conditions at all 37 homes inspected. Our inspections included 37 of 105 (35%) homes providing services for NNAMHS and SNAMHS clients. Because providers typically operate more than one home, the number of providers included in our inspections exceeded 70% of the total providers. (page 10)

The following are some examples of conditions observed during our inspections of 37 homes:

- Unsanitary conditions (36 homes) – Excessively dirty floors, ceilings, and walls; mold and mildew; rodent and insect infestations; and no hand soap or toilet paper in bathrooms. (page 10)
- Personal health and safety hazards (34 homes) – Expired, spoiled, or improperly stored food; broken bathroom and bedroom doors; and broken and exposed glass. (page 12)
- Fire safety hazards (33 homes) – Expired, non-inspected, or inaccessible fire extinguishers, and missing and disabled smoke detectors. (page 14)
- Inadequate medication management practices (28 homes) – Medication administration records (MAR) left blank, not up-to-date, or completed in advance. Medications were not properly stored, including unsecured, commingled, and expired medications. (page 16)
- Bleak living conditions (36 homes) – Insufficient quantities of food; inadequate lighting; insufficient bedding and linens; and non-functioning or damaged appliances. (page 18)

At two homes, we observed young children of the caregivers living in the homes. In one home, the child's parent was not present and the mentally ill clients provided childcare while the mother reportedly worked another full-time job outside the home. (page 21)

For 11 of 20 (55%) CBLA homes inspected in southern Nevada, the staff member identified as the caregiver spoke little to no English, the language of the clients living in the home. Caregivers are responsible for tasks that necessitate client interaction such as administering medications and supervising client activities. If caregivers are unable to communicate, clients may not receive the services they need, and those for which the State is paying. (page 22)

Most of the 20 CBLA providers we tested had not undergone required review and assessment procedures for certification, and when procedures were performed, they were untimely by up to 5 years. (page 25)

Sample SLA Southern NV News Stories 2016

Northeast Vegas house fire causes critical burn injuries

<http://www.fox5vegas.com/clip/12623031/northeast-vegas-house-fire-causes-critical-burn-injuries> 1.24 clip

2 hospitalized, 1 detained after northeast Vegas house fire

<http://www.fox5vegas.com/clip/12624308/2-hospitalized-1-detained-after-northeast-vegas-house-fire> 2.22

Fox 5 kvvu – tv

Suspect identified in northeast Vegas arson that burned woman

<http://www.fox5vegas.com/story/32552713/1-with-critical-burn-injuries-after-northeast-vegas-house-fire>

<http://www.fox5vegas.com/story/32552713/suspect-identified-in-northeast-vegas-arson-that-burned-woman>

Posted August 2, 2016 - 11:30am Updated August 2, 2016 - 7:52pm

Las Vegas woman who was hurt in Wednesday fire has died

<http://www.reviewjournal.com/news/las-vegas/las-vegas-woman-who-was-hurt-wednesday-fire-has-died>

www.reviewjournal.com/news/las-vegas/las-vegas-woman-who-was-hurt-wednesday-fire-has-died

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Public invited to comment... Henderson house fire...

Posted August 2, 2016 - 11:30am | Updated August 2, 2016 - 7:52pm

Las Vegas woman who was hurt in Wednesday fire has died



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By **LAWREN LINEHAN** and **RAVEN JACKSON**
LAS VEGAS REVIEW-JOURNAL

Caregiver, 60, dies after fire at group home

New charges possible for man suspected of starting blaze

By LAWREN LINEHAN and RAVEN JACKSON
LAS VEGAS REVIEW-JOURNAL

The woman critically injured last week in an intentionally set fire at a group home died Monday, according to the Clark County coroner.

Lolita Budiao, 60, was a caregiver to four men at the east valley home at 1009 Marion Drive, near Washington Avenue, according to the Las Vegas Fire Department.

During the July 27 fire, Budiao suffered second- and third-degree burns to 75 percent of her body, the department reported. She received treatment at the Lions Burn Care Center at University Medical Center before she died.

One of the men living in the home, Abebaw Kassa, 32, was charged with first-degree arson in connection with the early morning fire, Fire Department spokesman Tim Szymanski said last week.

It remained unclear Tuesday whether Kassa would face additional charges as a result of the woman's death. Paperwork to update the charges had not been submitted as of 5 p.m., according to the Clark County district attorney's office.

The Fire Department served as the arresting agency. Szymanski said additional or amended charges, if any, against Kassa might come this week.

► See FIRE, Page 10B

► FIRE

Continued from Page 1B

After the fire, Kassa was transported to UMC for treatment of minor smoke inhalation. He was questioned there before his arrest, Szymanski said.

According to an arrest report, the caregiver called the group home's owner and left a message that Kassa was setting the house on fire. The homeowner tried calling the woman back, but the line was busy.

The woman and four men she cared for, including Kassa, all were inside the home when the fire started, Szymanski said. One of the residents told investigators Kassa had locked the caregiver in a bathroom, and that she was yelling behind the locked door during the fire, the arrest report said.

Upon arrival, at least one firefighter saw a woman come out of the front door on fire, according to the report.

Fire Department investigators determined the fire began in the kitchen and extended to the living room. On the stove and kitchen counter, investigators found a chair and charred remains of what appeared to be cloth. That evidence led inves-

tigators to rule the fire was caused by "the application of open flame to ordinary combustibles," causing \$35,000 in damage.

Kassa is being held on \$25,000 bail at Clark County Detention Center.

Szymanski said the group home was unlicensed, so it is unclear what care the four men were receiving there.

The homeowner, Josefina Adams, also owns a home on Ronan Drive, about two miles from the home that burned, according to property records. The Ronan Drive home is listed as an assisted living facility with seven beds, according to the Nevada Division of Public and Behavioral Health's current Nevada Hospital and Healthcare Guide.

Adams is listed as the property's administrator. The seven beds are reserved for people with mental illnesses, according to AssistedLivingFacilities.org, a nationwide directory that lists licensed assisted living residences by state.

Adams declined comment when reached by phone Wednesday.

Review-Journal reporter Rachel Crosby contributed to this report. Contact Lauren Linehan at linehan@reviewjournal.com or at 702-383-0381. Find @[lawrenlinehan](https://twitter.com/lawrenlinehan) on Twitter. Contact Raven Jackson at rjackson@reviewjournal.com or 702-383-0381. Follow @[ravenmjackson](https://twitter.com/ravenmjackson) on Twitter.

State health inspectors launch emergency raid on northwest Reno group home

<http://www.rgj.com/story/news/2016/03/11/state-health-inspectors-launch-emergency-raid-northwest-reno-group-home/81671386/>

Sandoval on RGJ investigation into group homes: Mistakes were made

<http://www.rgj.com/story/news/2016/03/08/sandoval-rgj-investigation-into-group-homes-mistakes-were-made/81486212/>

State inspections of homes for the mentally ill uncover mostly minor issues

<http://www.rgj.com/story/news/2016/03/07/state-inspections-homes-mentally-ill-uncover-mostly-minor-issues/81460312/>

Erratic oversight left mentally ill living in squalid Sparks home

RGJ Sla article 2-29-16

<http://www.rgj.com/story/news/2016/02/25/fragile-system-spotty-oversight-left-mentally-ill-living-squalid-home/80636366/>

Project Uplift group homes owner: Don't throw me under the bus

<http://www.rgj.com/story/news/2016/03/17/project-uplift-group-homes-owner-dont-throw-me-under-bus/81931042/>

3/17/2016



Desert Regional \$55 Mill
 Rural \$10 mill
 Sierra \$26 mill
 Total \$91 Million

DESERT REGIONAL CENTER - BA3279
Supported Living (SLA) Program Cost Analysis
5 Year Projected Expenditures

<u>YEAR</u>	<u>% Growth Est.</u>	<u>Total SLA Budget</u>	<u>Explanation</u>
2016		\$ 55,626,154	Legislatively Approved
2016		\$ 60,232,852	Legislatively Approved
2018	4.2%	\$ 62,762,632	Based Upon Projected Growth %
2019	4.0%	\$ 65,273,137	Based Upon Projected Growth %
2020	4.2%	\$ 68,014,609	Based Upon Projected Growth %

RURAL REGIONAL CENTER - BA3167
Supported Living (SLA) Program Cost Analysis
5 Year Projected Expenditures

<u>YEAR</u>	<u>% Growth Est.</u>	<u>Total SLA Budget</u>	<u>Explanation</u>
2016		\$ 10,135,839	Legislatively Approved
2016		\$ 11,825,784	Legislatively Approved
2018	3.4%	\$ 12,227,861	Based Upon Projected Growth %
2019	3.1%	\$ 12,606,924	Based Upon Projected Growth %
2020	3.3%	\$ 13,022,953	Based Upon Projected Growth %

SIERRA REGIONAL CENTER - BA3280
Supported Living (SLA) Program Cost Analysis
5 Year Projected Expenditures

<u>YEAR</u>	<u>% Growth Est.</u>	<u>Total SLA Budget</u>	<u>Explanation</u>
2016		\$ 25,902,708	Legislatively Approved
2016		\$ 29,542,325	Legislatively Approved
2018	3.2%	\$ 30,487,679	Based Upon Projected Growth %
2019	3.2%	\$ 31,463,285	Based Upon Projected Growth %
2020	3.2%	\$ 32,470,110	Based Upon Projected Growth %

DESERT REGIONAL CENTER - BA3279
Supported Living (SLA) Program Cost Analysis
FY-2011

	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Totals	Monthly Average
SLA														
Number of Persons Served							423	418	421	425	422	427	2,536	423
Total Costs							\$ 512,600	\$ 508,918	\$ 541,184	\$ 541,573	\$ 543,610	\$ 535,457	\$ 3,183,342	\$ 530,557
Average Cost per Person	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$ 1,211.82	\$ 1,217.51	\$ 1,285.47	\$ 1,274.29	\$ 1,288.18	\$ 1,254.00	\$ 1,255.26	\$ 1,255.26
ISLA														
Number of Persons Served							526	531	529	536	546	544	3,212	535
Total Costs							\$ 2,984,849	\$ 2,845,599	\$ 2,983,361	\$ 2,950,101	\$ 3,001,539	\$ 2,997,417	\$ 17,762,866	\$ 2,960,478
Average Cost per Person	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	\$ 5,674.62	\$ 5,358.94	\$ 5,639.62	\$ 5,503.92	\$ 5,497.32	\$ 5,509.96	\$ 5,530.16	\$ 5,530.16

\$5,530.16

DESERT REGIONAL CENTER - BA3279
Supported Living (SLA) Program Cost Analysis
FY-2016

	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Totals	Monthly Average
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SLA

Number of Persons Served	322	314												
Total Costs	\$ 361,362	\$ 334,029												
Average Cost per Person	\$ 1,122.24	\$ 1,063.79	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

ISLA

Number of Persons Served	693	693												
Total Costs	\$ 4,209,896	\$ 4,189,688												
Average Cost per Person	\$ 6,074.89	\$ 6,045.73	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

<http://projects.propublica.org/tables/assisted-living-regulations#data-explainer>



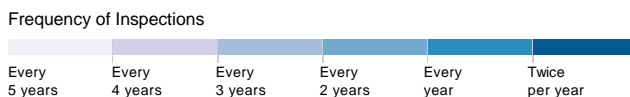
Life and Death in Assisted Living

State-by-State: Assisted Living Regulations

by *Hanna Trudo, Jonathan Jones and A.C. Thompson, ProPublica - October 29, 2013*

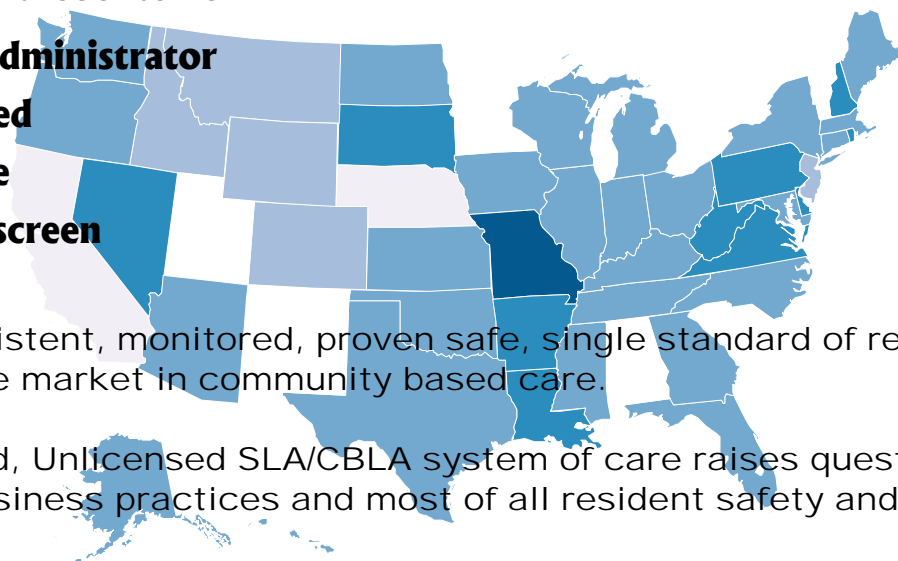
ProPublica set out to compile the key rules and regulations governing assisted living in all 50 states and the District of Columbia. This information was gathered from state regulatory agencies, an examination of state codes and other records, and a 2013 review prepared by the National Center for Assisted Living, an industry trade group.

These are the categories included here: the qualifications required for those who run assisted living facilities; the frequency of inspections; fines for problem facilities; staffing requirements, and whether states offer performance records of the facilities to the public online. *See more about the data.* » | [Related Story](#) »



Only Nevada answers yes to all study questions and has an on site annual survey. Beyond the topics studied Nevada is also a national leader by being one of the first states to require these items.

- Beltca certified administrator**
- sprinklers required**
- liability insurance**
- FBI finger print screen**



Producing a consistent, monitored, proven safe, single standard of regulations which allowed a fair free market in community based care.

Creating a second, Unlicensed SLA/CBLA system of care raises questions about fair, free trade and business practices and most of all resident safety and quality of life.

State	State Can Fine Facilities?	State Posts Inspection Data Online?	Administrators Required to Have High School Diploma, GED, or College Education?	Minimum Staffing Ratios?	Frequency of Inspections
Alabama B	Yes	Yes	Yes	Yes	No requirement for periodic inspections
Alaska A	Yes	No	No	No	Every two years
Arizona D	Yes	Yes	Yes	No	Every two years
Arkansas C	Yes	No	Yes	Yes	Every year
California E	Yes	No	Yes	No	Every five years
Colorado F	Yes	Yes	No	Yes	Every three years
Connecticut G	No	No	Yes	No	Every two years
Delaware H	Yes	Yes	Yes	No	Every year
Florida I	Yes	Yes	Yes	Yes	Every two years
Georgia J	Yes	Yes	No	Yes	Every two years

State	State Can Fine Facilities?	State Posts Inspection Data Online?	Administrators Required to Have High School Diploma, GED, or College Education?	Minimum Staffing Ratios?	Frequency of Inspections
Hawaii K	Yes	No	No	No	Every two years
Idaho M	Yes	Yes	Yes	No	Every three years
Illinois N	Yes	No	Yes	No	Every two years
Indiana O	Yes	Yes	Yes	No	Every 15 months
Iowa L	Yes	Yes	No	No	Every two years
Kansas P	Yes	No	Yes	No	Every 15 months
Kentucky Q	Yes	No	Yes	No	Every two years
Louisiana R	Yes	No	No	No	Every year
Maine U	Yes	No	No	Yes	Every two years
Maryland T	Yes	Yes	Yes	No	Every 15 months
Massachusetts S	Yes	No	Yes	No	Every two years
Michigan V	Yes	No	No	Yes	Every two years
Minnesota W	Yes	Yes	No	No	No requirement for periodic inspections
Mississippi Y	No	No	Yes	Yes	Every two years
Missouri X	Yes	Yes	Yes	Yes	Twice per year
Montana Z	No	No	Yes	No	Every three years
Nebraska c	Yes	Yes	No	No	Every five years
Nevada g	Yes	Yes	Yes	Yes	Every year
New Hampshire d	Yes	No	Yes	No	Every year
New Jersey e	Yes	Yes	Yes	No	Every three years
New Mexico f	Yes	Yes	Yes	Yes	No requirement for periodic inspections
New York h	Yes	Yes	Yes	No	Every 18 months
North Carolina a	Yes	Yes	Yes	Yes	Every two years
North Dakota b	Yes	No	No	No	Every two years
Ohio i	No	Yes	Yes	No	Every 15 months
Oklahoma j	Yes	Yes	No	No	Every 15 months
Oregon k	Yes	Yes	Yes	No	Every two years
Pennsylvania l	Yes	Yes	Yes	No	Every year
Rhode Island m	Yes	No	No	No	Every year
South Carolina n	Yes	No	Yes	Yes	No requirement for periodic inspections
South Dakota o	No	No	Yes	No	Every year
Tennessee p	Yes	No	Yes	No	Every 15 months
Texas q	Yes	Yes	Yes	No	Every two years
Utah r	Yes	No	Yes	No	No requirement for periodic inspections
Vermont t	Yes	Yes	No	No	No requirement for periodic inspections
Virginia s	Yes	Yes	Yes	No	Every year
Washington u	Yes	Yes	Yes	No	Every two years
Washington, D.C. y	Yes	Yes	No	No	Every year
West Virginia w	Yes	No	Yes	Yes	Every year
Wisconsin v	Yes	Yes	Yes	No	Every two years
Wyoming x	No	Yes	No	No	Every three years

About the data

The rules and regulations proved not easy to decipher. There is, for instance, no single, standard definition of assisted living. As well, each state defines and licenses assisted living differently. Many states set different staffing and training requirements depending on a facility's size, the levels of care offered, and other types of services. In addition, many states have also recently revised or are in the process of refining their rules and regulations. According to the National Center for Assisted Living, 18 states reported regulatory, statutory, or policy changes affecting assisted living and other residential care facilities in 2012.

States also vary in how much information about assisted living they post online. While some states post the entire inspection reports for individual facilities online, others post only a portion of the reports, a simple listing of violations, or the enforcement letters the state sent to individual facilities. Here, if a state is listed as "No" in this category, it means that the state does not post any information from either complaint or inspection reports on the Internet.

Most states require a high school diploma, a GED or some post-high school education as part of their qualifications to become an administrator of an assisted living facility. However, some states require high school diplomas for certain types of assisted living facilities, but not all. Similarly, some states, Alabama, Arkansas and Maine among them, set specific staffing ratios for certain types of assisted living facilities, such as those that offer specialty Alzheimer's and dementia care, but not all.

When it comes to the frequency of inspections, our graphic reflects the maximum time each state allows between routine inspections conducted by the state regulatory agency. In some of these states, certain facilities may be inspected more frequently. Our data does not include state investigations prompted by complaints, reports of abuse, or other incidents.

We intend this information to be of assistance to families, legislators, and to all involved in caring for, or advocating on behalf of, the elderly. We invite informed readers to offer clarifications to existing regulations or updates as rules and regulations are modified in the months ahead.

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