



Bureau of Assisted Living

STATE OF ASSISTED LIVING Annual Report 2015

March 8, 2016



Alfred C. Johnson, Director



Agenda

1. Bureau of Assisted Living (BAL) Regulatory Principles
2. BAL Staffing
3. Trends and Statistics
 - ✓ Assisted Living (AL) Capacity
 - ✓ Affiliations
 - ✓ AL Complaints
 - ✓ AL Self-Reports
 - ✓ AL Survey
 - ✓ Abbreviated Surveys
 - ✓ AL Enforcement
 - ✓ Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL)
4. Bureau of Assisted Living Strategies
5. Regulatory Stories
6. Wrap-Up



Bureau of Assisted Living Regulatory Principles



Use research and evaluation to drive program compliance and quality improvement. Methods ensure that actions are correct, timely, thorough, objective, and consistent across the bureau.



Recruitment and retention of appropriately educated, well-qualified regulatory and support services staff, with initial and ongoing training in regulatory theory and practice provided.



Promoting providers' knowledge, compliance, and accountability; compliance-related technical assistance; and staff development.



Bureau of Assisted Living

Assisted Living Survey Process

- Offsite Review
- Introduction
- Tour of Facility
- Observation
- Interviews (Consumer, Family, and Staff)
- Record Review (Consumer and Staff)

- Safety Code Review
- Compliance and Technical Assistance
- Exit Conference
- Survey Development
- Internal Quality Assurance
- Statement of Deficiency (SOD) Delivery and Plan of Correction (POC) Submission



Bureau of Assisted Living Staffing

Assisted Living Regional Directors

- Northeastern Regional Office
 - Kathy Lyons
- Western Regional Office
 - William Gardner
- Southern Regional Office
 - Open Position
- Southeastern Regional Office
 - Michelle Crockett



Bureau of Assisted Living Staffing

Quality Assurance Program Specialist, Senior

- Lynnette Traas
- Cindy O'Connell



Bureau of Assisted Living Staffing

Central Office Staff

- Colette Anderson, research technician
- Damon Scott, office operations program associate
- Lori Smithback, central licensing associate
- Chquota Carter, central licensing associate



Bureau of Assisted Living Staffing

Assisted Living Support Staff

- Southern Regional Office (SRO)
 - Thom Smith
 - Julie Mallder
- Western Regional Office (WRO)
 - Moua Luedtke
 - Augusta Crumble
- Southeastern Regional Office (SERO)
 - Vacant (2)
- Northeastern Regional Office (NERO)
 - Diane Van Rens
 - Vacant



Bureau of Assisted Living Staffing

Assisted Living Surveyors

Northeastern Regional Office

- Jerome Riederer
- Heather Schweiner
- Phyllis Witter
- Jule Degrave
- Vacant Nursing Consultant I
- Trisha Piotraschke
- Cari Gast
- Vicky Whittman
- Sandra Culligan



Bureau of Assisted Living Staffing

Assisted Living Surveyors

Southeastern Regional Office

- Bunny Booker
- MaryBeth Hoffman
- Sharon Gries
- Connie Knezic
- Tom Redding
- Geralyn Spitzer
- Joelle Verstegen
- Cindie Wilbur



Bureau of Assisted Living Staffing

Assisted Living Surveyors

Western Regional Office

- Cynthia Larson
- Sandy Finseth
- Mary Eckwright
- Ann Colbenson-Hallum
- Kris Carew
- Judy Jordan
- Kelly Haugen



Bureau of Assisted Living Staffing

Assisted Living Surveyors

Southern Regional Office

- Cheryl Bott
- Leann Fox
- Ron Kunferman
- Tina Lubick
- Roda Mclees
- Estrella Schnering
- Sharon Paulson
- Shannon Lane



Bureau of Assisted Living Regional Assignments

SERO

- Kenosha, Milwaukee, Racine

NERO

- Adams, Brown, Calumet, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Ozaukee, Portage, Shawano, Sheboygan, Washington, Waushara, Waupaca, Winnebago, Wood

SRO

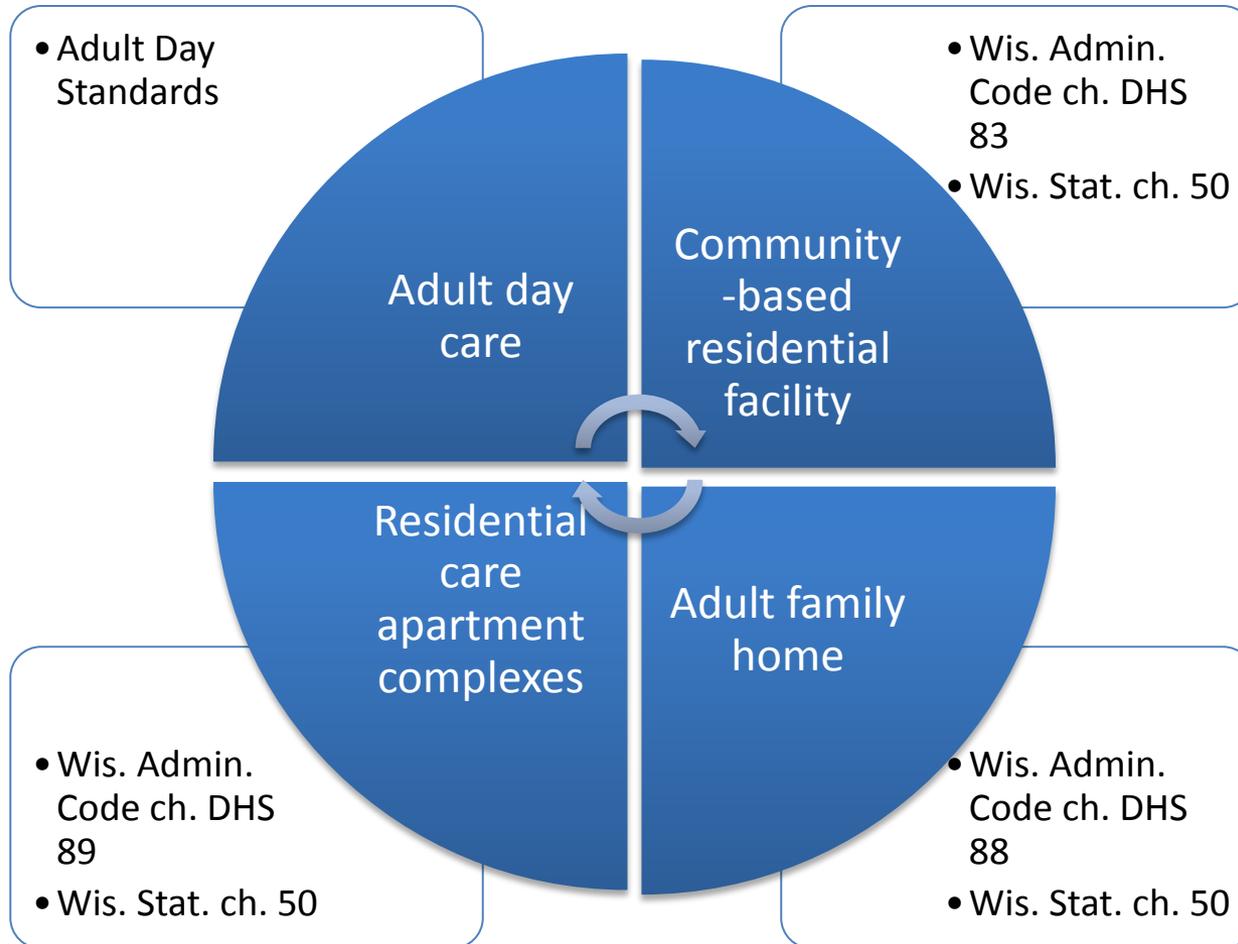
- Columbia, Crawford, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Richland, Rock, Sauk, Walworth, Waukesha

WRO

- Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Clark, Douglas, Dunn, Eau Claire, Florence, Forest, Iron, Jackson, Juneau, Langlade, La Crosse, Lincoln, Marathon, Monroe, Oneida, Pepin, Pierce, Polk, Price, Rusk, Sawyer, St. Croix, Taylor, Trempealeau, Vernon, Vilas, Washburn



Wisconsin Assisted Living Communities





Trends and Statistics





Assisted Living Trends

Provider growth continues:

Independent Adult Family Home (AFH)
Operators

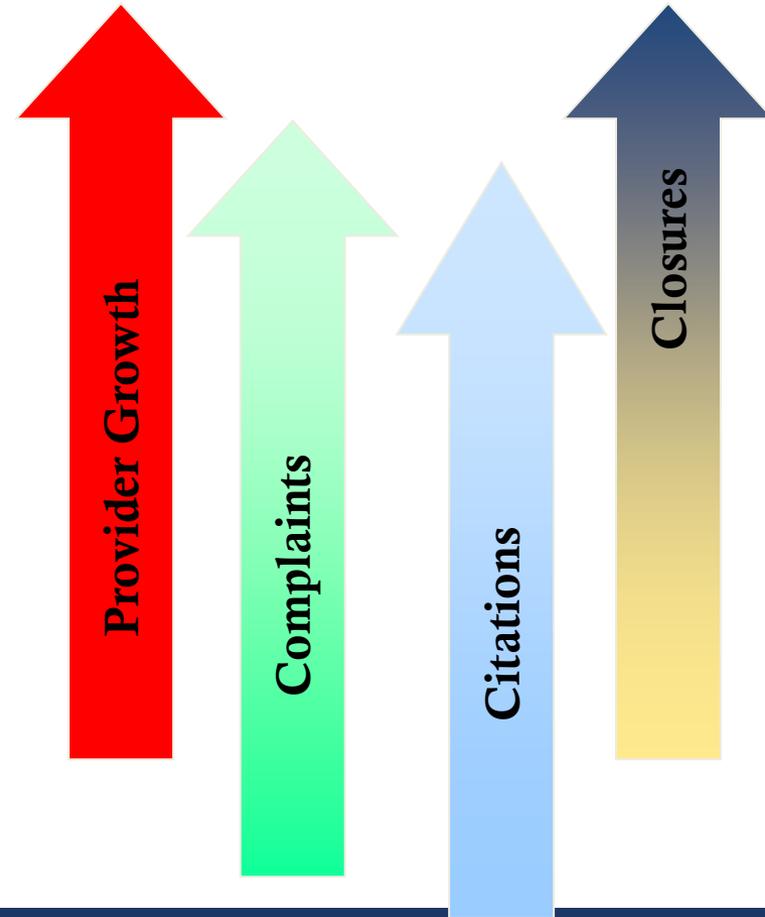
Complaints:

- Number of complaints are on the rise.
- Increase in complaints from medical professionals.
- Citations:

Repeat and/or uncorrected citations are on the rise.

Facility closures:

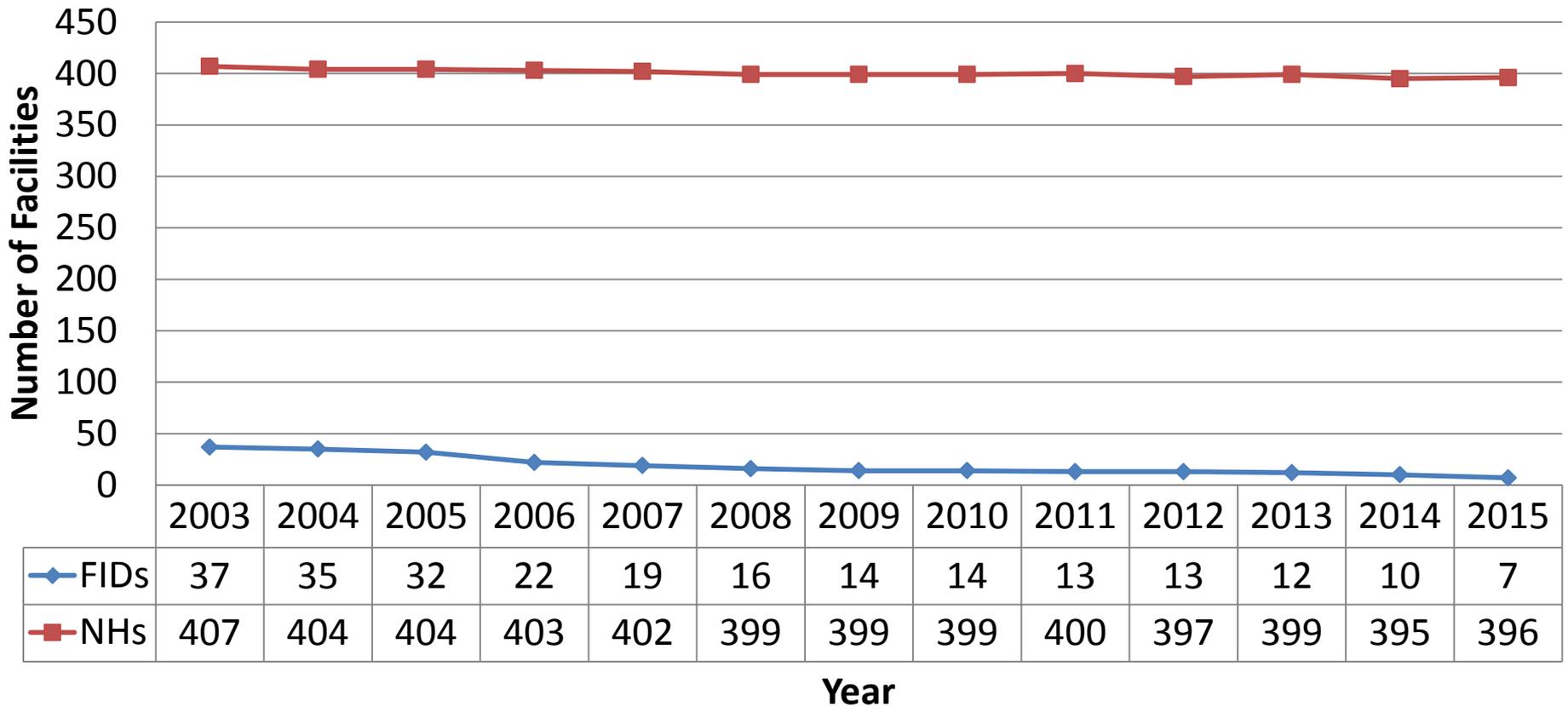
Community-Based Residential Facility (CBRF) or Adult Family Home (AFH) closing or selling





Nursing Home and Facility for Intellectual Disability (FID)

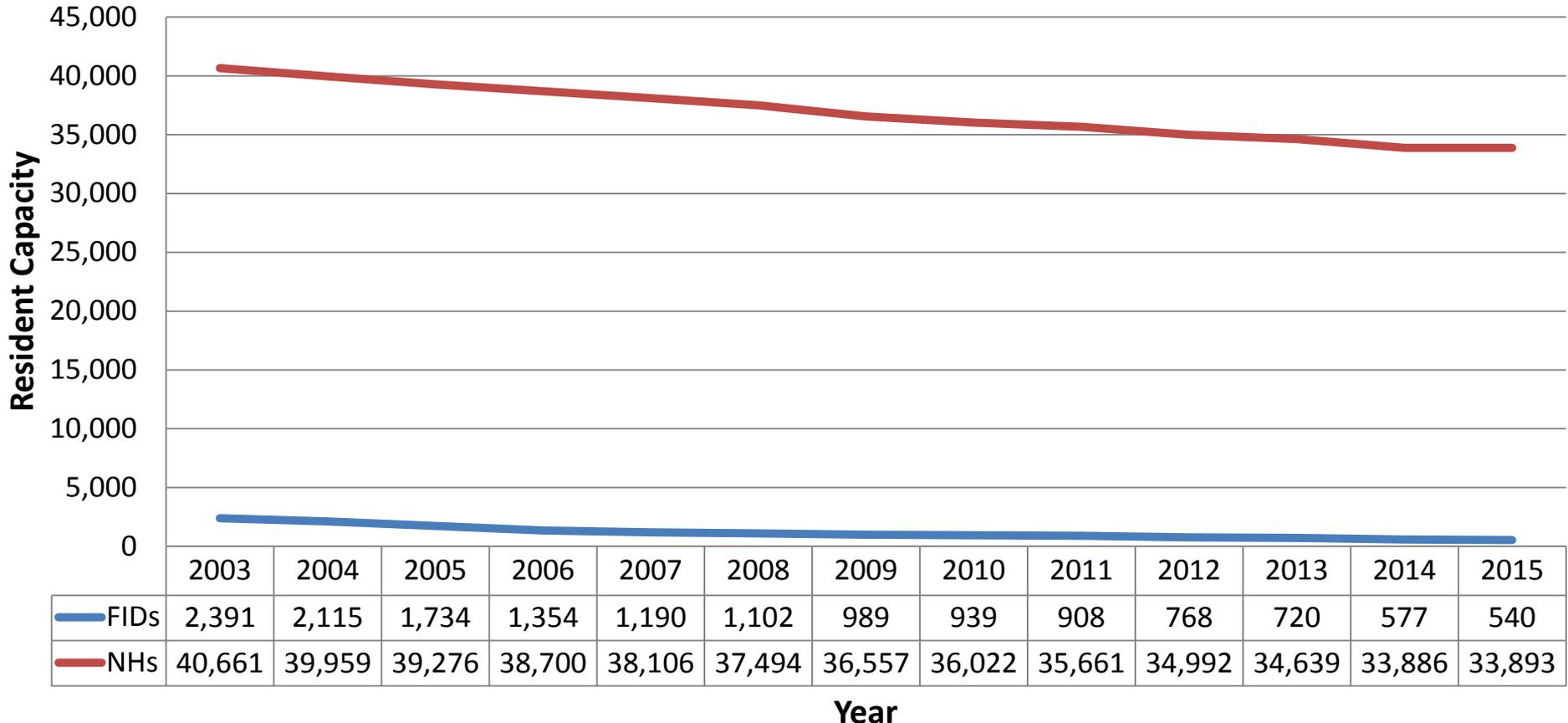
Trend in Number of Facilities





Nursing Home and Facility for Intellectual Disability (FID)

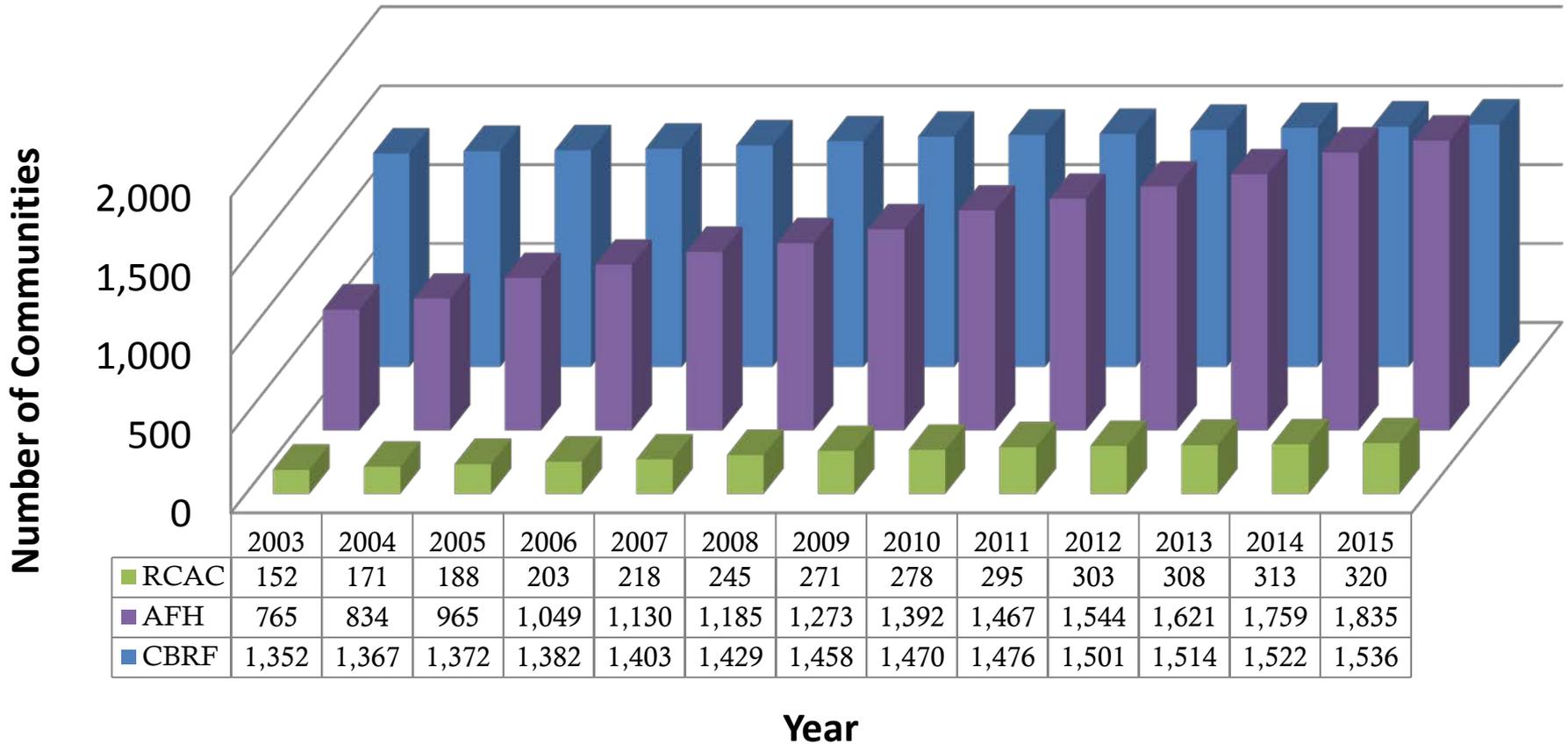
Trend in Capacity for Residents





Assisted Living Communities

Trend in Number of Communities

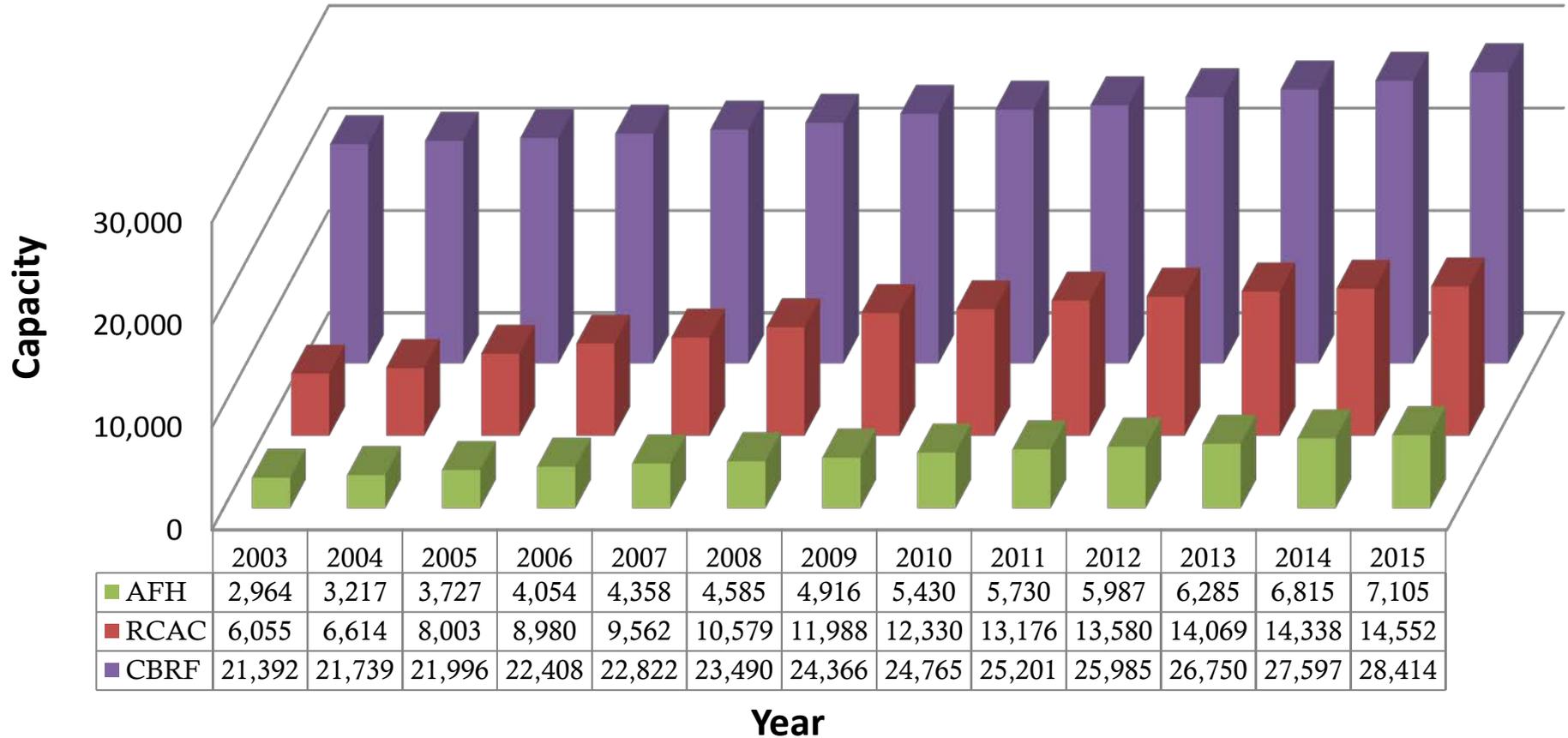


RCAC = Residential Care Apartment Complex



Assisted Living Capacity

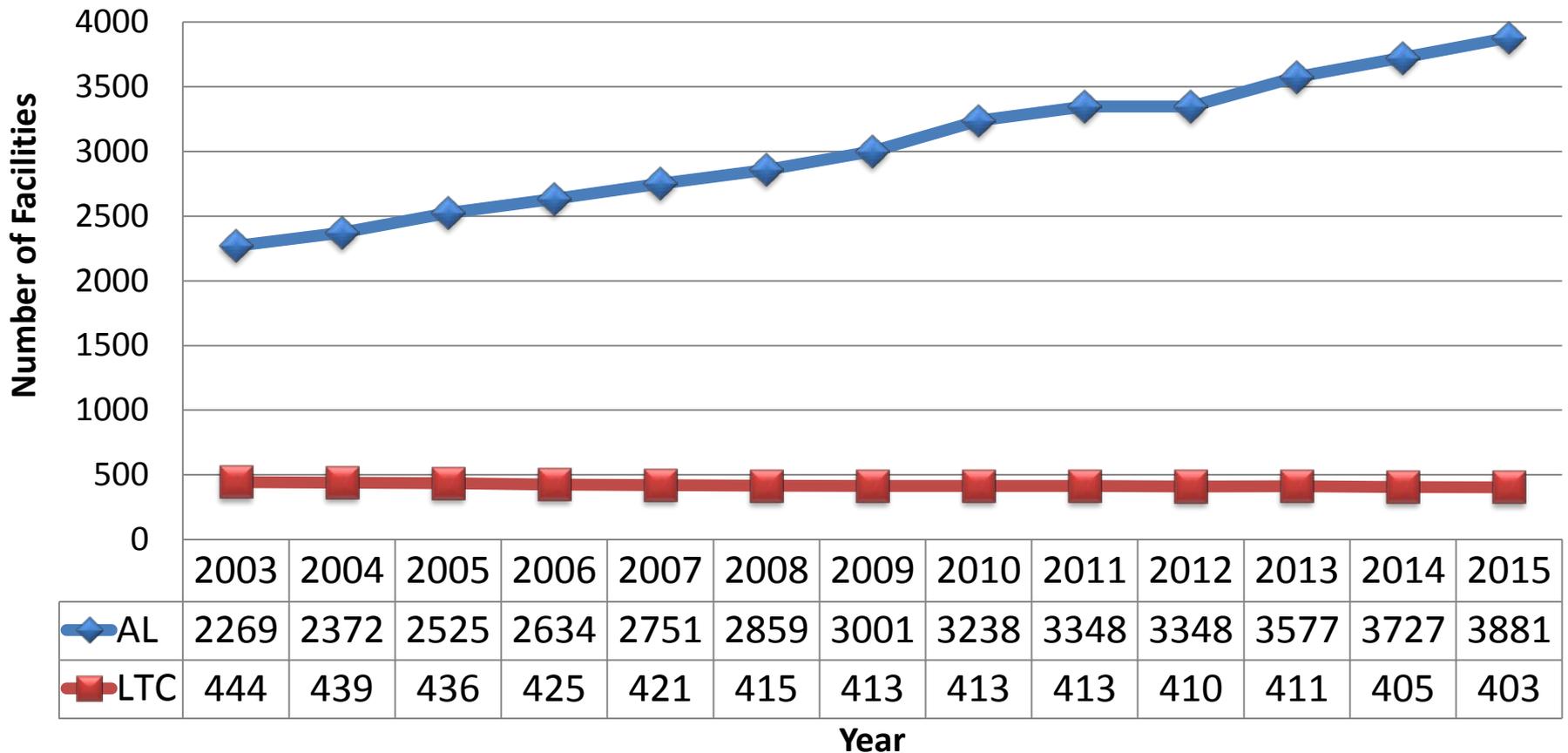
Trend in Assisted Living Capacity





Assisted Living vs. Long Term Care (LTC) Facilities

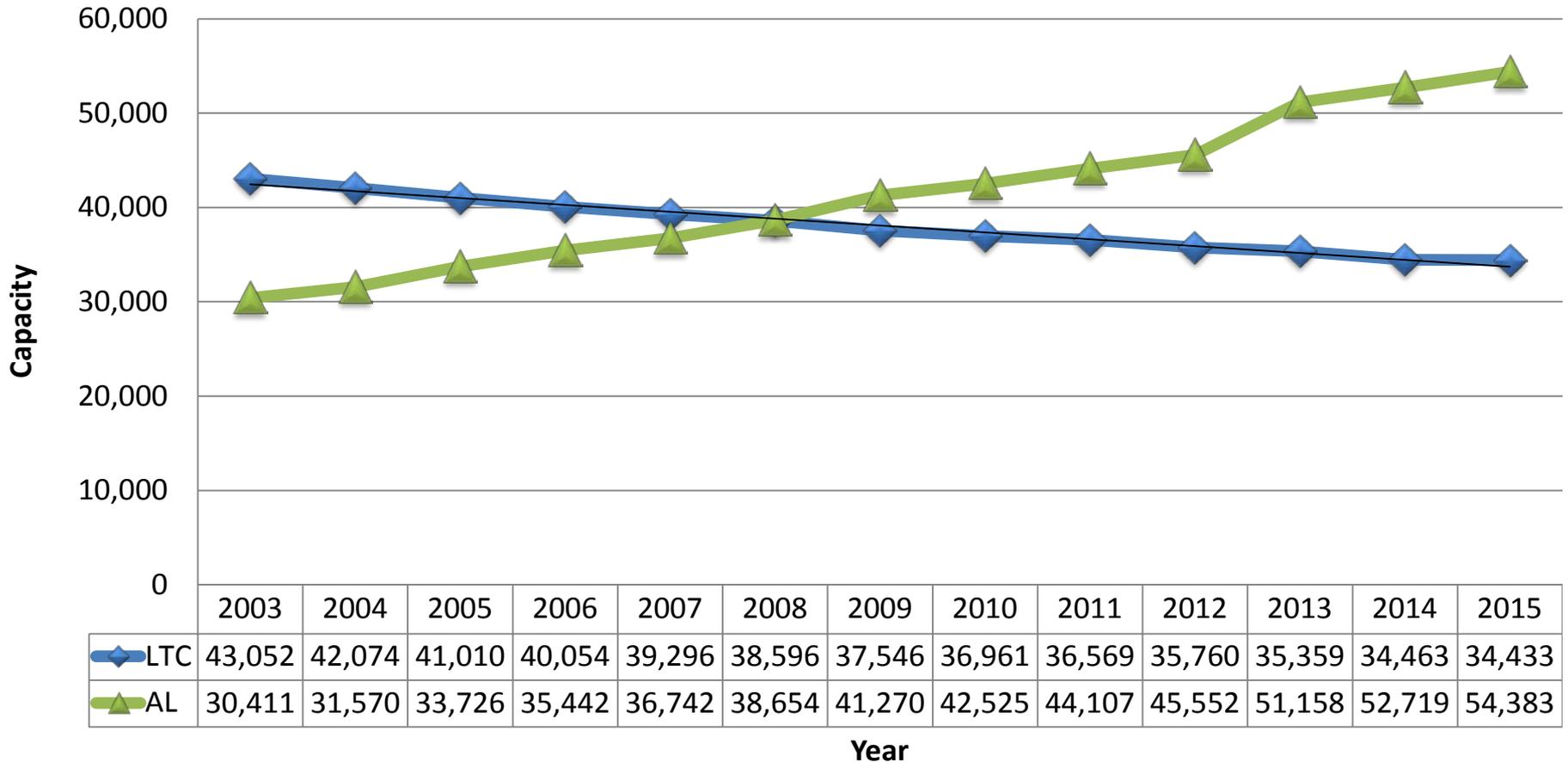
Trend in Number of Facilities





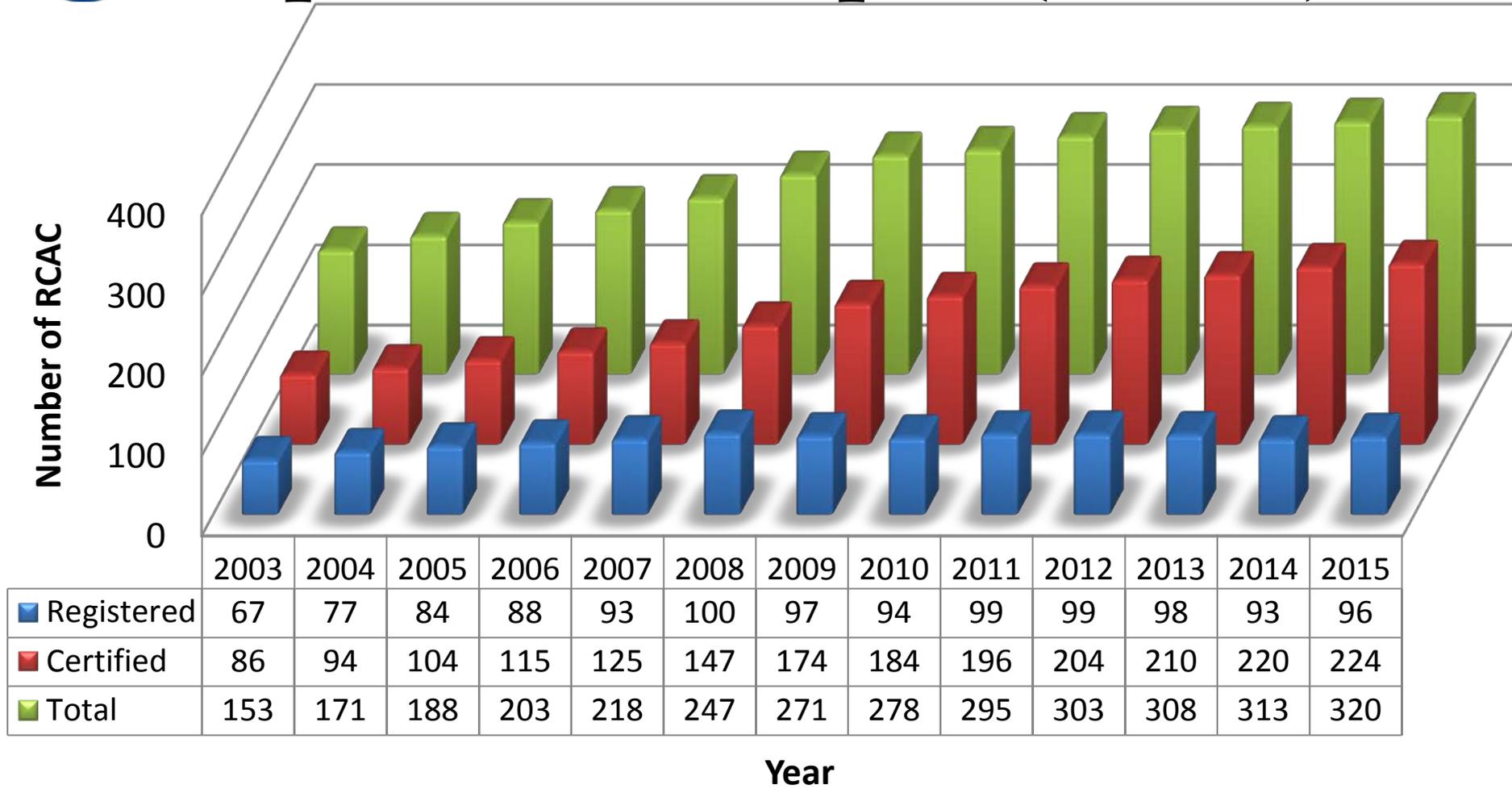
Assisted Living vs. LTC Capacity

Trend in Capacity for Residents





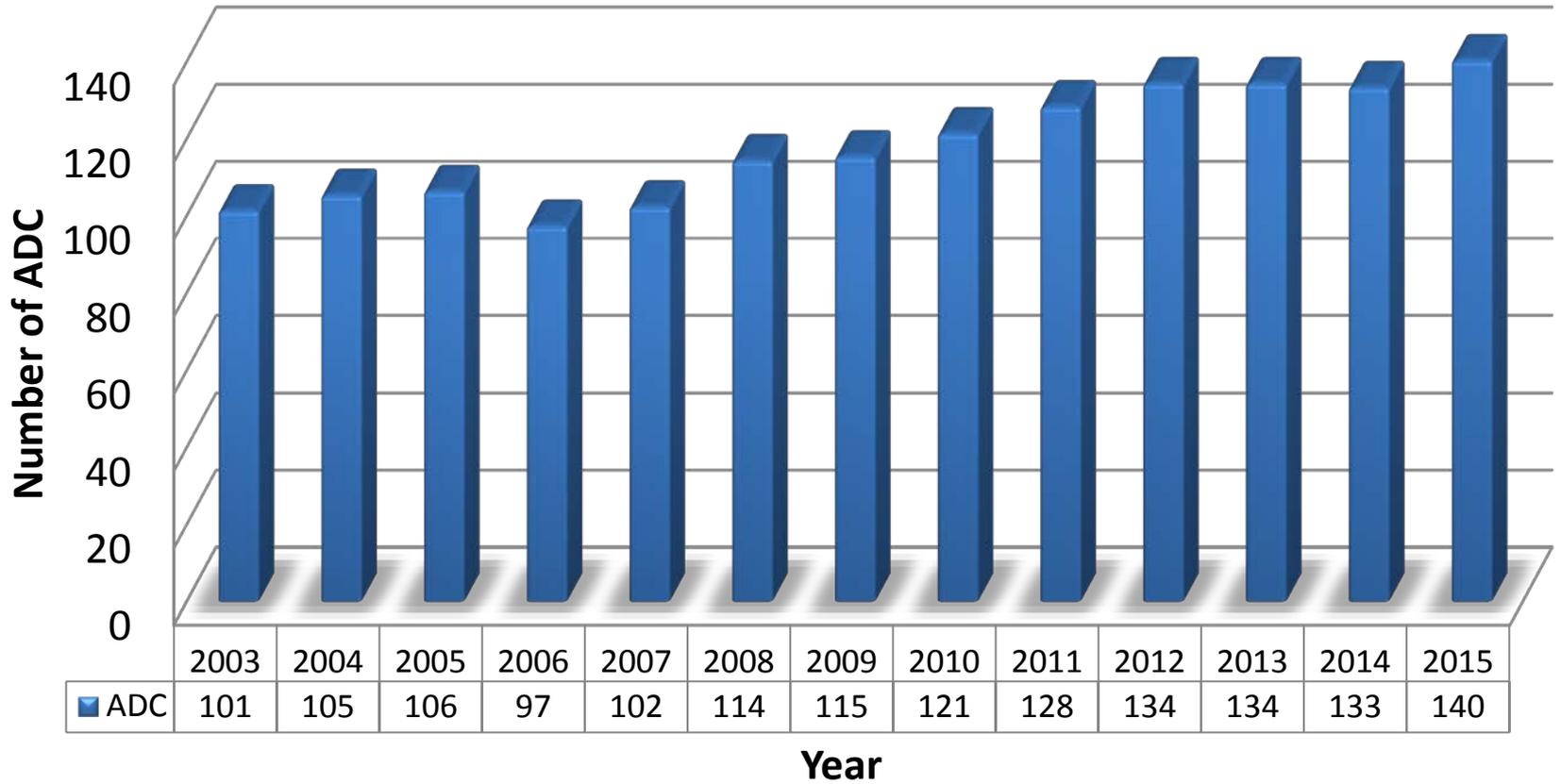
Residential Care Apartment Complex (RCAC)





Adult Day Care (ADC) Centers

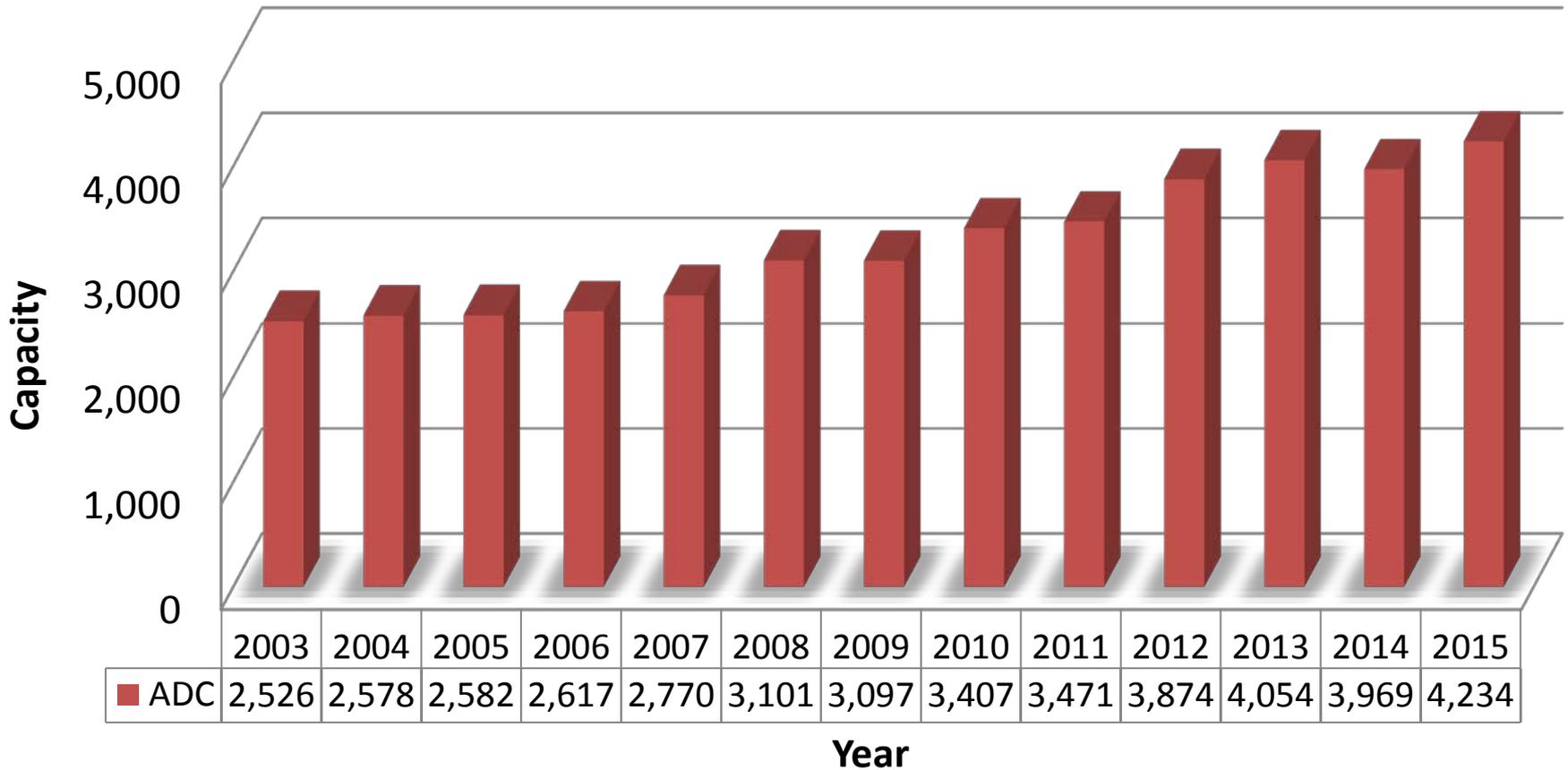
Trend in Number of Centers





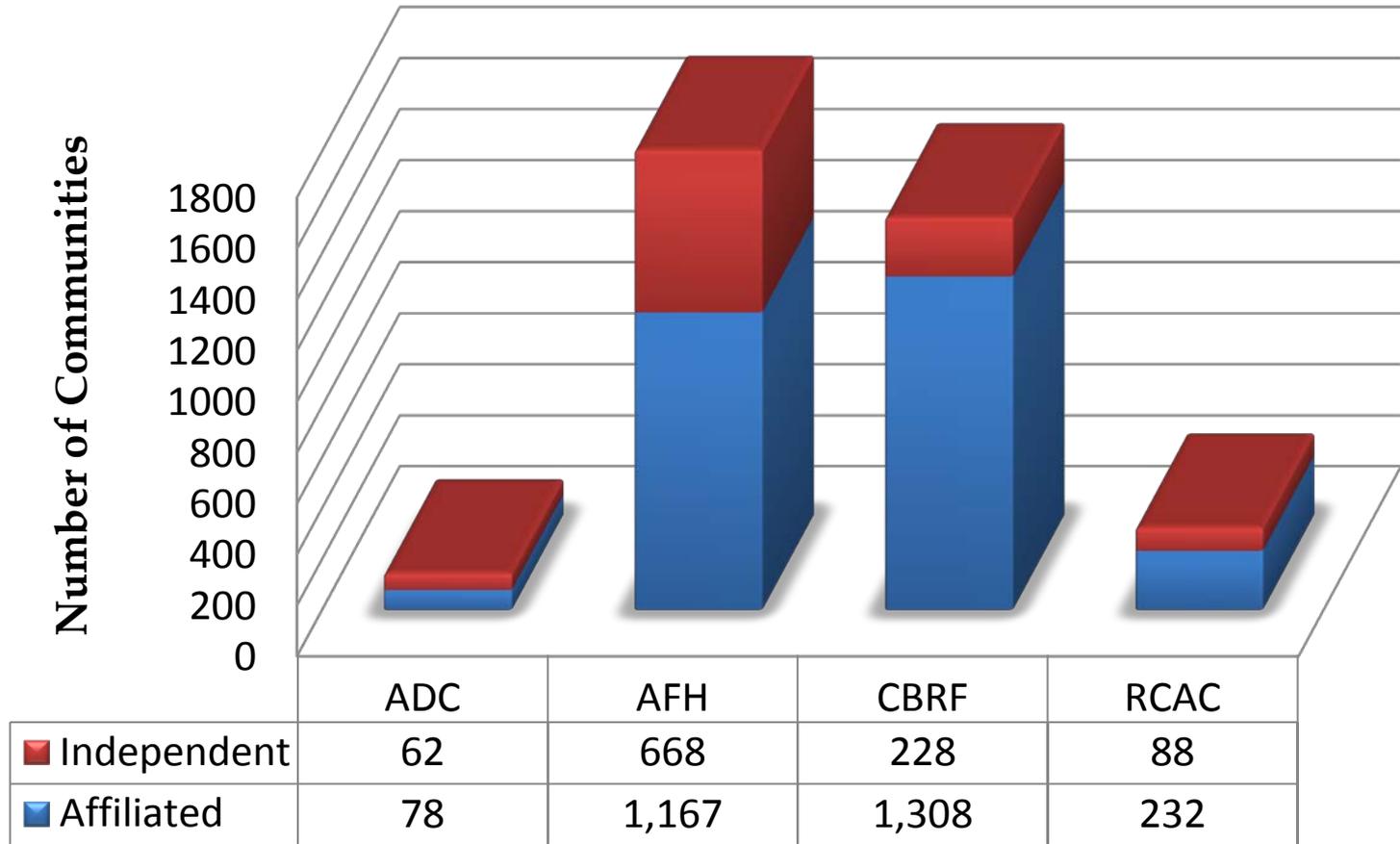
Adult Day Care Centers

Trend in the Capacity for Participants



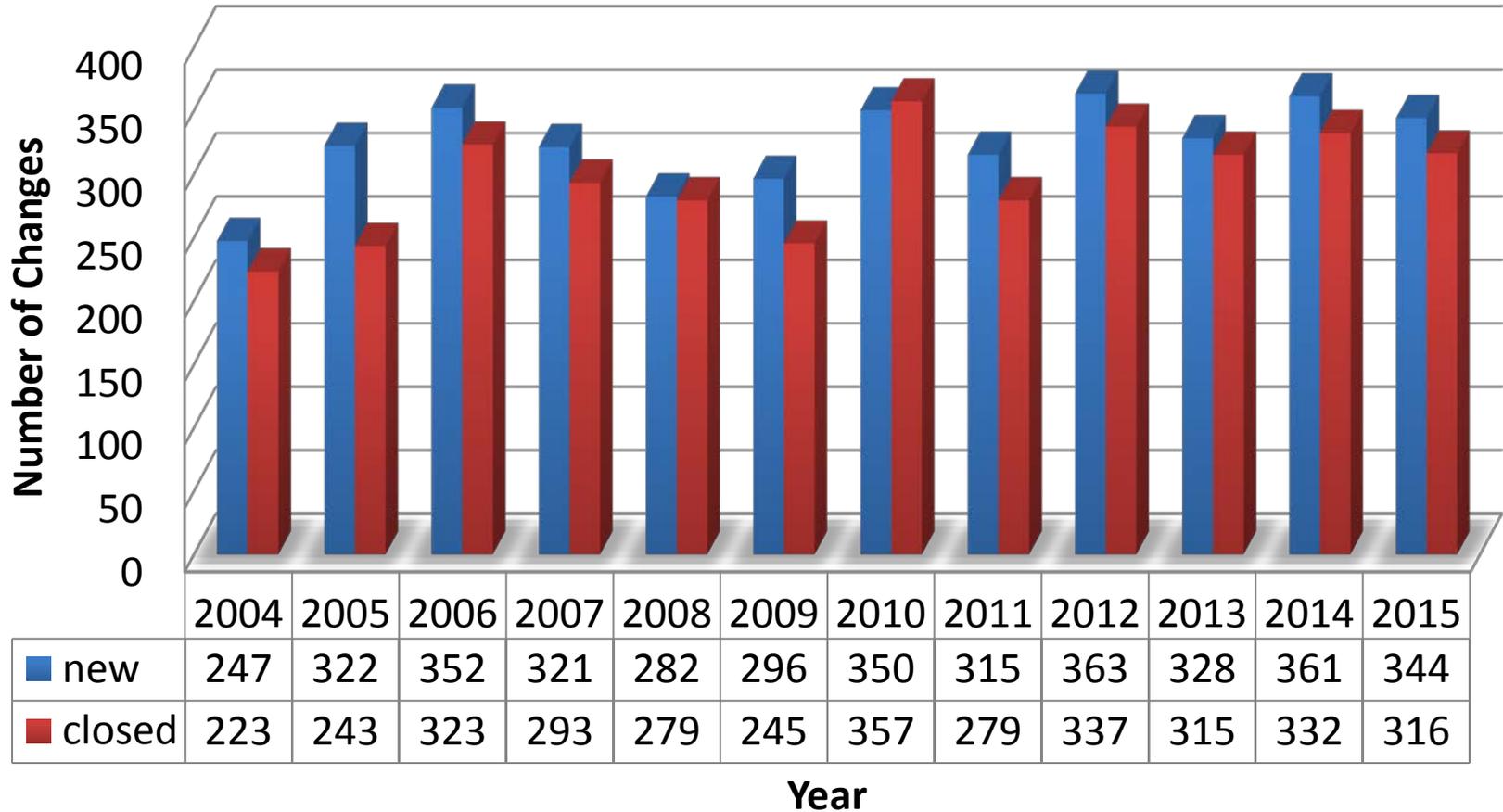


Assisted Living Communities by Affiliation CY 2015



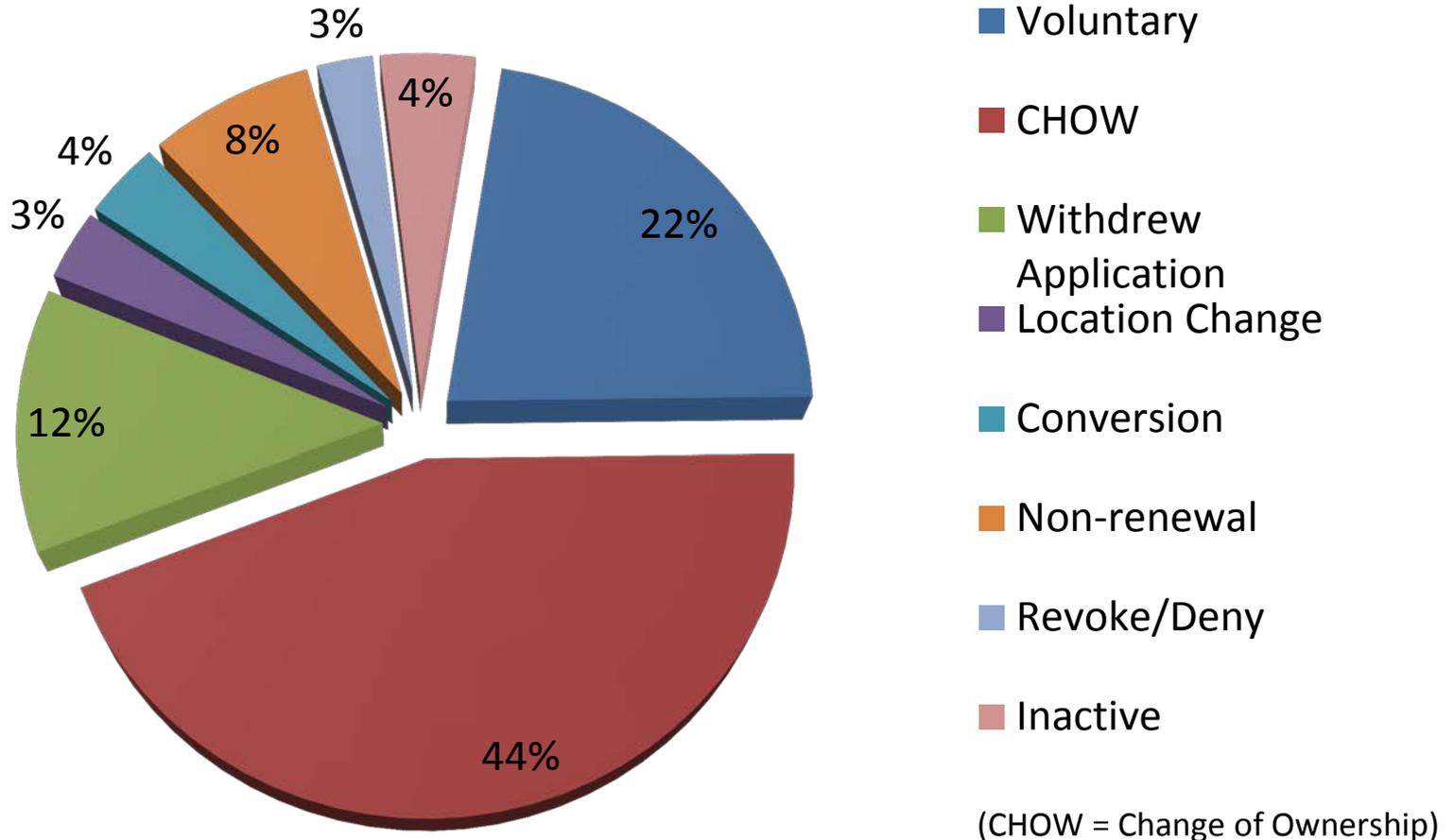


New AL vs. Closed AL





Why Facilities Closed CY 2015

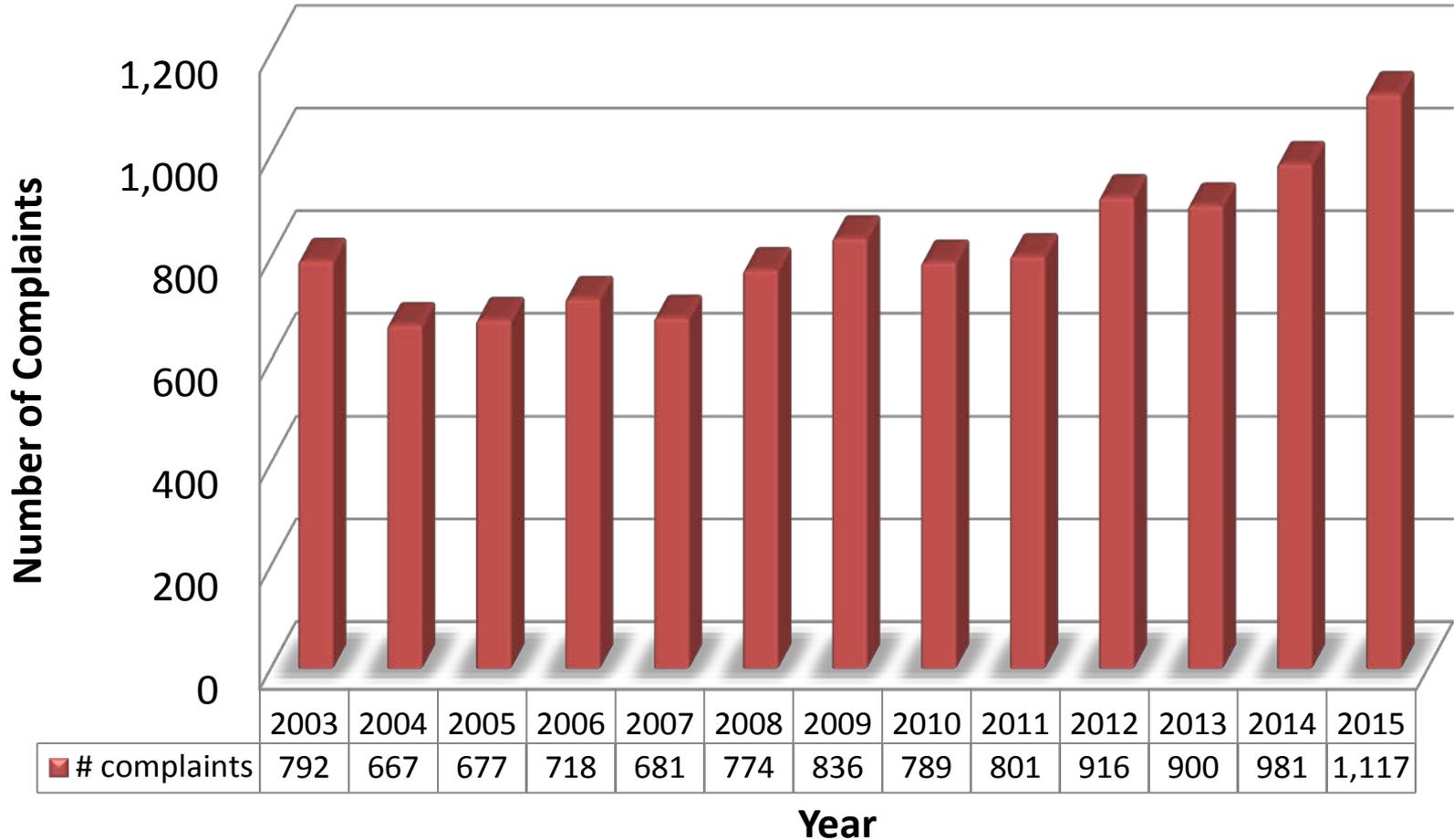




Assisted Living Complaints CY 2015



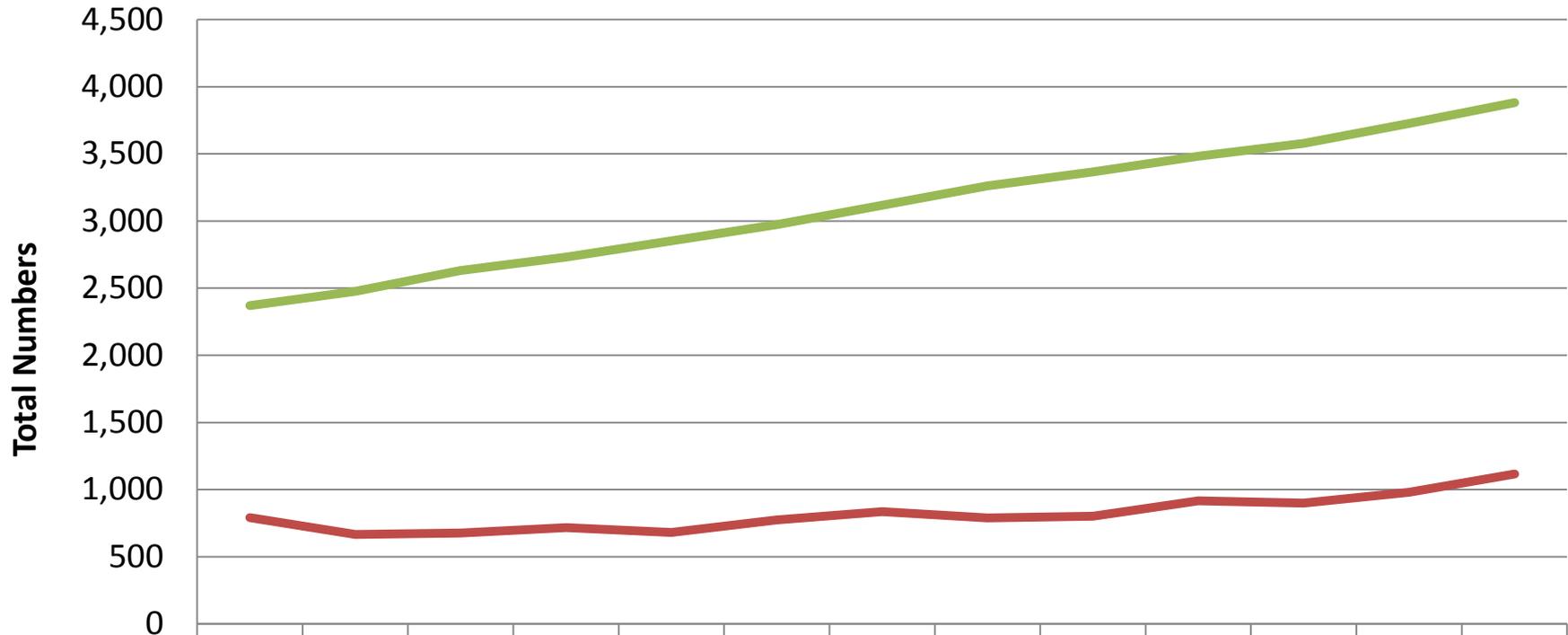
Assisted Livings Complaints Received





Complaints vs. Growth

2003–2015



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
# complaints	792	667	677	718	681	774	836	789	801	916	900	981	1,117
# AL Facilities	2,370	2,477	2,631	2,731	2,853	2,973	3,117	3,261	3,366	3,482	3,577	3,727	3,881

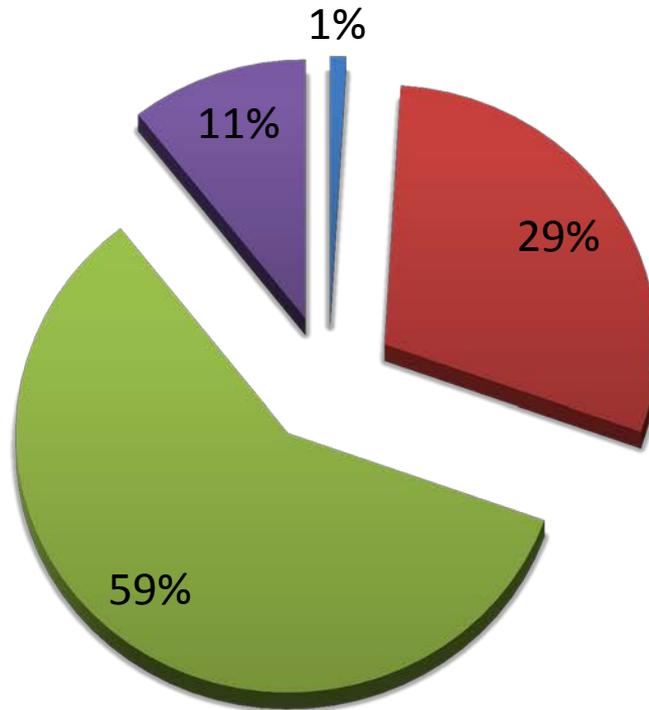
Years



Complaints Received CY 2015

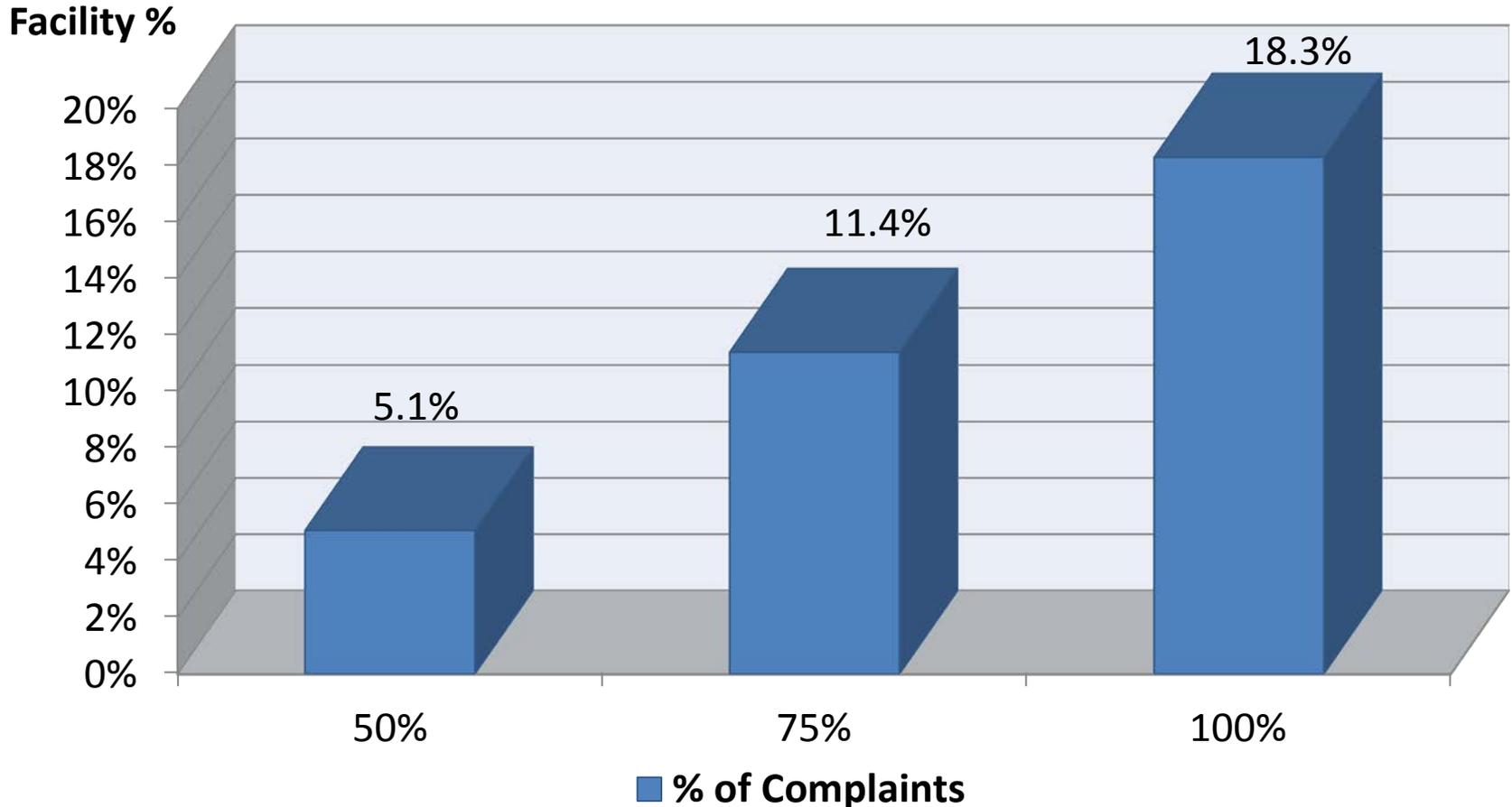
Complaints

■ ADC ■ AFH ■ CBRF ■ RCAC



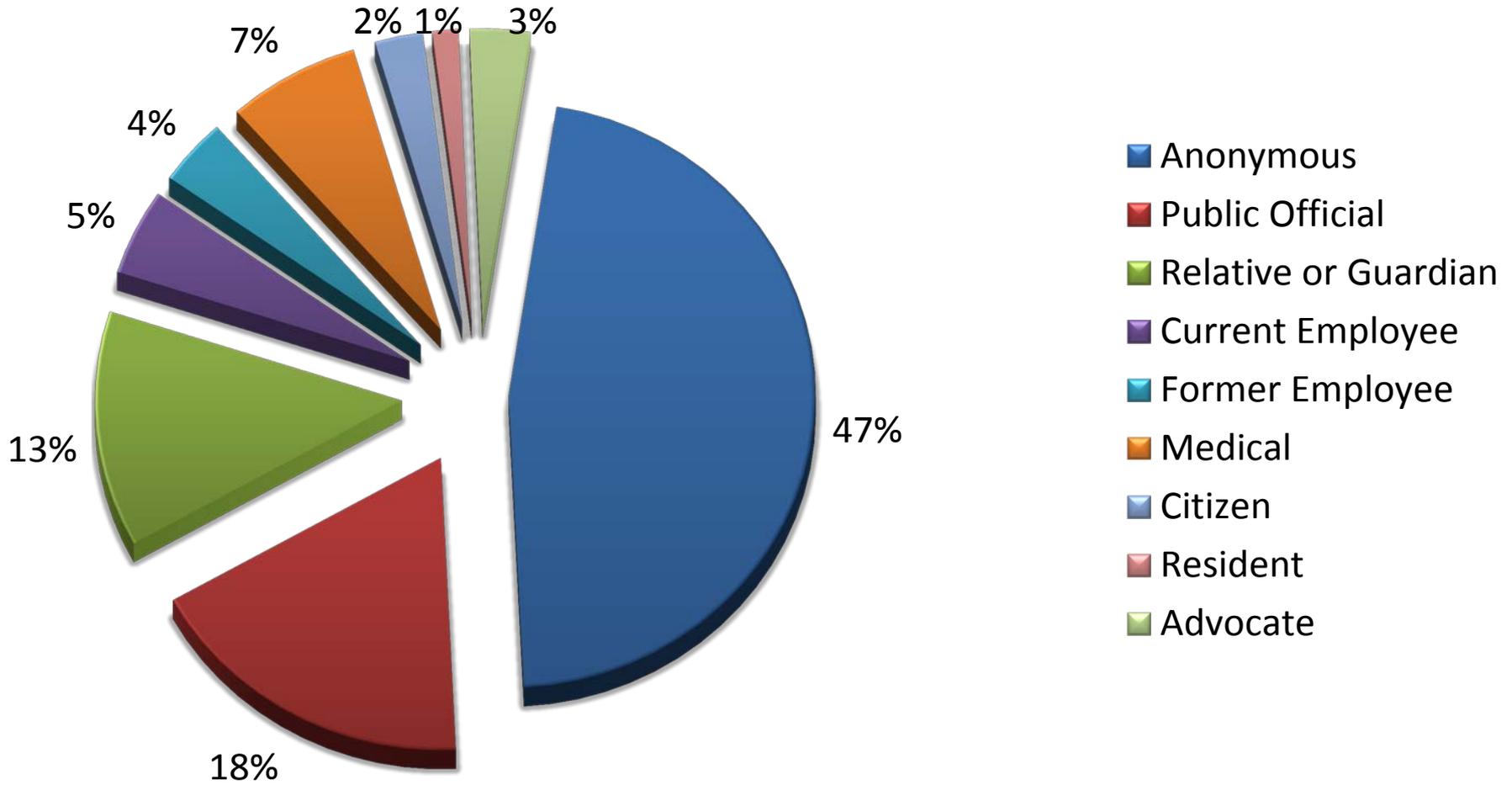


Percentage of Facilities Making Up a Percentage of Complaints





Source of Complaint CY 2015





Source of Complaint vs. Substantiation CY 2015

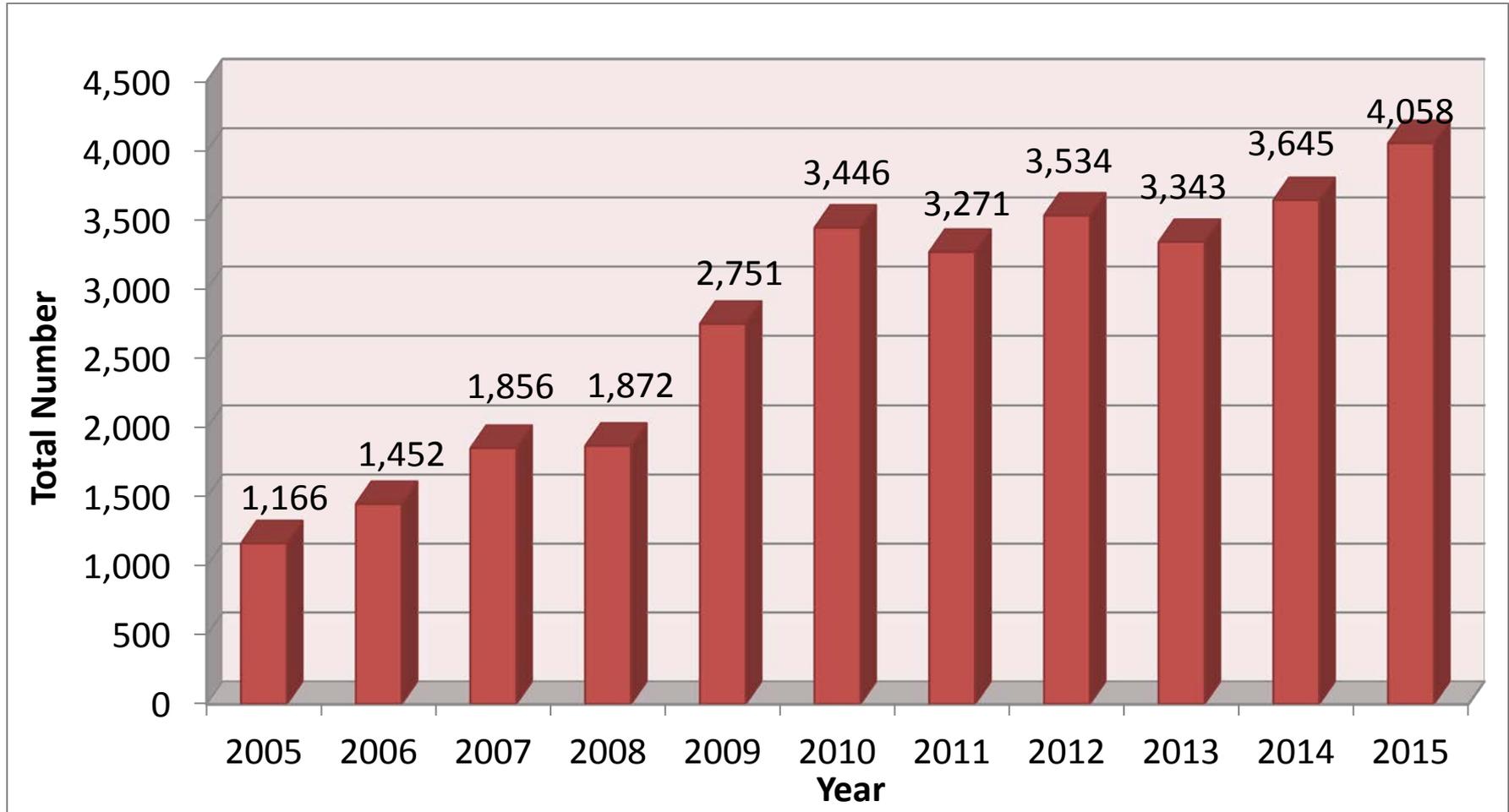
<u>Source</u>	<u>% Received and Investigated</u>	<u>% Substantiated</u>
Anonymous	47	36
Public Official	18	43
Relative or Guardian	13	41
Current Employee	05	24
Former Employee	04	28
Advocate	03	58
Citizen	02	39
Medical	07	52
Resident	<u>02</u>	<u>20</u>
	100%	43%



Assisted Living Self-Reports CY 2015



Self-Reports Received

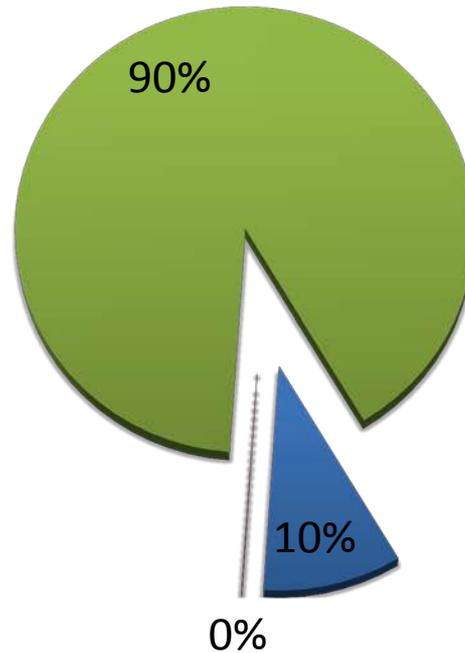




Self-Reports Received CY 2015 (4,058)

Self-Reports

■ Open Investigation ■ Review Next Visit ■ File

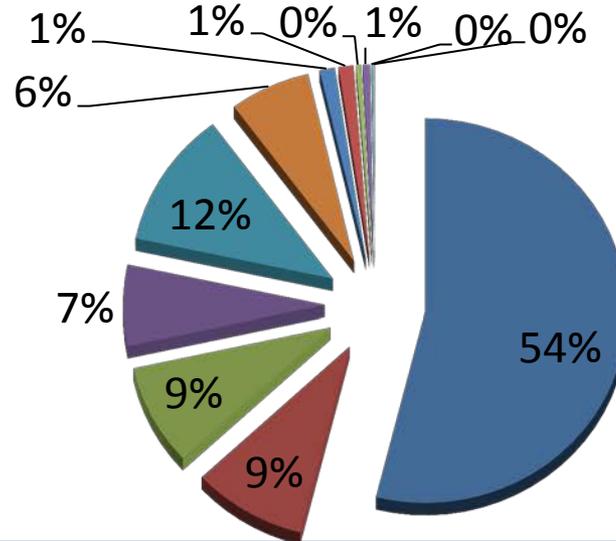




Number of Self-Reports by Subject Area CY 2015

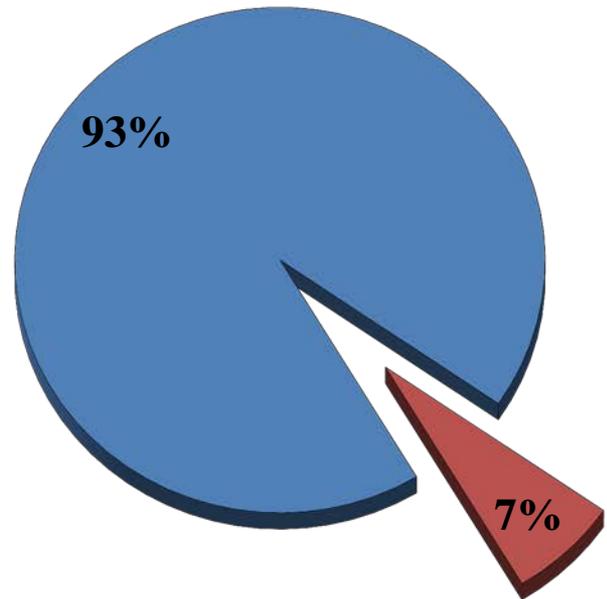
2015

- Falls
- Elopement
- Misappropriation
- Fire
- Resident Behavior
- Hospital (Not Fall)
- Abuse
- Communicable Disease
- Police
- Other
- Neglect
- Disaster or Evacuation





Self-Reports Investigated CY 2015 (548)



(SOD = Statement of Deficiency)



Abbreviated Surveys CY 2015

- No deficiency survey - 69%
- Statement of deficiency - 31%

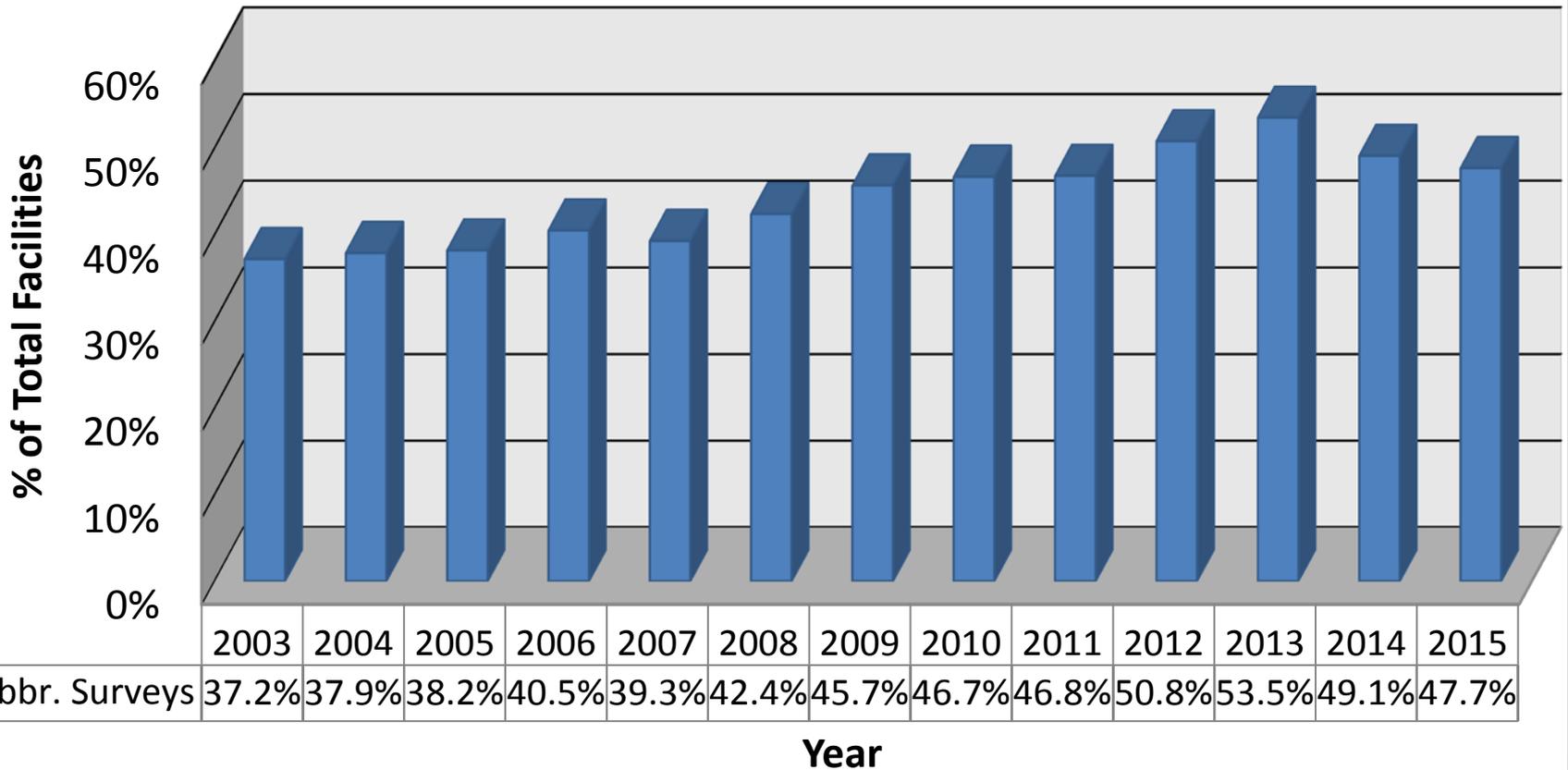


Facilities Qualifying for Abbreviated Surveys CY 2015

• Adult day care	68.9%
• Adult family home	49.9%
• Community-based residential facility	45.4%
• Residential care apartment complex	36.9%
• Statewide	47.7%

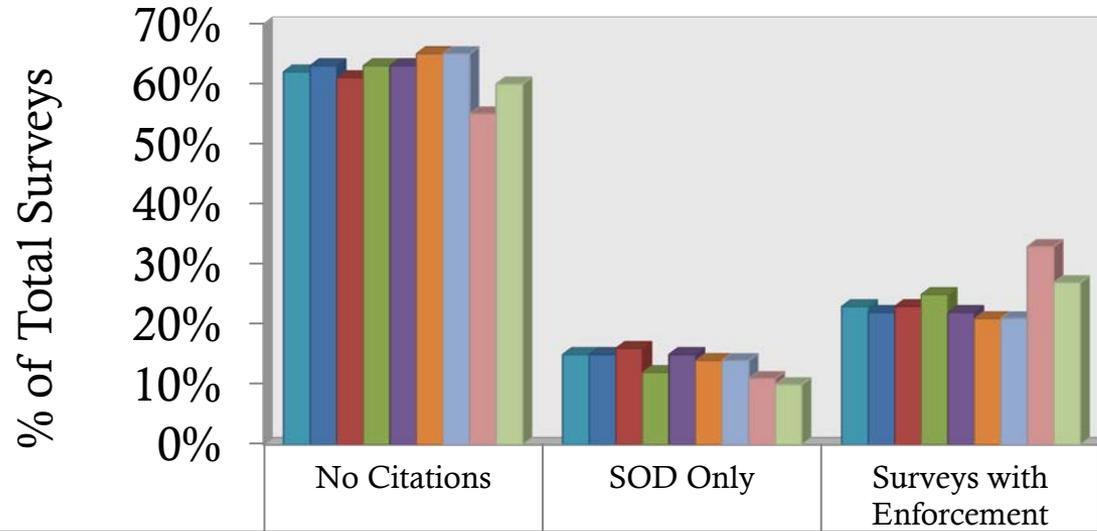


Facilities Qualifying for an Abbreviated Survey





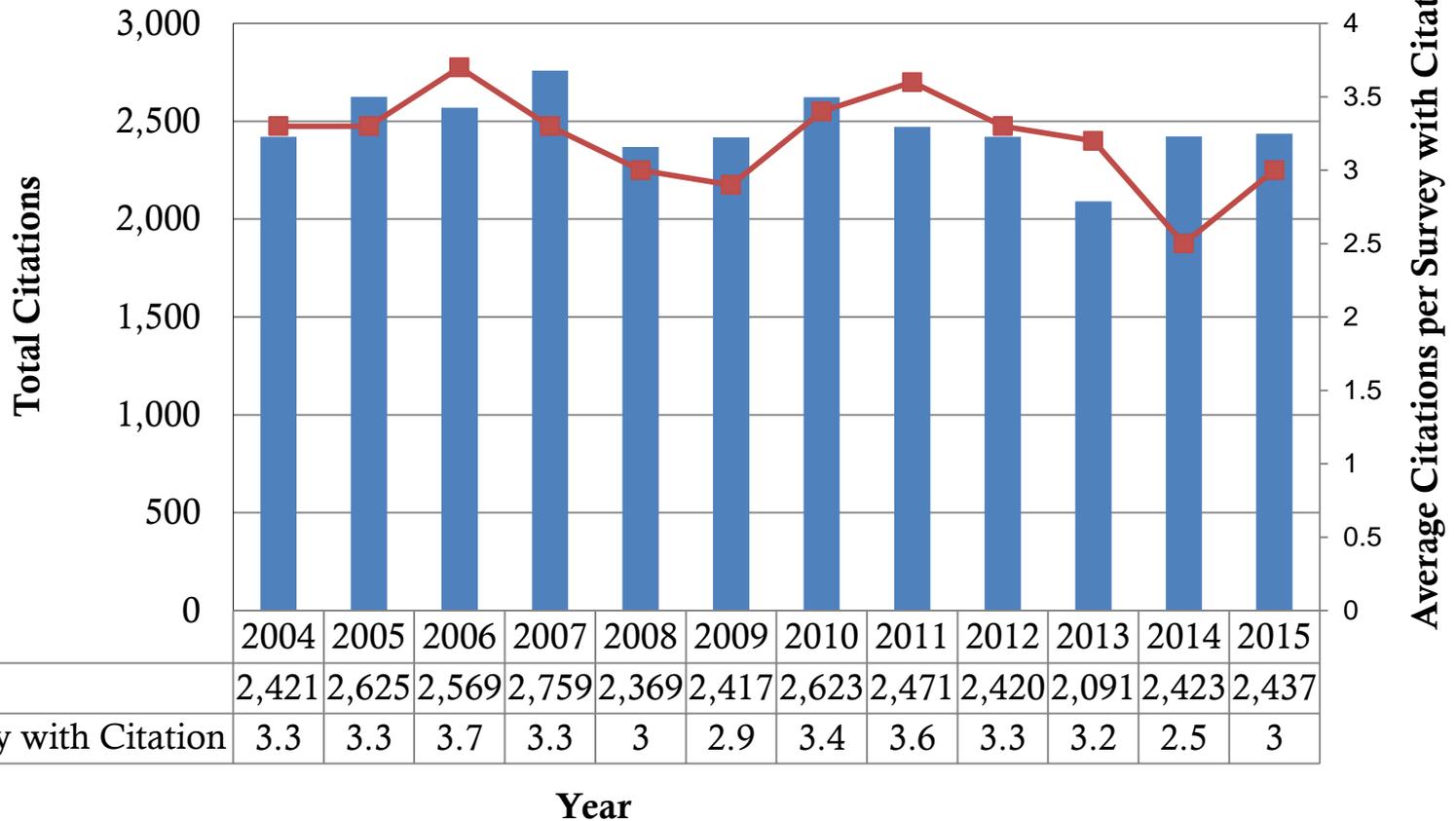
Statewide Survey Results



	No Citations	SOD Only	Surveys with Enforcement
■ 2007	62%	15%	23%
■ 2008	63%	15%	22%
■ 2009	61%	16%	23%
■ 2010	63%	12%	25%
■ 2011	63%	15%	22%
■ 2012	65%	14%	21%
■ 2013	65%	14%	21%
■ 2014 excludes initial & CHOW	55%	11%	33%
■ 2015	60%	10%	27%

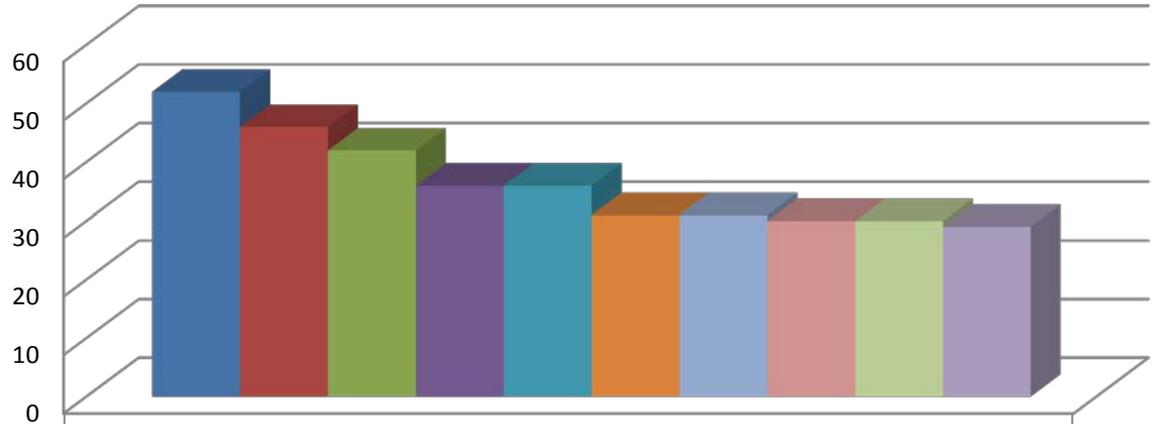


Assisted Living Citations Issued





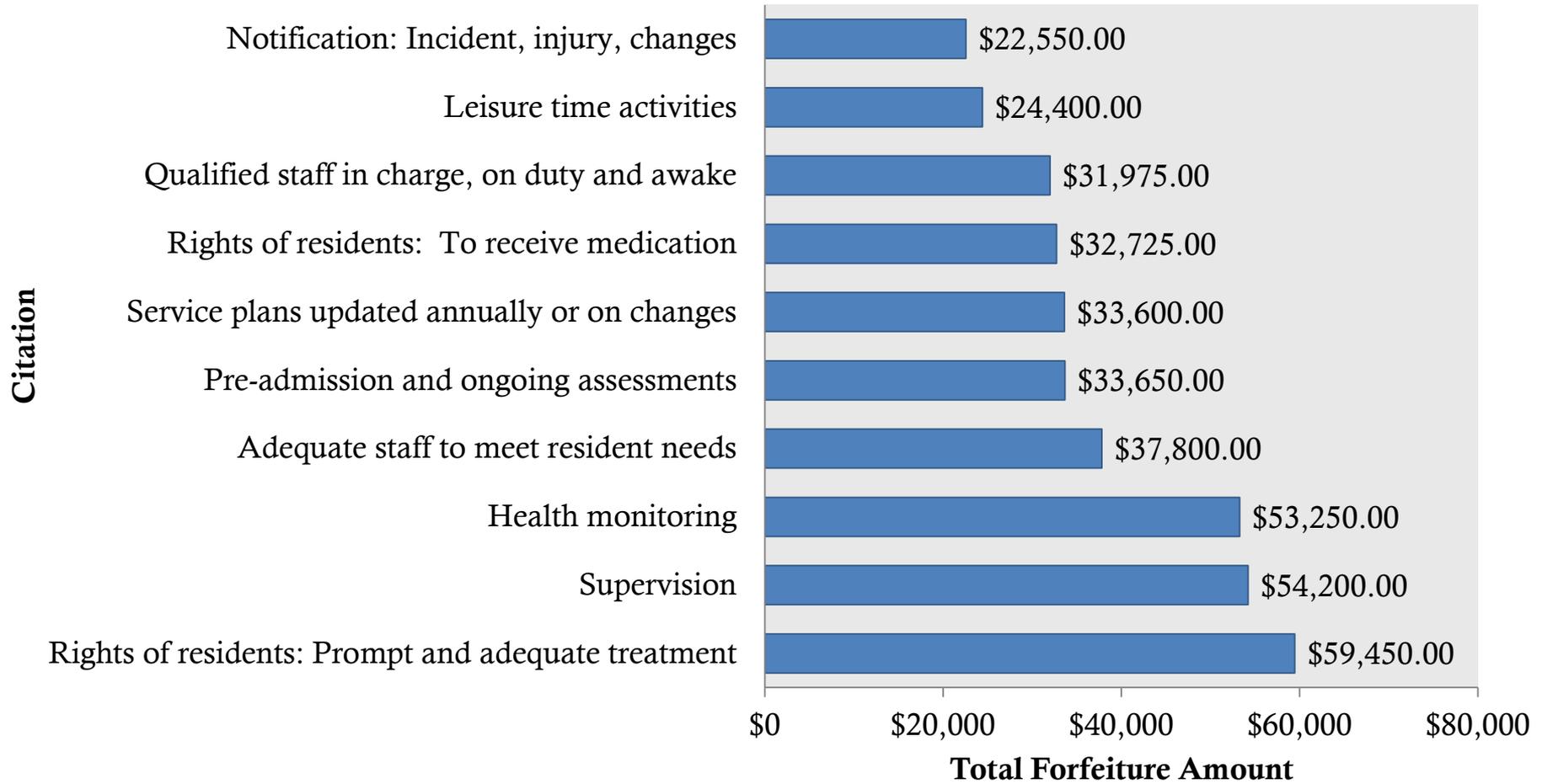
CBRF Top Ten Citations CY 2015



Citation	Number of Citations
83.47(2)(e) Other evacuation drills	52
83.35(3)(d) Service plans updated annually or on changes	46
83.47(2)(d) Fire drills	42
83.43(1) Environment safe, clean, and comfortable	36
83.35(1)(a) Pre-admission and ongoing assessments	36
83.38(1)(g) Health monitoring	31
83.20(2)(c) Training in first aid and choking	31
83.38(1)(b) Supervision	30
83.35(3)(a) Comprehensive individualized service plan	30
83.25 Continuing education	29

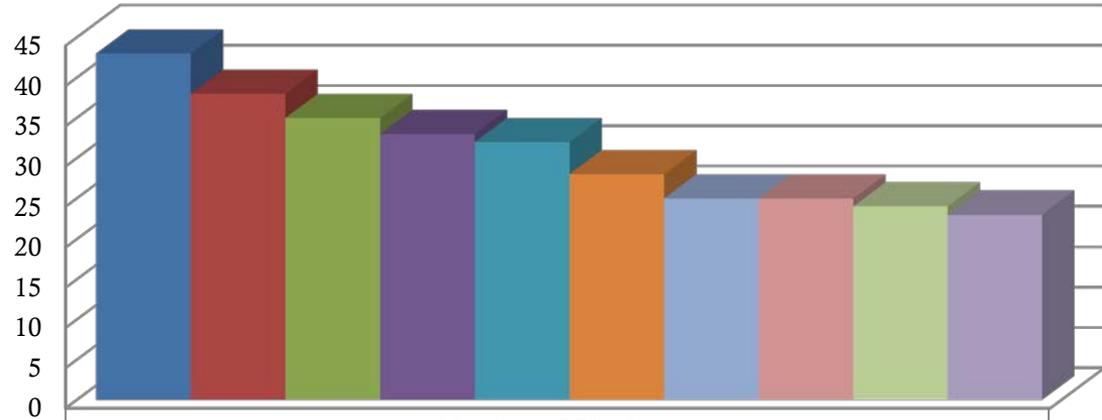


Top Ten Cites With Forfeiture CBRF CY 2015





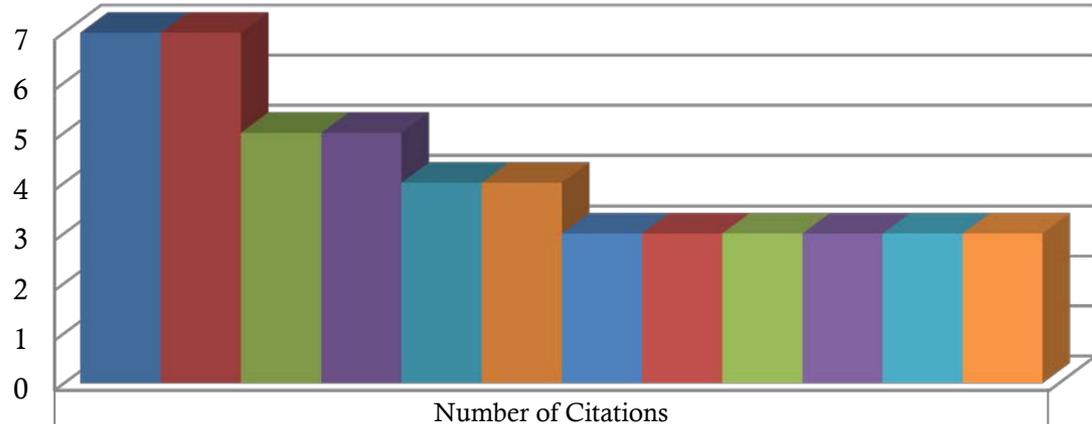
AFH Top Ten Citations CY 2015



Citation	Number of Citations
88.05(3)(a) Home environment	43
88.05(4)(d)2.b Fire Evacuation annual evaluation	38
88.04(2)(a) Responsibilities	35
88.06(3)(f) Review of individual service plan (ISP)	33
88.04(5)(a) Training: 15 hours within 6 months	32
88.07(3)(d) Medication: Written order	28
88.10(3)(l) Safe physical environment	25
88.05(4)(b)2 Smoke detectors: Testing and maintenance	25
88.05(4)(c)1 Exiting from the first floor	24
88.06(3)(a) Individual service plan and assessment	23



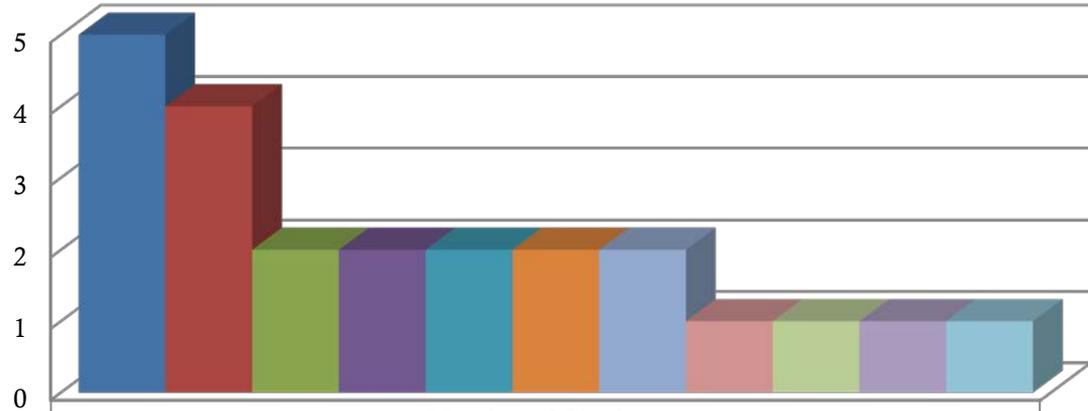
RCAC Top Ten Citations CY 2015



Citation	Number of Citations
89.23(4)(a)2 Services	7
89.34(16) Tenant Rights	7
89.23(4)(d)1 Services	5
50.034(8) Residential Care Apartment Complexes	5
89.23(4)(b)1 Services	4
89.23(2)(a)2.c Services	4
89.23(1) Services	3
89.23(3)(c) Services	3
89.34(17) Tenant Rights	3
89.34(2) Tenant Rights	3
89.28(1) Risk Agreement	3
89.27(1) Service Agreement	3



ADC Top Ten Citations CY 2015



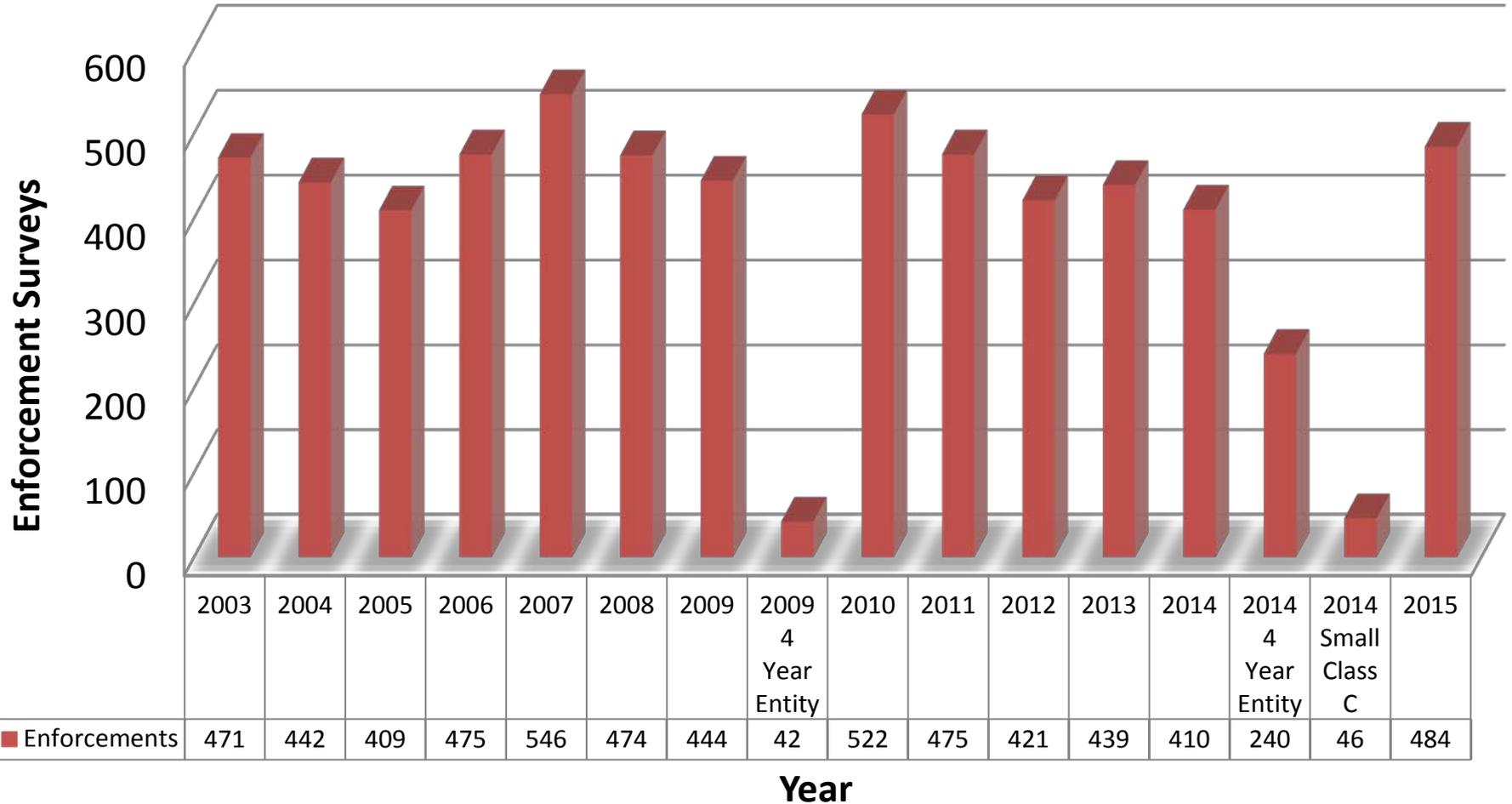
Citation	Number of Citations
■ II.a.(4) Personnel: Health examination	5
■ II.d.(4) Training: Continuing education	4
■ II.a.(1) Personnel: Staffing reports	2
■ III.b.(5) Safety: Emergencies plan	2
■ III.c.(4) Fire alarm and smoke detectors	2
■ I.c.(3) Plan: Reviewed and updated every 6 months	2
■ III.a.(10)(a) Sanitation: Food storage	2
■ I.a.(5) Program Rights	1
■ I.b.(3) Signed by participant	1
■ I.b.(5) Records	1
■ I.c.(2)(a) Plan: Comprehensive written assessment	1



Assisted Living Enforcement CY 2015

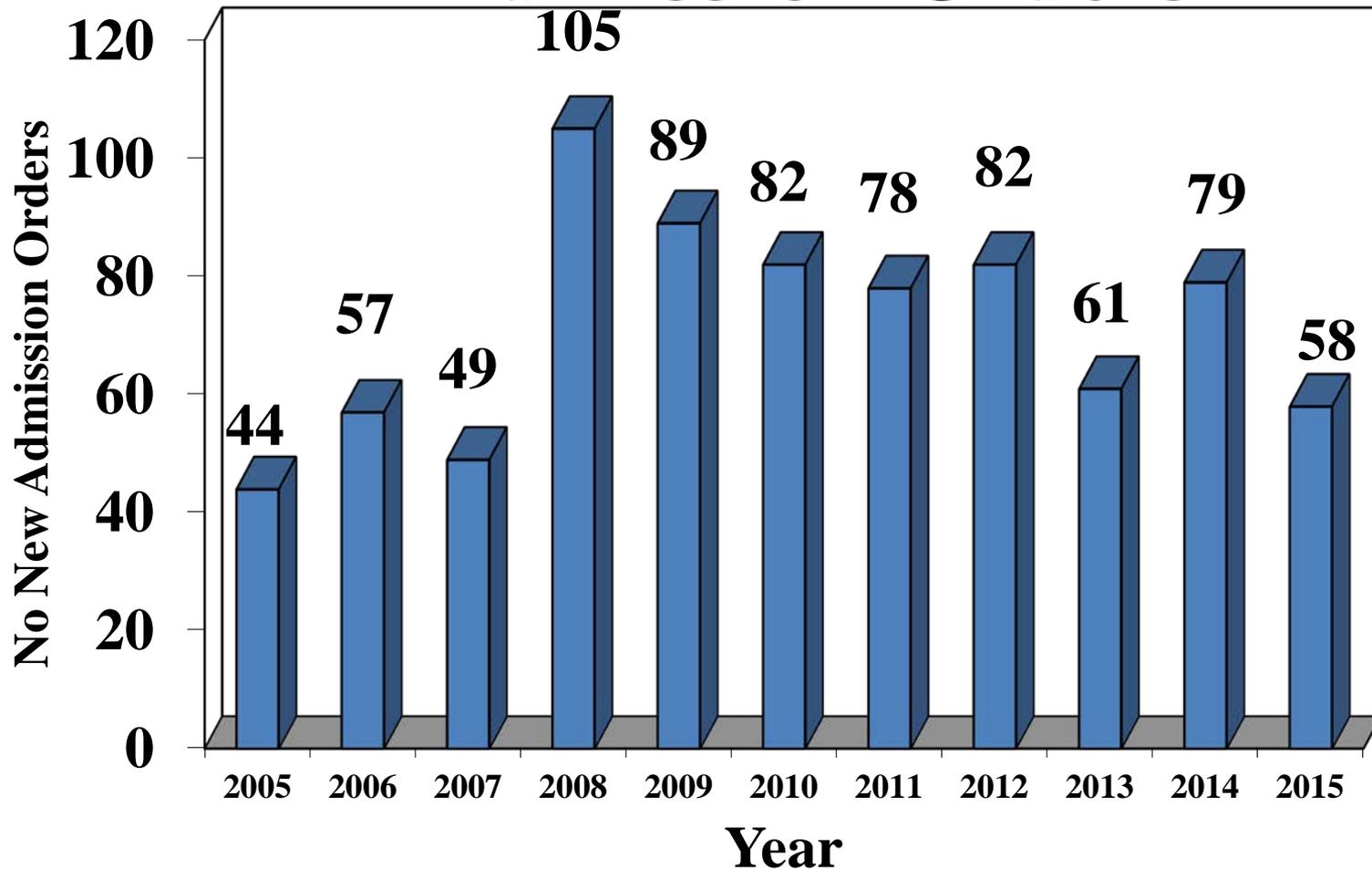


AL Surveys With Enforcement



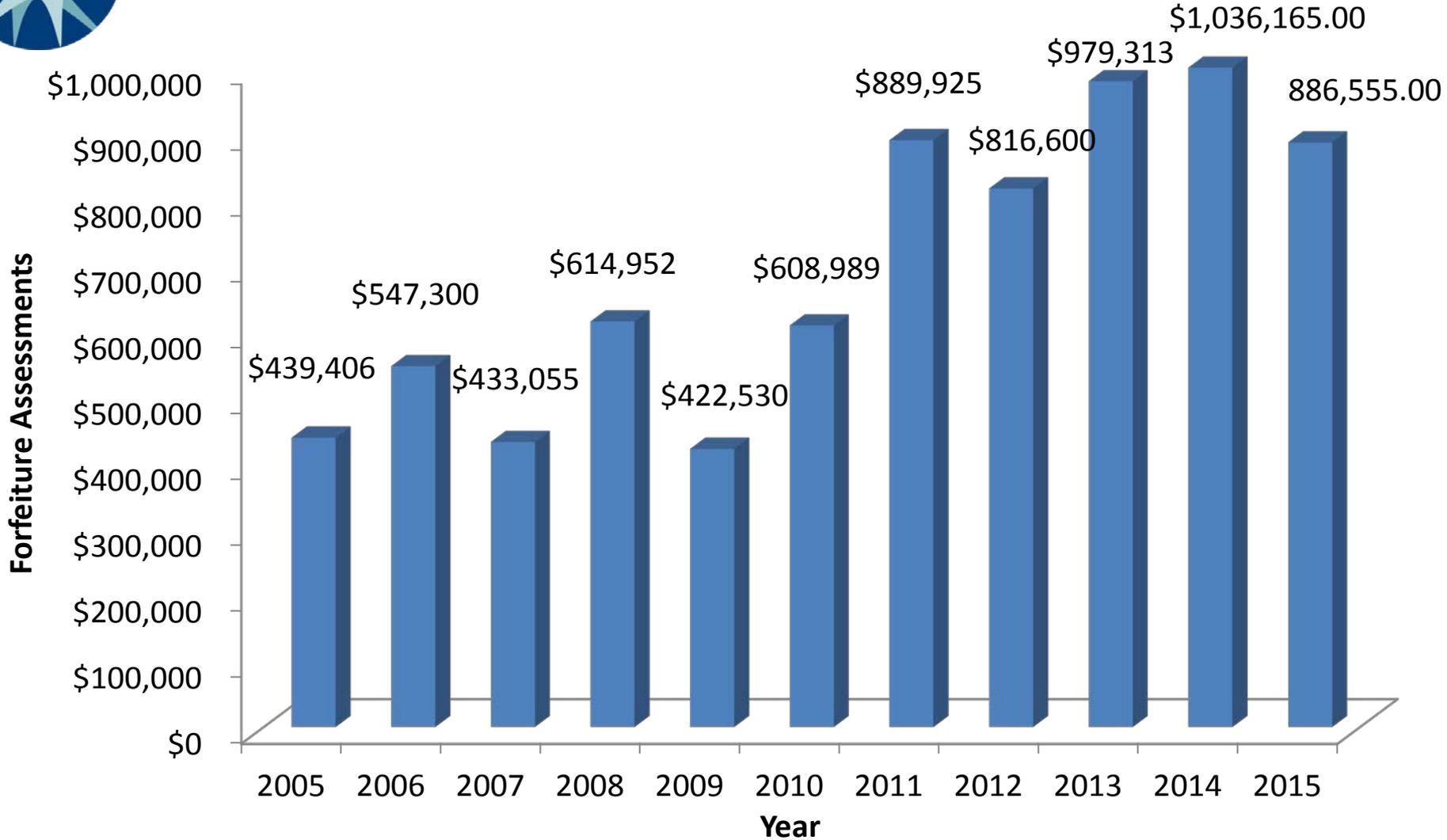


Assisted Living No New Admission Orders



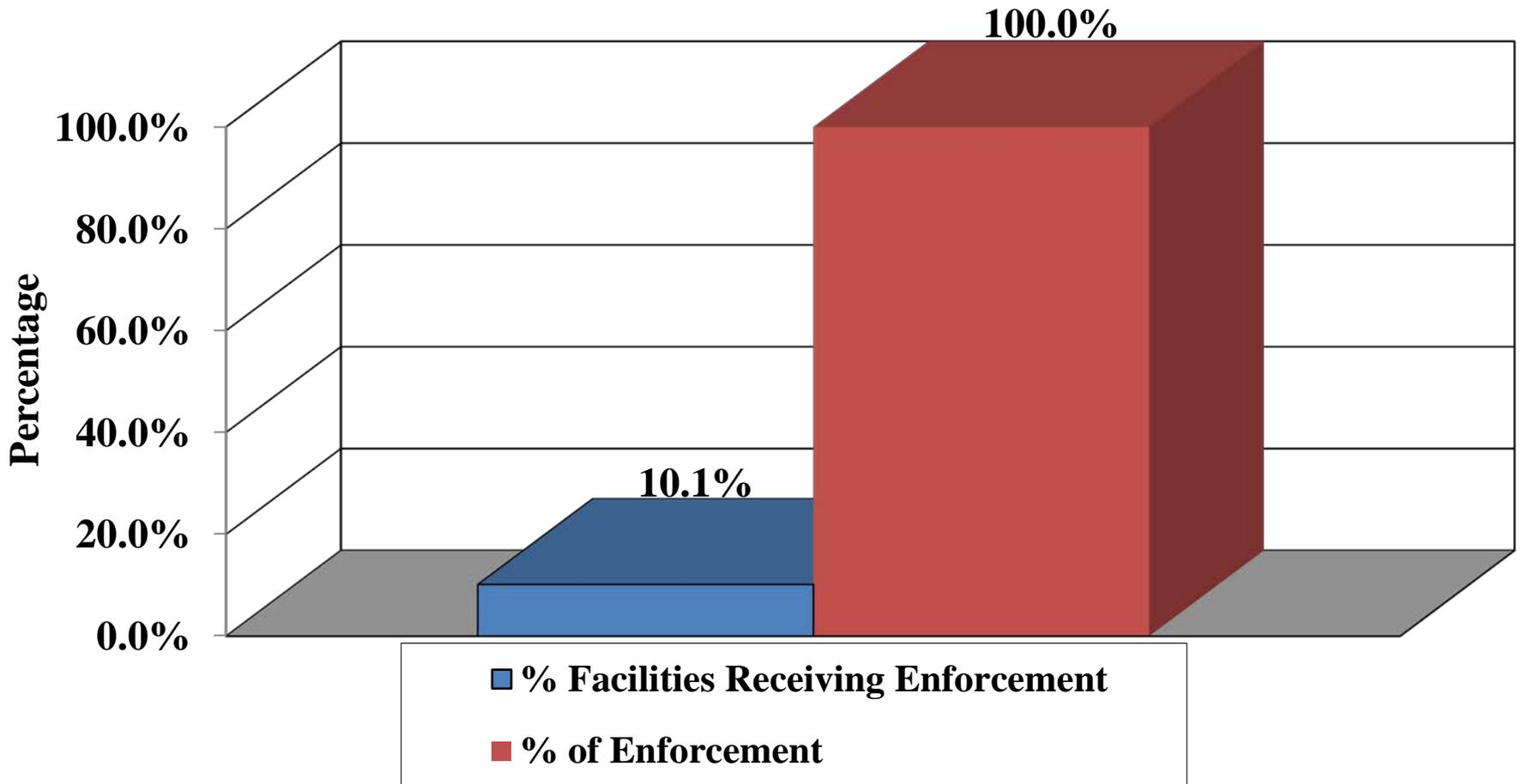


Forfeiture Assessments



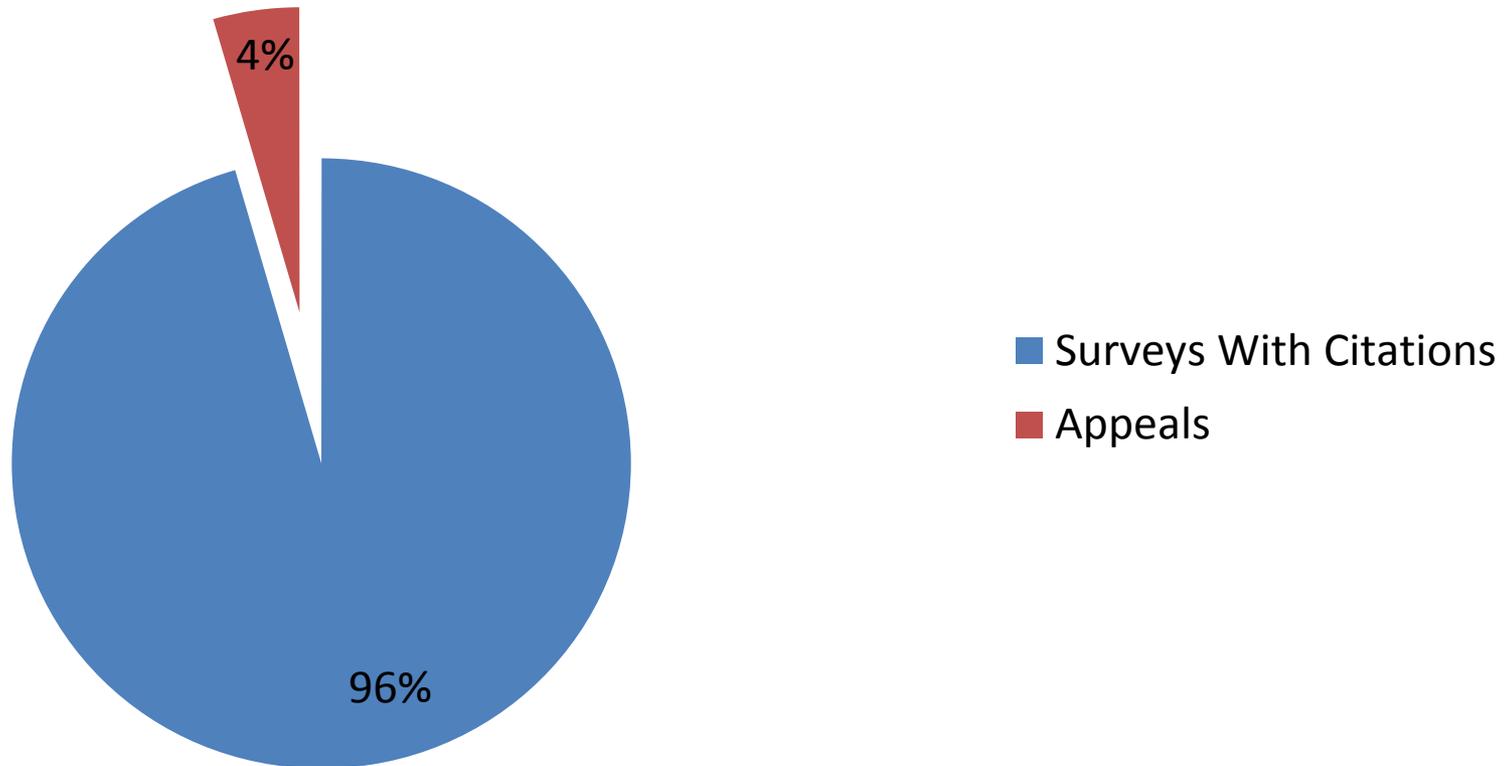


Percentage of Facilities Making Up a Percentage of Enforcements CY 2015





Assisted Living Surveys With Citations with Appeals CY 2015





Bureau of Assisted Living Strategies



2015 Year BAL Initiatives

- Resolve forums (self-reports and Home and Community Based Services (HCBS))
- Lean application process
 - Centralize licensing process
 - Develop e-licensure
 - Revise applications
 - Revise licensing process
- Supporting Older Adults with Intellectual Disabilities (ID) online training course
 - <http://continuingstudies.wisc.edu/classes/supporting-older-people-intellectual-disabilities>
- ISP train the trainer
 - Last class is scheduled for September 10–11.



2015 Year BAL Initiatives

- Root cause analysis workshops
- Transitions in care workgroup
- Assisting with HCBS implementation
- Continued implementation of WCCEAL
- Reducing falls webcast



2016 BAL Initiatives

- Completion of lean application project
 - CBRF application posted soon, other applications to follow
- E-licensure and e-payment system
- Resolve forums
- Conduct licensing application workshops



2016 BAL Initiatives

- Publish Assisted living self-report form
 - Self-report publication
- Hold Assisted Living Forum
- Evaluate assisted living survey enforcement system
- Pilot INTERACT (Interventions to Reduce Acute Care Transfers) tools
 - AL capabilities tool
- Assist in HCBS implementation



Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL)



Wisconsin Coalition for Collaborative Excellence in Assisted Living

- Provider association sponsored
- Department approved
- Comprehensive quality assurance (QA) and quality improvement (QI)



Internal Quality Assurance

- Essential to maintain quality!
- Structure, process, and outcome measures used to evaluate quality





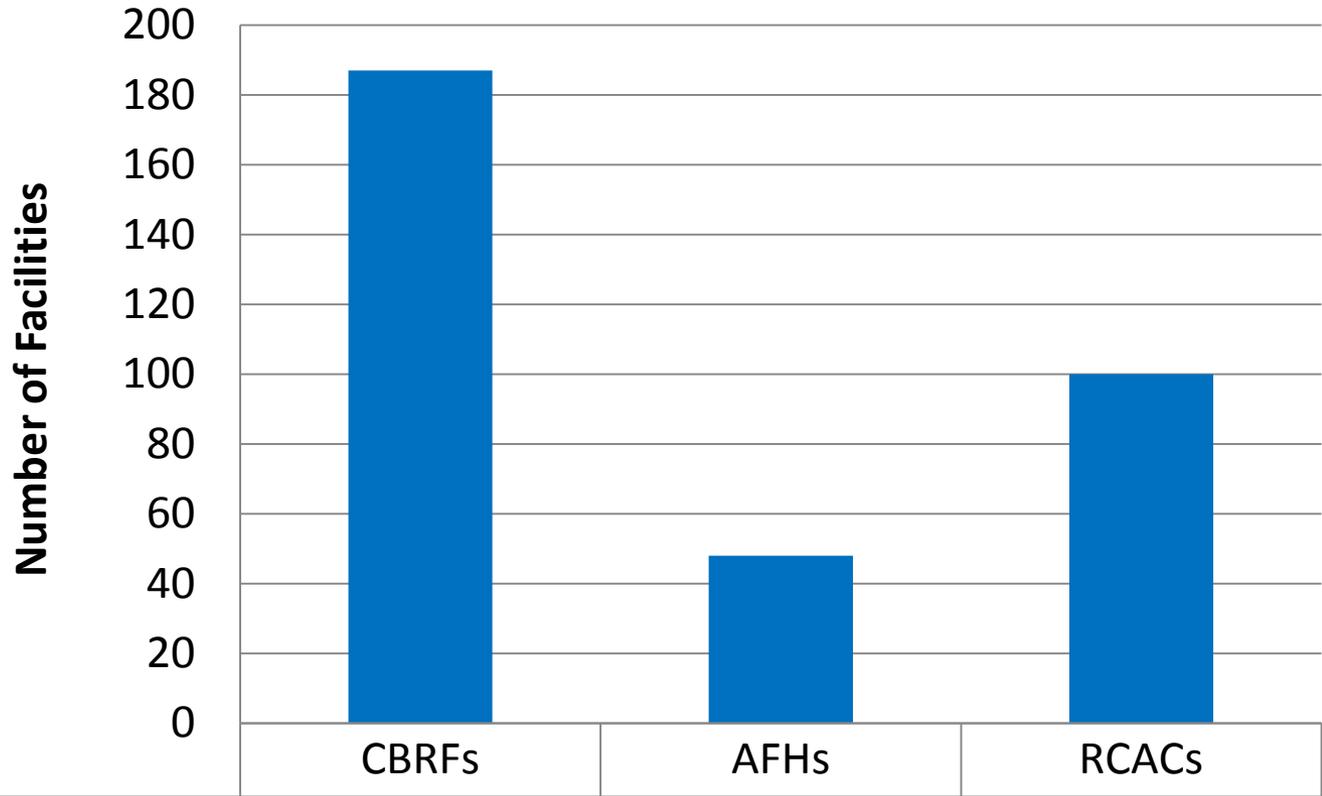


WCCEAL Regulatory Data CY 15





WCCEAL Regulated Communities CY 15

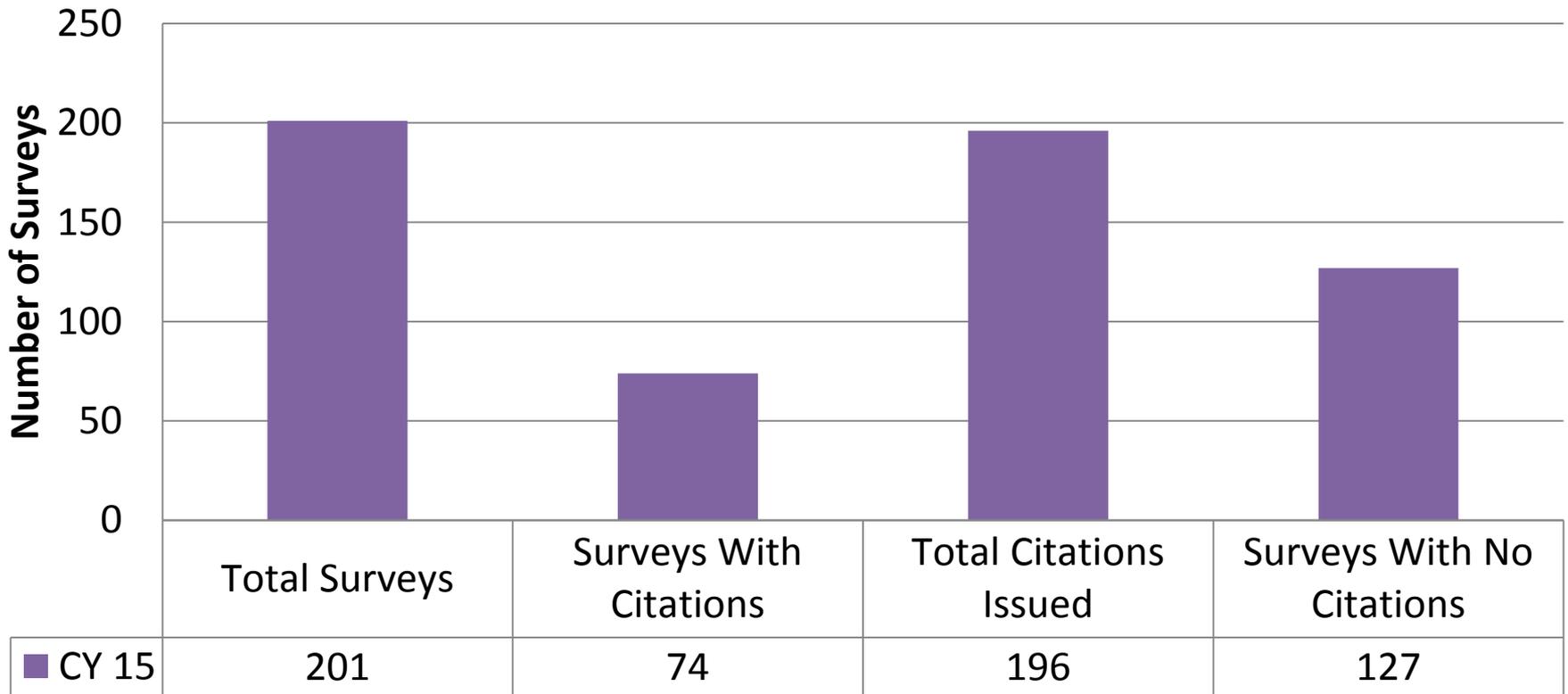


■ WCCEAL Assisted Living Communities	CBRFs	AFHs	RCACs
	187	48	100



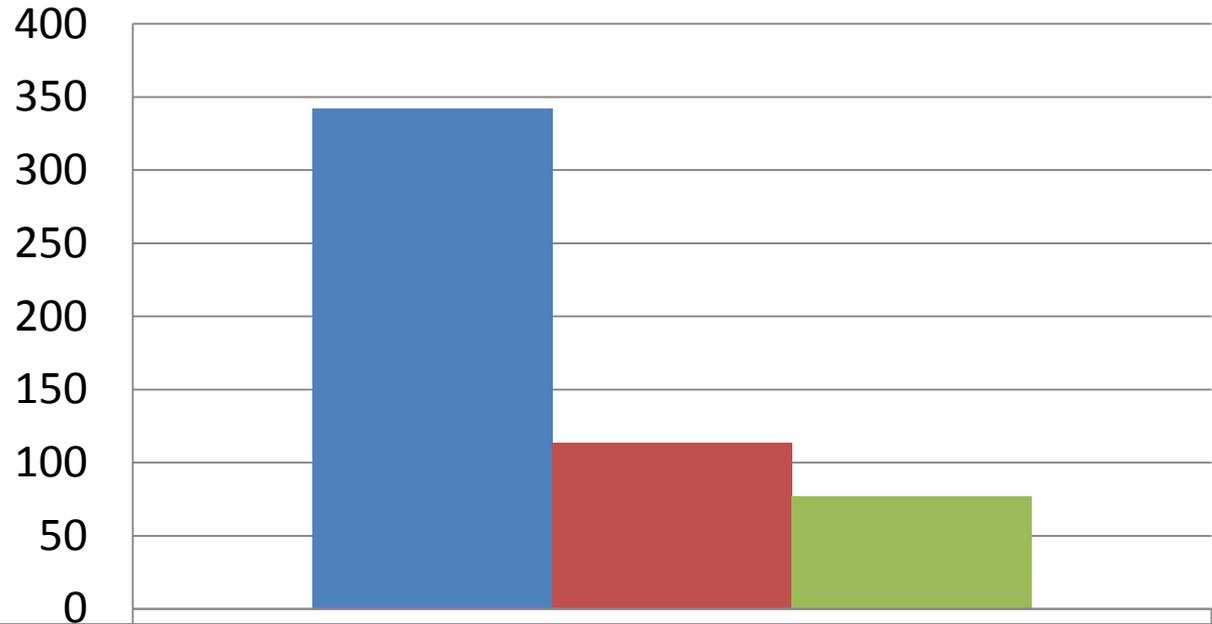
WCCEAL Regulated Communities Surveys Conducted

CY 15





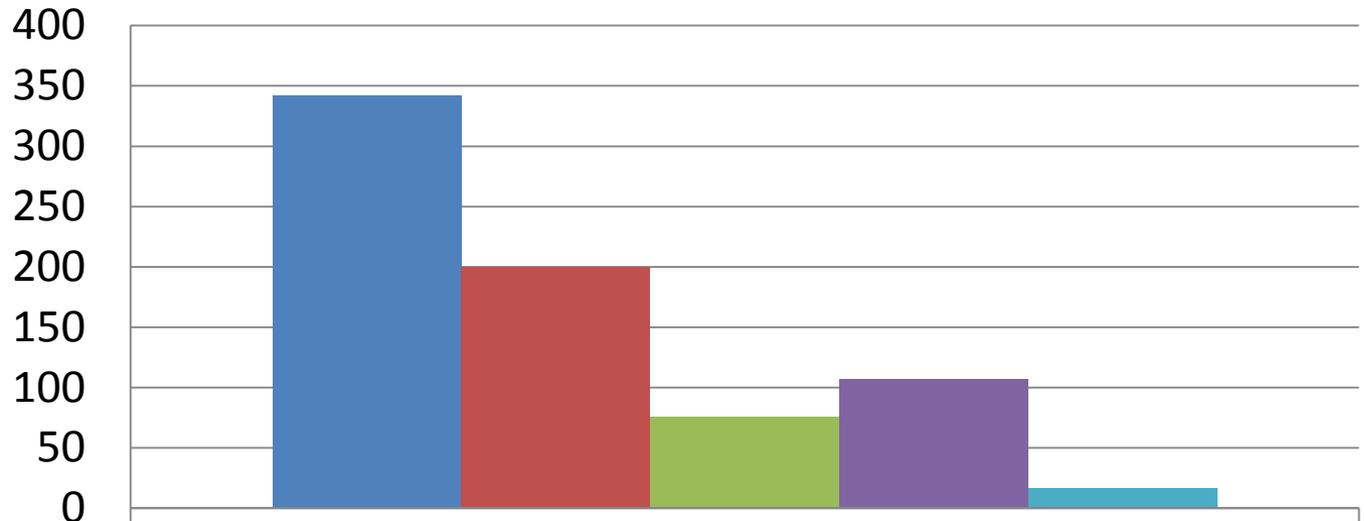
WCCEAL Members Complaints CY 15



Total Facilities	342
Total Complaints	114
Facilities With Complaints	77



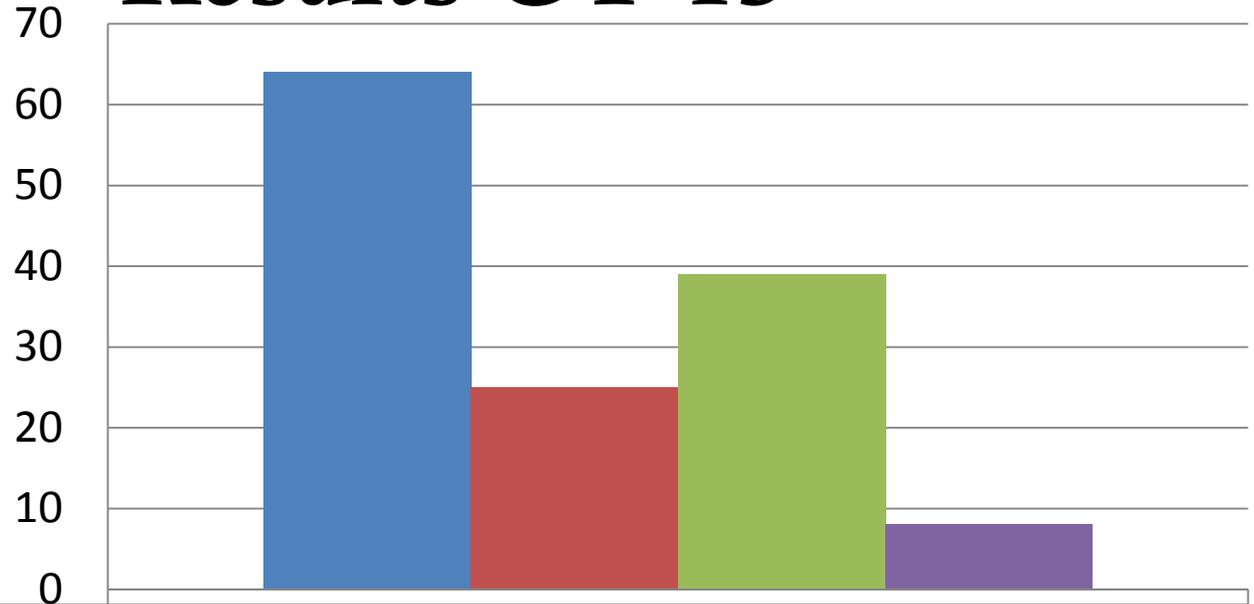
WCCEAL Regulated Communities Qualifying for Abbreviated Surveys CY 15



■ Total Number of Facilities	342
■ Qualifying Facilities	200
■ RCAC	76
■ CBRF	107
■ AFH	17



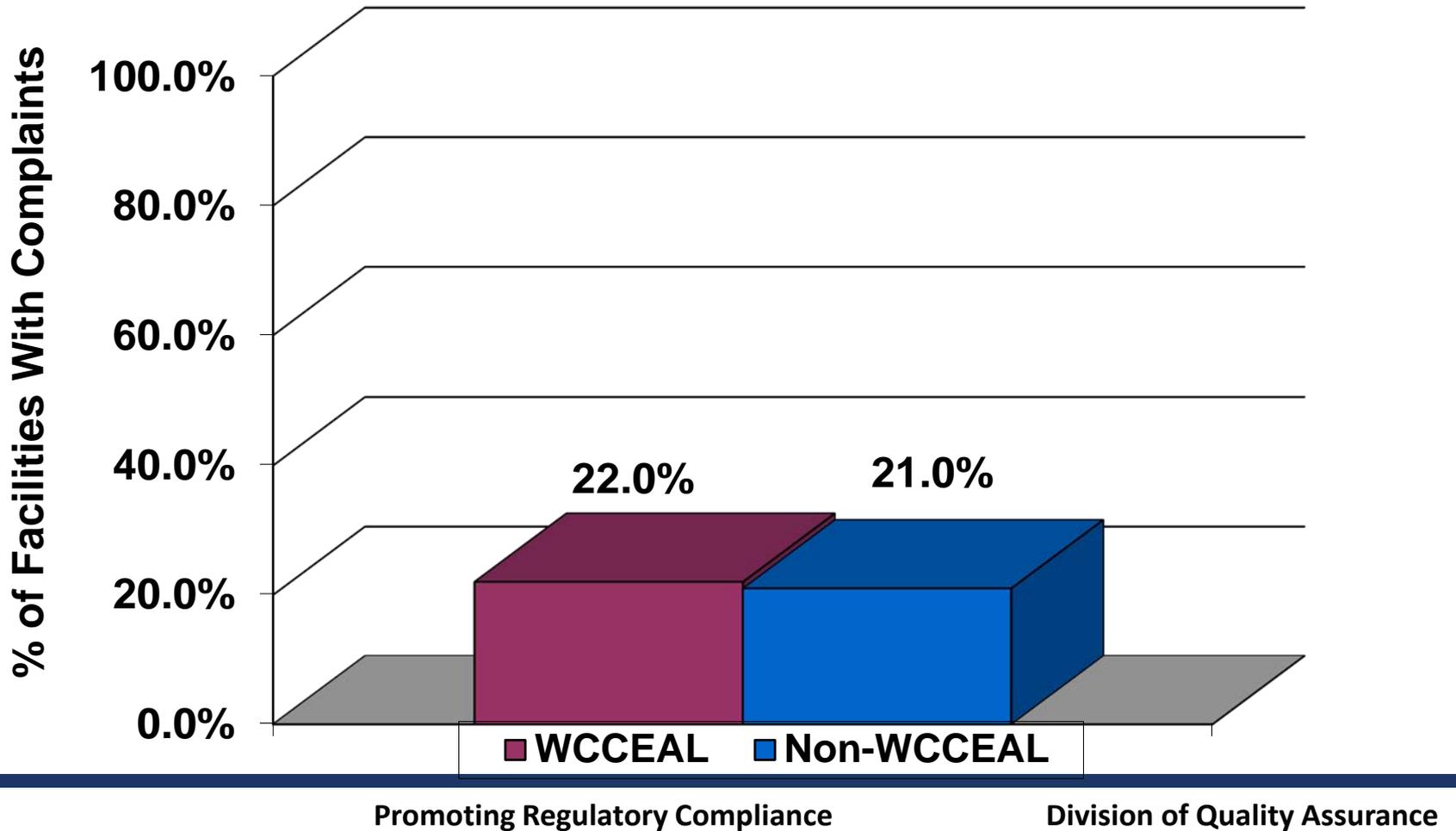
WCCEAL Regulated Communities Abbreviated Survey Results CY 15



■ Total Abbreviated Surveys	64
■ Surveys With No Citations	25
■ Surveys With Citations Only	39
■ Enforcement Action	8

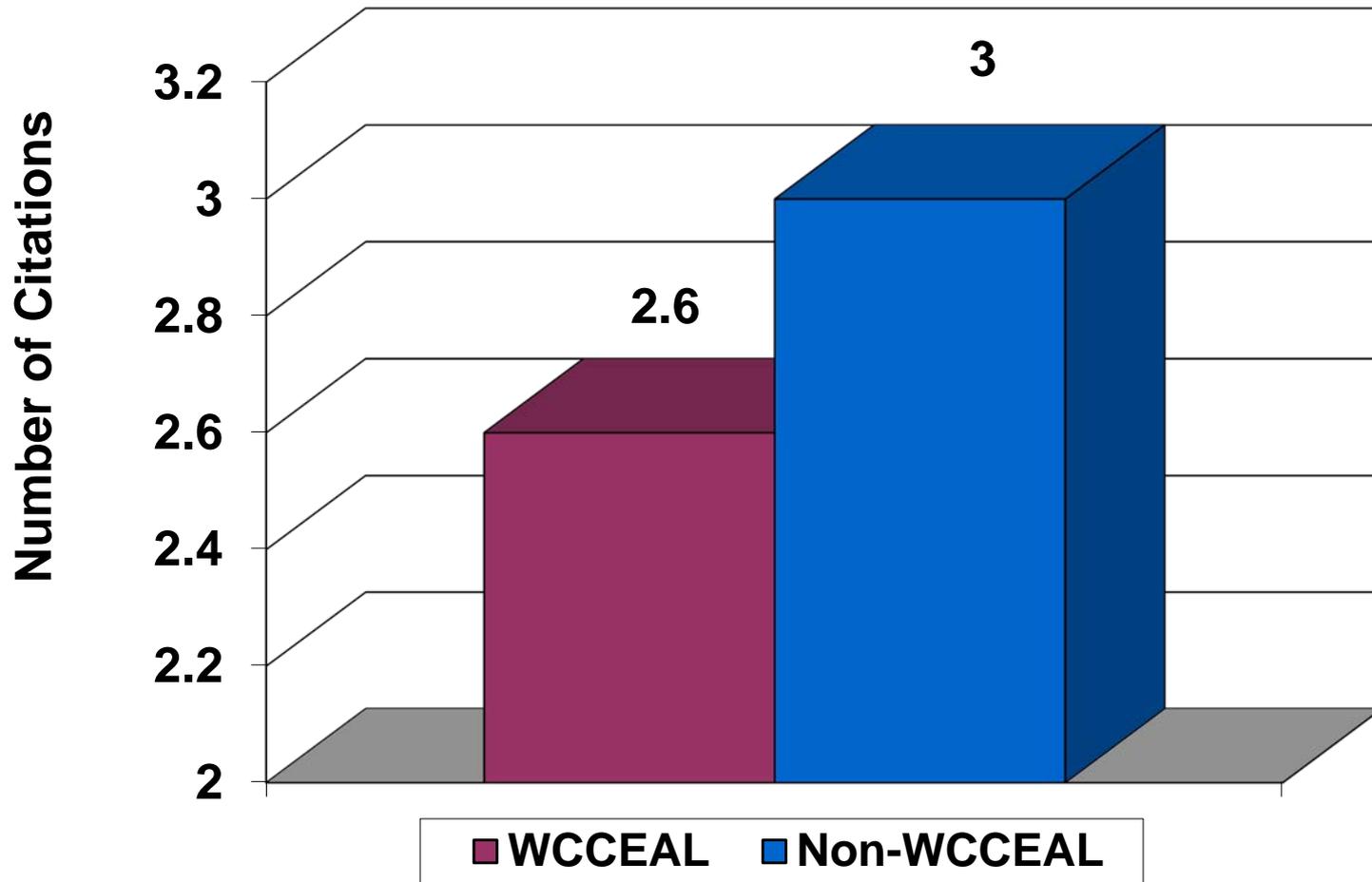


Percentage of Facilities with Complaints CY 15



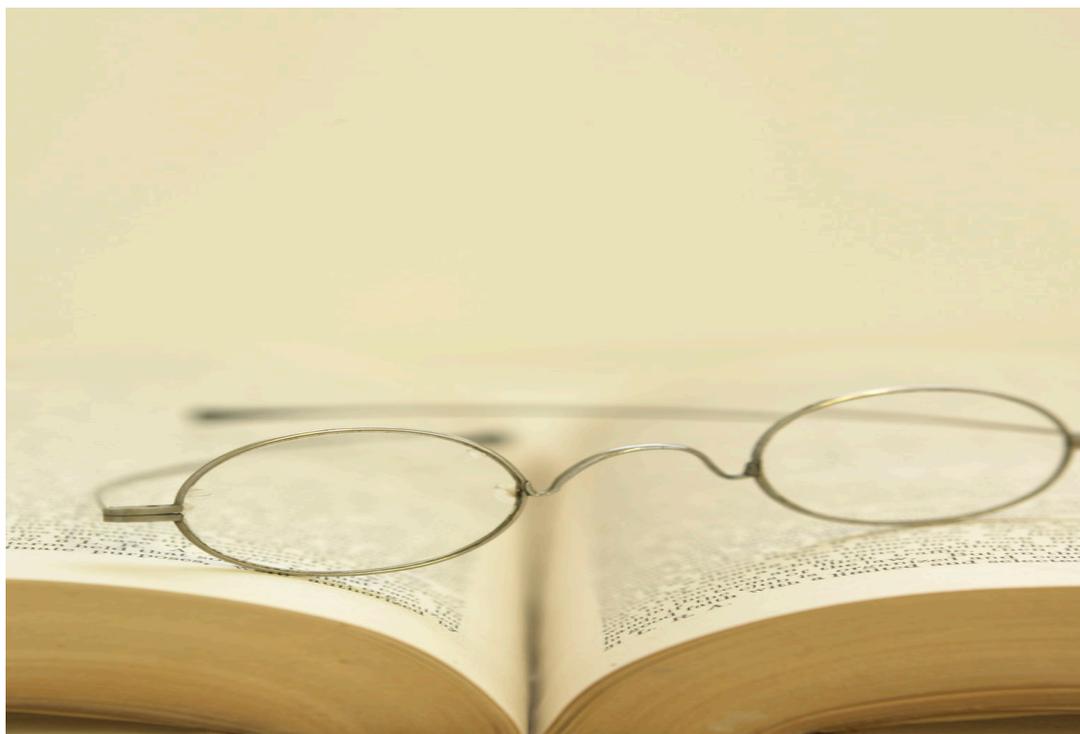


Average Citation per Survey with Citations CY 15





Regulatory Stories





Regulatory Stories

A resident with dementia and impaired mobility was at high risk for falls and required 24-hour supervision when seated in a Broda chair. The resident was unsupervised in the dining room and fell from the Broda chair, sustaining a serious head injury that required hospitalization (subdural hematoma).



Regulatory Stories

A facility did not provide needed supervision for a resident with dementia and a history of elopements. This was the fourth violation the facility received for failing to supervise residents who were unable to protect themselves. The resident left the facility, undetected, while caregivers were assisting another resident. The resident was discovered near a storage facility by a local citizen who called police. The low outdoor temperature was 30 degrees.



Regulatory Stories

A tenant with Alzheimer's disease remained in an RCAC without needed services or medical care after being confused for months. The tenant's condition deteriorated until he or she was hospitalized with altered mental status, dehydration, acute urinary tract infection (UTI), sepsis, acute kidney injury, and several deep tissue wounds on the buttocks, breasts, and flank. Hospital records indicated excoriated areas to groin and underneath breast [Tenant] is very dry and has unkempt hygiene. Stool (feces) noted on feet ... , bruises on buttocks, inner thighs, hips, including prominent ecchymosis surrounding bruising on the inner thighs ... and 2 fingerprint-type bruises on his or her right upper lateral arm. The facility had no current assessments or documentation. The facility's outdated record indicated, "[Tenant's] skin is in good condition with no open wounds." The tenant was discharged to hospice care.



Regulatory Stories

A licensee intimidated and antagonized a resident who was emotionally fragile and had a diagnosis of mental retardation. The licensee refused to permit private phone calls and yelled and interjected during the resident's calls to his or her therapist, case manager, and guardian. Therapy and case records indicate the licensee "yelled at the resident and therapist repeatedly" ... , told the resident to "stop bawling," and said, "What are you upset about? Do you even know? ... You jump from one subject to another." The licensee could be overheard (in a taped voice message to the case manager) saying, "You already cooked the goose. I give up. I'm not talking to you." The licensee stated, "Sometimes there is a need to yell at residents." The resident attempted suicide after stating she or he "couldn't take it anymore." In addition, the licensee forced [the resident] to walk despite having ankle pain and knee pain when she/he is usually transported in a wheelchair. In the past, the licensee was cited for making a disabled resident wear a bleach-stained shirt and stay in her room for 8 hours as punishment when the resident accidentally spilled bleach.



Regulatory Stories

A resident with intellectual and developmental disabilities was missing from the home from 10:00 p.m. until 8:30 the following morning. The caregiver on duty did not contact law enforcement or the resident's legal guardian. The resident was located in a nearby town and had been sexually abused.



Regulatory Stories

The facility admitted a resident with developmental disabilities, impaired safety awareness, and a long history of falls. No preadmission assessment was completed and the resident was admitted to the second floor of the home. Exits to the home were not ramped to grade level. The resident fell down the stairs several times, sustaining serious injuries in subsequent incidents. After an incident where the resident fell and hit his or her face on the sidewalk, the resident was taken to the emergency room for stitches to his/her face. Falls continued and 2 weeks later, the resident fell off the stairs and was taken to the hospital by ambulance with a fractured leg that required surgical repair. During surgery, the resident went into acute respiratory failure and required intubation. The resident was readmitted to the AFH non-weight bearing and in a wheelchair. She/he required a hooyer lift for transfers; however, the lift did not fit in the bathroom. Steps were not taken to protect subsequent falls and the resident was found on the floor. Although the resident complained of knee pain, the staff dismissed the complaints as attention-seeking. Several hours passed and the complaints persisted. Without assessing for injury, the resident was transferred with the hooyer lift and then transported by a caregiver to the emergency room. The resident was found to have re-fractured the left femur and was hospitalized.



**Alfred C. Johnson, Director
Bureau of Assisted Living
Phone: 608-266-8598
Email: alfred.johnson@wi.gov**