
Note

The Critical Need for State Regulation of Assisted Living Facilities: Defining “Critical Incidents,” Implementing Staff Training, and Requiring Disclosure of Facility Data

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INTRODUCTION

There is a systemic issue of unchecked, alarming incidents happening to one of the nation’s most vulnerable populations: the elderly. In Hialeah, Florida, an elderly resident with mental illness was left in a bathtub of scalding water and later died from burns.¹ In Sandy Springs, Georgia, a facility failed to eradicate an insect infestation in a resident’s room for an entire week; the resident died after being repeatedly attacked by ants in bed.² At a senior complex in Fairmont, Minnesota, residents complained of pain and fatigue, and several were hospitalized, over a several month timespan before the facility discovered an employee was stealing patient medication and replacing it with over-the-counter drugs.³ When the complex made lackluster investigatory efforts, residents filed formal complaints with the Minnesota Department of Health to ensure future prevention of this type of

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1. Rob Barry, Michael Sallah & Carol Marbin Miller, *Neglected to Death Part 1: Once Pride of Florida; Now Scenes of Neglect*, MIA. HERALD (June 25, 2012, 3:50 PM), <https://www.miamiherald.com/news/special-reports/neglected-to-death/article1938076.html>.

2. Atlanta J.-Const., *Allegations of Neglect, Abuse at Georgia Elder Facilities*, U.S. NEWS & WORLD REP. (Sept. 29, 2019, 10:10 AM), <https://www.usnews.com/news/best-states/georgia/articles/2019-09-29/allegations-of-neglect-abuse-at-georgia-elder-facilities>.

3. Chris Serres, *Left to Suffer: Abused, Ignored Across Minnesota*, STAR TRIB. (Nov. 12, 2017), <https://www.startribune.com/senior-home-residents-are-abused-and-ignored-across-minnesota/450623913> [<https://perma.cc/E5WF-W8TC>].

incident.⁴ After nine months, the Department had not interviewed any residents and the senior complex disseminated a dismissal letter stating “‘no resident’ was ‘negatively harmed’ by the incident.”⁵

Unfortunately, these stories are not uncommon. In 2016, the Minnesota Department of Health received 25,226 complaints of “neglect, physical abuse, unexplained serious injuries, and thefts” in housing facilities for the elderly; shockingly, ninety-seven percent of these complaints were never investigated.⁶ This unsettling statistic is not a problem unique to Minnesota.⁷ Rather, this problem—enabled by minimal federal oversight and inadequate state regulation of assisted living facilities—echoes throughout assisted living facilities in every state across the country.⁸ Particularly problematic for elder health and well-being, state structures for assisted living regulation vastly differ with respect to their understanding and handling of “critical incidents,” and how such incidents are reported, investigated, and disclosed.⁹ Tightening state regulation of assisted living facilities surrounding elderly abuse and neglect, including increased preventative measures, meaningful tracking and reporting, and increased public disclosure of such incidents, will remedy the current lack of protection for the nation’s vulnerable elderly population.

With growing popularity of assisted living facilities as an end-of-life care option,¹⁰ an aging baby boomer population,¹¹ and an increase in serious health conditions seen in assisted living facilities,¹²

4. *Id.*

5. *Id.*

6. *Id.*

7. *See, e.g.,* Atlanta J.-Const., *supra* note 2 (“An investigation . . . into hundreds of senior assisted living and large personal care homes in Georgia turned up more than 600 allegations involving neglect and 90 of abuse by caregivers over the past four years.”); Barry et al., *supra* note 1 (detailing an investigation of Florida assisted living facilities that uncovered a pattern of severe resident neglect resulting in death and ultimately concluding that “critical breakdowns in a state enforcement system . . . has left thousands of people to fend for themselves in dangerous and decrepit conditions”).

8. *See infra* Parts II.A–B.

9. *See infra* Part II.B.

10. *Aging in Place or Assisted Living Facility: Where Do Retirees See Themselves Living?*, RET. LIVING (Jan. 2, 2020) [hereinafter Retirement Living], <https://www.retirementliving.com/aging-in-place-or-an-assisted-living-facility-where-do-retirees-see-themselves-living> [https://perma.cc/5MLJ-85CR].

11. U.S. GOV’T ACCOUNTABILITY OFF., GAO-18-179, MEDICAID ASSISTED LIVING SERVICES: IMPROVED FEDERAL OVERSIGHT OF BENEFICIARY HEALTH AND WELFARE IS NEEDED 2 (2018) [hereinafter GAO REPORT 2018] (“The demand for assisted living services is expected to increase as a result of the aging of the nation’s population . . .”).

12. *See infra* notes 40–43 and accompanying text.

revamping state regulation of assisted living facilities is an undeniable priority to protect America's elderly population.

Part I of this Note will explore the nature of assisted living facilities, including discussion of the minimal federal regulation and differences between state regulatory regimes. Then, Part II of this Note will discuss the unlikely regulation of assisted living facilities at the federal level and the implications of uninformed state regulations surrounding critical incidents and public disclosure. Finally, Part III of this Note will propose a solution addressed to state legislatures and appropriate state agencies calling for enactment of legislation and regulations to tighten oversight of assisted living facilities. Particularly, this Note builds off of the Centers for Medicare & Medicaid Services' oversight efforts and suggests that states address assisted living facility resident health and well-being through the route of critical incident tracking and public disclosure of facility information. Namely, this Note proposes that state legislatures should: (1) adopt comprehensive definitions of "critical incidents," (2) mandate assisted living facility staff training on abuse and neglect to ensure critical incidents are accurately reported, and (3) require readily accessible public disclosure of assisted living facility information. This three-part solution will require states to abandon the Centers for Medicare & Medicaid Services's oversight tools, and instead, create and designate responsible agencies and reliable tracking systems to oversee inspection, reporting, compliance, and discipline of non-compliant assisted living facilities. Ultimately, this Note will conclude that states, rather than the federal government, are in the best position to address the inadequacies of state regulation surrounding critical incidents and to ensure assisted living facility resident health and well-being.¹³

I. UNDERSTANDING ASSISTED LIVING FACILITIES

The term "assisted living facility" has proven difficult to define, due to the diversity among facilities in the services provided, size of facility, and severity of resident needs.¹⁴ Despite this, assisted living facilities share the common problem of inadequate regulation at both the federal and state levels.¹⁵ To appreciate the problematic state of current assisted living facility regulation, background regarding

13. Other topics, such as regulation for dementia care, facility ownership information, and staffing ratios, are undoubtedly important areas ripe for state regulatory improvement. However, these issues are outside the scope of this Note.

14. See *infra* Part I.A.

15. See *infra* Parts II.A–B.

federal and state regulatory efforts surrounding abuse and neglect among assisted living facility residents is crucial.

This Part summarizes the scope of “assisted living facilities” and details the current framework of federal and state regulation of assisted living facilities. Section A provides an overview of the varying services assisted living facilities offer and their increasing popularity with the new generation of elderly Americans. Section B details the very limited role the federal government plays in assisted living regulation and oversight. Section C discusses the variation among states’ regulation regarding “critical incident” definitions, reporting and reviewing critical incidents, staff training requirements, and the availability of facility information to the public.

A. DEFINING ASSISTED LIVING FACILITIES: VARIETY OF SERVICES OFFERED AND INCREASING POPULARITY

There is no standard or widely accepted definition for “assisted living facility.”¹⁶ Advocacy groups, organizations, and individual states all define it differently.¹⁷ Despite the absence of a uniform definition, the common understanding of assisted living facilities is that they revolve around a social care model,¹⁸ rather than a medical care model,¹⁹

16. ROBERT MOLLIKA, ARI HOUSER & KATHLEEN UJVARI, AARP PUB. POL’Y INST., ASSISTED LIVING AND RESIDENTIAL CARE IN THE STATES IN 2010, at 2 (2010), https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/residential-care-insight-on-the-issues-july-2012-AARP-ppi-ltc.pdf [<https://perma.cc/6MYX-L2EC>].

17. *Id.* (“The Assisted Living Federation of America defines assisted living as a long-term care option that combines housing, support services, and health care, as needed. Assisted living is designed for individuals who require assistance with everyday activities such as meals, medication management or assistance, bathing, dressing, and transportation. The National Center for Assisted Living . . . describes assisted living as residences that offer a multifaceted residential setting that provides personal care services, 24-hour supervision and assistance, activities, and health-related services designed to minimize the need to relocate; accommodate individual residents’ changing needs and preferences; maximize residents’ dignity, autonomy, privacy, independence, choice, and safety; and encourage family and community involvement.”).

18. Candace L. Kemp, Mary M. Ball & Molly M. Perkins, *Individualization and the Health Care Mosaic in Assisted Living*, 59 GERONTOLOGIST 644, 644–45 (2019); see also Kihye Han, Alison M. Trinkoff, Carla L. Storr, Nancy Lerner & Bo Kyum Yang, *Variation Across U.S. Assisted Living Facilities: Admissions, Resident Care Needs, and Staffing*, 49 J. NURSING SCHOLARSHIP 24, 25 (2017) (explaining social care models provide an “attractive” and “homelike alternative” to medical care models (such as nursing homes), while still providing basic services like assistance with activities of daily living).

19. Kemp et al., *supra* note 18, at 644; see Han et al., *supra* note 18 (showing that social care facilities are “not intended to address serious health needs . . . [and] are not generally required to have a full complement of nurses, certified nursing assistants, or medical staff”).

and provide assistance with things such as: resident oversight, assistance with activities of daily living,²⁰ meal preparation, and medication administration.²¹ In addition to these basic services, some assisted living facilities provide more specialized services such as social work, mental health services, occupational therapy, physical therapy, and skilled nursing.²² Typically, residents in assisted living facilities pay in correspondence to the level of care they need.²³ In contrast, the typical nursing home provides around the clock monitoring and medical care by medical staff.²⁴ This is because many nursing home residents need constant care and supervision due to more severe medical conditions.²⁵ Additionally, physical, occupational, and speech therapy services are much more prevalent in nursing homes.²⁶

From a practical perspective, uncertainty surrounding what constitutes an “assisted living facility” creates barriers for advocacy organizations, such as the National Center for Assisted Living²⁷ and the Long Term Care Community Coalition,²⁸ to compile consistent,

20. “Activities of daily life” include bathing, dressing, transferring, toileting, and eating. *Activities of Daily Life (ADLs) and Instrumental Activities of Daily Life (IADLs)*, SENIORHOUSINGNET (July 11, 2019), <https://www.seniorhousingnet.com/advice-and-planning/activities-of-daily-life-adls-and-instrumental-activities-of-daily-life-iadls> [<https://perma.cc/6DCB-TBA4>].

21. Kemp et al., *supra* note 18, at 644.

22. NAT’L CTR. FOR ASSISTED LIVING, 2019 ASSISTED LIVING STATE REGULATORY REVIEW, at i (2019) [hereinafter NCAL], https://www.ahcancal.org/Assisted-Living/Policy/Documents/2019_reg_review.pdf [<https://perma.cc/93ZL-XZQ9>].

23. *Residential Facilities, Assisted Living, and Nursing Homes*, NAT’L INST. ON AGING (May 1, 2017), <https://www.nia.nih.gov/health/residential-facilities-assisted-living-and-nursing-homes> [<https://perma.cc/C7VP-BBM5>].

24. *Id.*

25. *Id.*

26. *See id.*

27. The National Center for Assisted Living (NCAL) is a group dedicated to voicing the concerns of the assisted living community through “national advocacy, education, networking, professional development, and quality initiatives.” *About NCAL*, NAT’L CTR. FOR ASSISTED LIVING, <https://www.ahcancal.org/Assisted-Living/About-NCAL/Pages/default.aspx> [<https://perma.cc/ZM7F-9R57>]. Additionally, NCAL works at the state level to enhance local education about assisted living and help local facilities improve their quality. *Id.*

28. The Long Term Care Community Coalition (LTCCC) is a similar organization to NCAL. Specifically, LTCCC is an advocacy network for elders in nursing homes, assisted living facilities, and other similar residential settings. *About LTCCC*, LONG TERM CARE CMTY. COAL. (2017), <https://nursinghome411.org/about-ltccc/> [<https://perma.cc/9R7H-MJR7>]. The LTCCC focuses on both federal and state law and strives to improve quality and efficiency of elder care facilities. *Id.*

accurate data on these facilities.²⁹ Similarly, fluctuating definitions create uncertainty among prospective residents regarding the types of services offered at a particular assisted living facility in any given state.³⁰

Despite these definitional uncertainties, it has been estimated that there are approximately more than 800,000 individuals residing in assisted living facilities in the United States, which is more than the number of individuals living in nursing home facilities.³¹ This number is expected to grow rapidly due to an aging baby boomer population,³² increasing life expectancy,³³ and the heightened preference for assisted living facilities over nursing homes.³⁴

Above all else, the next generation of elderly Americans prefer to age at home with an in-home caregiver.³⁵ However, the next generation of elderly Americans cited moving into an assisted living facility as the next preferred option, followed by moving in with a family member.³⁶ As a last resort, these individuals chose moving into a

29. See Jason M. Breslow, *Catherine Hawes: Assisted Living Is a "Ticking Time Bomb,"* PUB. BROAD. SERV.: FRONTLINE (July 30, 2013), <https://www.pbs.org/wgbh/frontline/article/catherine-hawes-assisted-living-is-a-ticking-time-bomb> [https://perma.cc/PFY2-229L] ("I call it the problem of the tall, thin blonde. I could say I'm a tall, thin blonde. It doesn't make me one. But if I say I'm an assisted living [facility], I am an assisted living [facility].").

30. *Id.* ("So for consumers who looked at the nomenclature of assisted living and think they understand it, it's a real problem because every single one is different.").

31. NCAL, *supra* note 22; see also Han et al., *supra* note 18, at 24; Howard Gleckman, *What We Don't Know - - but Should - - About Assisted Living Facilities*, FORBES (Feb. 5, 2018, 3:51 PM), <https://www.forbes.com/sites/howardgleckman/2018/02/05/what-we-dont-know-but-should-about-assisted-living-facilities> [https://perma.cc/Y25S-QUS4] ("[T]here are nearly twice as many assisted living (ALF) and other residential care facilities (more than 30,000 in 2014) in the U.S. than nursing homes (about 15,000).").

32. GAO REPORT 2018, *supra* note 11; see also U.S. GOV'T ACCOUNTABILITY OFF., GAO-17-61, NURSING HOMES: CONSUMERS COULD BENEFIT FROM IMPROVEMENTS TO THE NURSING HOME COMPARE WEBSITE AND FIVE-STAR QUALITY RATING SYSTEM 1 (2016) [hereinafter GAO REPORT 2016] (stating there are 76 million baby boomers born between the years 1946 and 1964).

33. GAO REPORT 2018, *supra* note 11.

34. Retirement Living, *supra* note 10 (reporting that when survey participants were asked what they would do if they could no longer live on their own, 52% said they would stay at home with a caregiver, 30% would move into an assisted living facility, 16% would move in with family or friends, and 1.6% would move into a nursing home; a similar survey from 2016 reported that 17% of respondents chose assisted living facility and 4% chose nursing home).

35. *Id.*

36. *Id.*

nursing home.³⁷ This overwhelming preference for assisted living facilities over nursing homes is due, in part, to assisted living facilities' commitment to the social care model, which strives for a more attractive and homelike environment, rather than a focus on medical treatment and illness.³⁸ Emphasis on the social care model lessens the anticipated need for a full medical staff, such as nursing assistants, nurses, and physicians.³⁹

The assumption underlying assisted living facilities is that they provide minimal assistance to residents. Despite this, data suggests that assisted living facility populations experience health concerns similar to nursing home populations.⁴⁰ For example, the typical assisted living facility resident is eighty-five years old, needs help with multiple activities of daily living, and requires medication administration.⁴¹ Additionally, most assisted living residents have at least one chronic condition such as heart disease or cognitive impairment.⁴² The presence of serious health conditions in assisted living facilities will likely rise due to individuals increasingly citing "failing health" as the leading factor for why they decide to move into an assisted living facility.⁴³

In short, assisted living facility services vary greatly by facility, there is a broad spectrum of resident medical needs, and elderly Americans cite assisted living facilities as an increasingly popular option. The limited federal oversight for assisted living facility regulation is discussed below.

37. *Id.*

38. Han et al., *supra* note 18.

39. *Id.*

40. *Id.* at 27.

41. Kemp et al., *supra* note 18, at 645; *see also* Han et al., *supra* note 18 ("A substantial number of assisted living residents have medical and physical conditions, such as multiple chronic diseases, dementia, behavioral impairment, and activities of daily living (ADL) impairment that require regular nursing care.").

42. Kemp et al., *supra* note 18, at 645 ("75% hav[e] multiple comorbidities, 33% have heart disease, 28% have depression, 17% are diabetic, and estimates of cognitive impairment range from approximately 40% to 70%.").

43. *See* Retirement Living, *supra* note 10 ("When asked which factors would push them to move into an assisted living facility rather than age in place, nearly 75 percent of respondents said failing health would be the leading factor. This is still the same leading push factor from 10 years ago but up about 25 percent. . . . Following failing health, the loss of the ability to drive (almost 30 percent) and a financial crisis (just over 20 percent) are [other] top factors . . ." (emphasis omitted)).

B. LIMITED ROLE OF THE FEDERAL GOVERNMENT IN ASSISTED LIVING REGULATION

Unlike nursing homes, assisted living facilities are only broadly regulated by the federal government.⁴⁴ The federal government, more specifically, the Centers for Medicare & Medicaid Services (CMS), is able to regulate nursing facilities through disbursement of Medicare⁴⁵ and Medicaid⁴⁶ funding.⁴⁷ To operate licensed nursing home facilities, states must ensure strict compliance with federal regulations.⁴⁸ The complexities of these regulations allow for little variation between states regarding minimum nursing home licensure requirements.⁴⁹ Importantly, these federal regulations involve affairs of: resident rights, “administration, quality assurance, performance improvement, compliance and ethics, and person-centered care planning, among other factors.”⁵⁰

Similar to nursing homes, Medicare does not cover assisted living facility services.⁵¹ However, Medicaid does pay for some medical and non-medical assisted living services, but it does not cover room and board charges for assisted living facilities.⁵² This benefit administration allows the federal government, through CMS, some oversight and regulatory authority over assisted living facilities.⁵³ In 2014, forty-eight states that covered assisted living services through Medicaid programs reported collectively spending approximately \$10 billion on

44. GAO REPORT 2018, *supra* note 11. See generally *Licensure of Facilities*, WESTLAW EDGE, <https://www.westlaw.com> (follow “Secondary Sources” hyperlink; then follow “50 State Surveys” hyperlink; then follow “50 State Regulatory Surveys” hyperlink; then follow “Healthcare” hyperlink; then follow “Licensure of Facilities” hyperlink) (providing state-by-state regulation information for long-term care facilities); Breslow, *supra* note 29 (“[W]hen you go to Congress and you say the federal government ought to be supporting what the state regulators are doing, they wave their hands. Monkey hands we call it: See no evil, hear no evil, speak no evil. Oh, we don’t have any money in assisted living.”).

45. Medicare is the federal health insurance program for individuals over 65, disabled individuals, and individuals experiencing end-stage renal disease. GAO REPORT 2016, *supra* note 32, at 1 n.1.

46. Medicaid is the federal-state jointly administered health insurance program for low-income individuals. *Id.*

47. *Id.* at 1.

48. *Id.*

49. See *id.*

50. 42 C.F.R. § 483, subpart B (2019).

51. NCAL, *supra* note 22.

52. GAO REPORT 2018, *supra* note 11, at 6.

53. See *id.*

assisted living services.⁵⁴ In recent years, most states have expanded their Medicaid coverage to include select assisted living facility services,⁵⁵ using “home and community-based services” (HCBS) waivers,⁵⁶ which are the most common avenue for state coverage of assisted living facility services.⁵⁷ Federal and state Medicaid spending for HCBS, which includes but is not limited to assisted living expenses, totaled \$87 billion in 2015, surpassed the Medicaid spending for nursing homes.⁵⁸

The federal government sets a vague framework to guide state oversight of assisted living facilities. Particularly, the federal government approves state HCBS waiver applications and renewals, and reviews state annual HCBS program reports.⁵⁹ States are responsible for oversight of their Medicaid HCBS programs and must work within broad federal requirements⁶⁰ for administration of such programs.⁶¹ These broad federal requirements, in part, require that states monitor and meet requirements to assure “beneficiary health and welfare.”⁶²

Prior to March 2014, CMS’s only requirement for state HCBS waiver applications and renewals mandated that states, on an ongoing basis, “identif[y] address[] and seek[] to prevent instances of abuse, neglect, and exploitation.”⁶³ In March 2014, to increase oversight, CMS added four additional requirements for state HCBS waiver

54. *Id.* at 10. Across these forty-eight states, more than 330,000 Medicaid beneficiaries received assistance from more than 130 programs. *Id.*

55. NCAL, *supra* note 22, at i n.4 (“More than 40 states have some [Medicaid] option to cover services for assisted living communities. In some states the benefit is limited, for example by low enrollment caps or recipient eligibility limited by condition, such as only for individuals with traumatic brain injury.”).

56. GAO REPORT 2018, *supra* note 11, at 1–2, 2 n.3 (“HCBS waivers are authorized under Section 1915(c) of the Social Security Act.”).

57. For a breakdown of other Medicaid programs states use to cover assisted living service programs, see *id.* at 14.

58. *Id.* at 1. State administration of Medicaid for assisted living services through HCBS waivers permits states to “target certain populations, limit enrollment, or restrict services to certain geographic areas.” *Id.* at 2.

59. *Id.* at 7.

60. *Id.* at 8 (listing six requirements states must adhere to for HCBS waiver programs: (1) ultimate administrative authority reserved for the Medicaid agency; (2) “level of care consistent with care provided in a hospital, nursing facility, or intermediate care facility”; (3) adequate system for ensuring adequate providers; (4) “effective system for reviewing the adequacy of service plans”; (5) “effective system for assuring waiver participant health and welfare”; (6) “adequate system for insuring financial accountability of the waiver program”).

61. *Id.* at 6–7.

62. *Id.* at 8.

63. *Id.* at 28 tbl.6.

applications.⁶⁴ Namely, the updated CMS guidelines required states to: (1) create a system to ensure HCBS waiver beneficiary health and welfare;⁶⁵ (2) create a critical incident management system;⁶⁶ (3) follow their own state policies regarding use and/or prohibition of restraints and seclusion;⁶⁷ and (4) establish overall health care standards.⁶⁸ Despite these waiver approval and renewal guidelines, CMS's oversight of assisted living facilities is spotty due to wide discretion for states, whose actions vary significantly, to establish their own licensing, investigation, oversight, and reporting requirements.⁶⁹

In addition to HCBS waiver application requirements, CMS mandates annual reporting obligations. In particular, CMS instructs states to report the "HCBS waiver's impact on (1) the type and amount, and cost of services provided and (2) the health and welfare of Medicaid beneficiaries receiving waiver services."⁷⁰ Beyond these two vague annual reporting requirements, CMS does not specify which information is required for state "oversight" of assisted living facilities.⁷¹ Specifically, CMS lacks guidelines on: "1) what states are supposed to report as deficiencies, 2) how they are to identify which deficiencies are most significant, and 3) the extent to which states need to explain the steps taken to ensure that deficiencies do not recur."⁷² Adding to the problem of lackluster guidelines, CMS permits state Medicaid agencies to delegate oversight authority to other agencies.⁷³ As a result, state Medicaid agencies differ on what information they receive

64. *Id.* at 28. Notably, the 2014 amendments to CMS's HCBS waiver requirements generally did not change the way the agency monitors states once the HCBS waivers were approved. *Id.*; *see also infra* note 166 and accompanying text.

65. GAO REPORT 2018, *supra* note 11, at 28 tbl.6.

66. The critical incident reporting and management system requires states to check a box indicating that they have such a program on the HCBS waiver application, but CMS does not require states to report any data of such systems on annual reports. Because of this, CMS cannot confirm whether states actually operate effective critical incident reporting systems that they indicate on their HCBS waiver applications. *Id.* at 28 tbl.6, 30-31.

67. *Id.* at 28 tbl.6.

68. *Id.*

69. *Id.* at 8-9.

70. *Id.* at 28.

71. *Id.* at 29.

72. *Id.*; *see id.* at 17-19 (showing that states vary significantly in how they monitor beneficiary health and welfare including how they monitor critical incidents and beneficiary harm).

73. *Id.* at 17.

from their delegated agencies and what information they independently review.⁷⁴

When CMS requested 2014 critical incident reporting data from states, more than half of the states were unable to provide CMS with the number of critical incidents⁷⁵ reported.⁷⁶ In its 2018 report,⁷⁷ the Government Accountability Office (GAO) shed light on the inadequacies of CMS oversight of assisted living facilities, which is largely due to gaps in state reporting.⁷⁸ Essentially, the existing CMS requirements for state Medicaid agencies allow states to technically “comply” with requirements without actually ensuring safeguards for beneficiary health and well-being in assisted living facilities.⁷⁹

More specifically, the CMS State Medicaid Manual instructs states to “check the appropriate boxes regarding the impact of the [HCBS] waiver on the health and welfare” of assisted living facility residents.⁸⁰ Namely, states must confirm that “beneficiary health and welfare safeguards have been met,”⁸¹ that all necessary corrective action procedures were taken,⁸² and that all providers were “properly trained, supervised, and certified.”⁸³ When states check these boxes on annual reports, they are off the CMS oversight hook until their waiver renewal year.⁸⁴

This reality is best illustrated through example. In 2015, CMS discovered that one of the states seeking HCBS waiver renewal had not disclosed any problems in annual reports between 2011 and 2015, but in fact, there had likely been a “pervasive failure” by the state to assure the health and welfare of beneficiaries during the annual

74. *See id.* at 19 (“For example, although all critical incident reports were reviewed in the 48 states by either the state Medicaid agency, the agency delegated administrative responsibilities, or another agency; in 16 of those states, the state Medicaid agency was not involved in those reviews Such reviews, including any critical incidents found, may not have been communicated back to the state Medicaid agency . . .”).

75. *See infra* Part I.C.1 (discussing critical incidents).

76. GAO REPORT 2018, *supra* note 11, at 33.

77. The 2018 GAO report reviewed only Medicaid-covered assisted living facilities. *Id.* at 4 n.6.

78. *Id.* at 33.

79. *Id.* at 29–30.

80. *Id.* at 29 (citing U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., STATE MEDICAID MANUAL § 2700.6 (2015)).

81. *Id.* at 29.

82. *Id.* at 29 n.36.

83. *Id.*

84. *See id.* at 30.

reporting years.⁸⁵ In particular, the state underinformed CMS on the rate of suspicious beneficiary deaths and the state did not have sufficient corrective action procedures in place.⁸⁶ While this state was technically “complying” with the CMS requirements, the state was not protecting HCBS waiver beneficiary health and welfare to the extent CMS erroneously assumed.

Upon completion of the 2018 study, the GAO posited three recommendations to CMS for increased federal oversight of assisted living facility regulation to improve HCBS waiver beneficiary health and well-being: (1) “CMS should provide guidance and clarify requirements regarding the monitoring and reporting of deficiencies that states using HCBS waivers are required to report on their annual reports”; (2) “CMS should establish standard Medicaid reporting requirements for all states to annually report key information on critical incidents, considering, at a minimum, the type of critical incidents involving Medicaid beneficiaries, and the type of residential facilities, including assisted living facilities, where critical incidents occurred”; and (3) “CMS should ensure that all states submit annual reports for HCBS waivers on time as required.”⁸⁷

In short, the federal government plays an extremely limited role in the regulation of assisted living facilities. CMS presents vague reporting requirements for HCBS waiver applications and renewals, as well as state annual reporting requirements. As a result, there are significant gaps and discrepancies in state reporting of assisted living facilities.⁸⁸ These gaps in state reporting are explained in detail below.

85. *Id.*

86. *Id.*

87. *Id.* at 34.

88. The lack of CMS federal oversight of assisted living facilities as compared to nursing homes is perfectly illustrated by the COVID-19 pandemic. According to CMS, as of July 2, 2020, over 30,000 nursing home residents died as a result of COVID-19. Allison Pecorin, *7,000 Killed in Assisted Living Due to COVID-19, Report Finds*, ABC NEWS (July 2, 2020, 4:09 AM), <https://abcnews.go.com/Politics/7000-killed-assisted-living-due-covid-19-report/story?id=71560689> [<https://perma.cc/X977-PAWV>]. Nursing homes received significant federal aid and increased federal oversight in light of the pandemic. *Id.* In stark contrast, CMS was unaware of the number of COVID-19 related deaths in assisted living facilities due to minimal federal oversight. *See id.* A recent investigation estimated that close to 7,000 assisted living facility residents died from COVID-19, but the exact number could not be determined. *Id.* Unlike nursing homes, these facilities were not subject to increased oversight and did not receive increased federal aid. *Id.* State Medicaid agency reports to CMS for assisted living facilities will likely still result in an unconfirmed number of COVID-19 deaths, due to differences in state reporting.

C. STATE VARIATION OF ASSISTED LIVING FACILITY REGULATION

As discussed above, states vary significantly on assisted living regulation and oversight.⁸⁹ States are becoming increasingly concerned about elder care in assisted living facilities and are gradually making small changes to state regulatory regimes to enhance assisted living resident well-being.⁹⁰ This Section will explain the differences in state regulatory regimes with respect to: (1) defining “critical incidents,” (2) inspection and reporting surrounding critical incidents, (3) staff training surrounding critical incidents, and (4) public disclosure requirements of facility information. These four regulatory areas speak to states’ respective understandings of what constitutes a reportable critical incident and how such incidents should be monitored, reported, prevented, and ultimately disclosed. In turn, state regulatory regimes surrounding these areas lay the foundation for assisted living facility resident health and well-being.

1. Defining “Critical Incidents”

CMS requires states to track and keep records of “critical incidents” that occur in assisted living facilities.⁹¹ In essence, “critical incidents” refer to events that cause or have potential to cause harm to assisted living facility residents.⁹² However, there is no federal definition of a “critical incident,” and states have surprisingly different conceptions of the term.⁹³ All reporting states define physical, emotional, and sexual abuse as a “critical incident.”⁹⁴ The state consensus begins to break down when considering other categories of incidents. Specifically, the GAO report found that, out of the forty-eight surveyed states, there were several states that ignored fairly serious incidents, such as: unexplained death (not a critical incident in three states), missing residents/patients (not a critical incident in two states),

89. See *supra* notes 69–74 and accompanying text.

90. See NCAL, *supra* note 22, at iii (“More than half of states reported changes between June 2018 and June 2019 that will affect assisted living communities. . . . [S]tates continue efforts to enhance protections for residents, which were the majority of changes. Specifically, the most common changes were to: disclosure or notification requirements, efforts to prevent or address alleged abuse or neglect, staff training, emergency preparedness and life safety.”).

91. See *supra* notes 63–69 and accompanying text.

92. GAO REPORT 2018, *supra* note 11, at 20 tbl.3 (defining “critical incident reports” as “generated reports of incident of potential or actual beneficiary harm”).

93. *Id.* at 24 n.33 (“State programs within a state can vary from one program to the next in what is considered a critical incident.”).

94. *Id.* at 24.

police or doctor referral to Adult Protective Services (not a critical incident in three states).⁹⁵

State variation becomes more prominent with respect to less alarming incidents, such as: minor injuries not requiring medical attention (not a critical incident in thirty-one states), discharge and eviction from the facility (not a critical incident in twenty-four states), physical infrastructure issue (not a critical incident in eighteen states), injuries needing medical attention, but not hospitalization (not a critical incident in twelve states), suspected criminal activity by provider (not a critical incident in eight states), medication errors (not a critical incident in seven states), threat or attempt of suicide (not a critical incident in seven states), unauthorized use of seclusion (not a critical incident in six states), injuries resulting in hospitalization (not a critical incident in five states), and unauthorized use of restraints (not a critical incident in five states).⁹⁶ Not only do states differ in their definitions of critical incidents, they also differ in their inspection and reporting abilities of critical incidents.

2. Inspection and Reporting of Critical Incidents

The 2018 GAO report revealed that twenty-six state Medicaid agencies were unable to provide critical incident information to CMS when requested “for their largest program covering assisted living services.”⁹⁷ State Medicaid agencies cited inadequate tracking systems as a reason for their inability to provide comprehensive information to CMS.⁹⁸ Particularly, nine states stated their systems were unable to track incidents by provider type, resulting in the state’s inability to distinguish between assisted living facilities and other home and community based services,⁹⁹ such as “home health care, personal care, adult day care, [and] respite care.”¹⁰⁰ Further, nine states explained they entirely lacked a system to collect critical incidents, and five states reasoned their system could not identify individual Medicaid beneficiaries to track such incidents.¹⁰¹ Collectively, the twenty-two states that provided critical incident information to CMS reported a total of 22,921 critical incidents involving Medicaid beneficiaries in

95. *Id.* at 25.

96. *Id.* at 42.

97. *Id.* at 23.

98. *Id.* at 24.

99. *Id.*

100. Joshua M. Wiener, Jane Tilly & Lisa Maria B. Alecxih, *Home and Community-Based Services in Seven States*, HEALTH CARE FIN. REV., Spring 2002, at 89, 89.

101. GAO REPORT 2018, *supra* note 11, at 24.

their largest programs that covered services in assisted living facilities.¹⁰² Individually, the number of critical incidents reported by the twenty-two states ranged from 1 to 8,900, with six states reporting over 1,000 critical incidents.¹⁰³

As previously mentioned, CMS permits state Medicaid agencies to delegate oversight and enforcement authority to other agencies.¹⁰⁴ Among states that allow state Medicaid agencies to delegate oversight authority, some lack notification or review procedures to ensure information¹⁰⁵ is reported back to the state Medicaid agency.¹⁰⁶ Specifically, in sixteen out of forty-eight states, the state Medicaid agency outsourced critical incident reporting and was never notified and did not review the information.¹⁰⁷ Further, in twenty-three states, investigations of harm to resident health and well-being were conducted by a delegated agency, separate from the state Medicaid agency, and only six states indicated Medicaid agencies were *always* notified of the investigation.¹⁰⁸ Related to defining, inspecting, and reporting critical incidents are states' efforts in preventing critical incidents. As such, states' staff training requirements surrounding critical incidents are discussed below.

3. Staff Training Surrounding Critical Incidents

There are no federal standards for staff training in assisted living facilities.¹⁰⁹ Important to note, assisted living facilities vary state-by-

102. *Id.* at 23.

103. *Id.*

104. *See supra* notes 72–74 and accompanying text.

105. GAO REPORT 2018, *supra* note 11, at 20 (showing that, typically, information that state Medicaid agencies or state-delegated agencies review includes critical incident reports, patient service plans, facility inspection results, and complaints from beneficiaries, relatives, and facility employees); *id.* (stating that patient care plans are “comprehensive care plans that identify services provided to beneficiaries based on their needs and preferences”).

106. *E.g., id.* at 24 (showing that Georgia lacks a centralized system for tracking data). *But see id.* (demonstrating that, in Nebraska, Adult Protective Services is responsible for investigating critical incident reports. However, once the Adult Protective Services initiates an investigation, the Nebraska state Medicaid agency is immediately and automatically notified).

107. *Id.* at 20 tbl.3 (noting that an additional eighteen state Medicaid agencies did not review patient care plans; eleven did not review information provided by beneficiaries, relatives, or employees; ten did not review complaints and grievances; and twenty-one did not review inspection results).

108. *Id.* at 24 tbl.4.

109. LONG TERM CARE CMTY. COAL., ASSISTED LIVING FACT SHEET: STAFF TRAINING REQUIREMENTS, <https://nursinghome411.org/wp-content/uploads/2019/01/LTCCC>

state in staffing requirements, staffing ratios, and staff training. Particularly important to this Note, however, are the differences in staff training requirements.

Assisted living facility staff includes administrators or managers,¹¹⁰ licensed health care professionals such as registered nurses, licensed practitioner nurses, physicians, and direct care workers.¹¹¹ Direct care workers are typically unlicensed¹¹² and provide daily personal care and facility services to residents.¹¹³ Notably, all states require assisted living facilities to staff a facility administrator or manager.¹¹⁴ Only thirty-eight states require assisted living facilities to have a licensed professional either available (twenty-four states) or on staff for several hours per week (fourteen states).¹¹⁵

Similar to states' variation in defining "critical incident," states vary significantly regarding ongoing staff training requirements for direct care workers and facility administrators.¹¹⁶ Specifically, some states mandate a specific number of hours of training on specific topics,¹¹⁷ others merely mandate "general training,"¹¹⁸ and a few states

-Assisted-Living-Fact-Sheet-Staff-Training-Competency.pdf [https://perma.cc/3HQN-9MDA].

110. Assisted living facility managers and administrators are in charge of daily operations, staffing, oversight, and regulatory compliance. U.S. DEP'T OF HEALTH & HUM. SERVS., COMPENDIUM OF RESIDENTIAL CARE AND ASSISTED LIVING REGULATIONS AND POLICY: 2015 EDITION (2015) [hereinafter COMPENDIUM OF RESIDENTIAL CARE], <https://aspe.hhs.gov/basic-report/compendium-residential-care-and-assisted-living-regulations-and-policy-2015-edition#overview> [https://perma.cc/C77Z-NNDH].

111. *Id.*

112. Although direct care workers are unlicensed, most states have some sort of training or certification required to be a direct care worker in assisted living facilities. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.* ("Some states' regulations require only that staff be trained, whereas other specify numerous topics that must be covered, the number of training hours required, the completion of approved courses, or some combination thereof . . .").

117. *Id.* ("Forty states require an orientation, with the number of hours ranging from 1 (Missouri) to 80 (North Carolina) . . . Forty states also require continuing education or in-service training for direct care workers, ranging from 4 to 16 hours; 13 states do not specify the number of hours . . ."). For example, Arkansas requires six hours of ongoing training per year for staff and specifies particular topics of training that must be completed within a certain timeframe from the start of staff employment. NCAL, *supra* note 22, at 25.

118. Colorado, Connecticut, Delaware, and Washington, D.C. have general ongoing staff training requirements that do not explicitly mandate training for abuse, neglect, and critical incidents. NCAL, *supra* note 22, at 42, 47, 54.

have no explicit ongoing training requirements.¹¹⁹ Contrarily, most states do not require ongoing training for licensed professionals because they satisfy requirements through their state licensure.¹²⁰

Among the states that mandate training on specific topics, such topics can range from emergency preparedness, memory loss care, residents' rights, medication administration, and detecting abuse and neglect, to name a few.¹²¹ Several states have training policies that specifically mandate training surrounding the detection, prevention, and reporting of resident abuse and neglect.¹²² Put simply, staff training requirements surrounding critical incidents vary significantly by state. Similar to staff training, public disclosure of facility data is directly related to assisted living resident health and well-being. This topic is discussed below.

4. Public Disclosure of Facility Information

Unlike the Five-Star Quality Rating System for nursing homes,¹²³ there is not a resource or general repository for assisted living facility ratings. In the absence of federal regulations, states are at liberty to determine what information, including critical incident reporting and other facility-related information, assisted living facilities are required to disclose and on what platform.¹²⁴

According to the 2018 GAO report, thirty-four of the forty-eight states reported they disclosed critical incident information either by phone, website, or in-person when an individual made an inquiry.¹²⁵

119. There are three states that do not have staff training requirements: Tennessee, Mississippi, and North Dakota. *See* LONG TERM CARE CMTY. COAL., *supra* note 109.

120. COMPENDIUM OF RESIDENTIAL CARE, *supra* note 110.

121. RICHARD J. MOLLOT, SEAN WHANG & DARA VALANEJAD, LONG TERM CARE CMTY. COAL., ASSISTED LIVING: PROMISING POLICIES AND PRACTICES FOR IMPROVING RESIDENT HEALTH, QUALITY OF LIFE, AND SAFETY 18 (2018), <https://nursinghome411.org/wp-content/uploads/2018/10/LTCCC-Report-on-Assisted-Living.pdf> [<https://perma.cc/ZK28-38T5>].

122. Maine, Louisiana, Kansas, and Pennsylvania all explicitly require assisted living facilities to organize an orientation or other training program that covers procedures for reporting neglect, abuse, and critical incidents. *See id.* at 32.

123. CMS publishes a "Five-Star Quality Rating System" for nursing home facilities to increase public transparency of the quality of nursing home facilities, which allows families to compare facility ratings and make informed decisions on where to spend the end of their lives. There is an overall rating for each facility and then a separate rating for the categories of health inspections, staffing, and quality measures. *See Five-Star Quality Rating System*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 7, 2019), <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsqrs> [<https://perma.cc/23D5-LJHU>].

124. Breslow, *supra* note 29.

125. GAO REPORT 2018, *supra* note 11, at 26.

However, only twenty-two of these states disclose assisted living facility corrective action to address such incidents.¹²⁶ The remaining fourteen states did not disclose critical incident data in any form.¹²⁷

In addition to critical incident variation, states vary on disclosure levels of other health and safety-related information. Namely, facility inspection information is available in forty-seven out of forty-eight states in some form.¹²⁸ Unfortunately, this statistic is not as significant as it sounds because out of those forty-seven states, only thirty-six states disclose the information online.¹²⁹ Lastly, data regarding complaints and grievances filed against a specific facility are not available in any form in twelve states.¹³⁰

Although some states may publicly disclose facility critical incidents, inspection, and health information, only three states provide rating systems that allow prospective residents and their family members to do a comparative evaluation of facility quality and rating.¹³¹ In Arizona, the website provides an A–D rating of each facility, where “A” is the highest and “D” is the lowest.¹³² In Ohio, the website determines the quality of the facility based on a “Resident Satisfaction Survey Score.”¹³³ Lastly, in North Carolina, a website provides a star rating score based on inspection data from the North Carolina Division of Health Service Regulation.¹³⁴

To aid the public on the availability and process for obtaining assisted living facilities records, “A Place for Mom”¹³⁵ reviewed each

126. LONG TERM CARE CMTY. COAL., ASSISTED LIVING FACT SHEET: DETECTING AND ADDRESSING ABUSE AND NEGLECT, <https://nursinghome411.org/wp-content/uploads/2019/01/LTCCC-Assisted-Living-Fact-Sheet-Abuse-Neglect.pdf> [<https://perma.cc/M96P-B5T3>].

127. GAO REPORT 2018, *supra* note 11, at 26.

128. *Id.* at 27.

129. *Id.*

130. *Id.* Additionally, in four states, sanctions and penalties imposed on a specific facility are not available to the public in any form. *Id.*

131. Long Term Care Cmty. Coal., *Assisted Living State Requirements Chart*, NURSINGHOME411 [hereinafter *State Requirements*], <https://nursinghome411.org/assisted-living-state-requirements-chart> [<https://perma.cc/R3DU-E5HX>] (offering a comparative look of state regulation of assisted living facilities).

132. *Id.*; *Long Term Care Facilities Licensing Provider & Facility Databases*, ARIZ. DEP’T HEALTH & SERVS. (Aug. 4, 2020), https://www.azdhs.gov/documents/licensing/databases/LT_CARE_LIST.pdf [<https://perma.cc/2DSC-4V4F>].

133. *State Requirements*, *supra* note 131.

134. *Id.*; *Facility Inspections, Ratings and Penalties*, N.C. DIV. HEALTH SERV. REGUL., <https://info.ncdhhs.gov/dhsr/acls/star/search.asp> [<https://perma.cc/7333-G2V8>] (Aug. 22, 2018).

135. A Place for Mom is a company that provides referral assistance to families and individuals in the search of senior living options, including assisted living facilities.

states' disclosure level.¹³⁶ To conduct this review, the organization considered the nature of information disclosed to the public, the ease of access, and the frequency of inspections.¹³⁷ State disclosure levels were categorized as "Exceptional," "High,"¹³⁸ "Moderate,"¹³⁹ or "Basic," based on evaluation of over a dozen criteria.¹⁴⁰ Twenty states were categorized as "Exceptional," which means that the state maintains a unified online database that is searchable.¹⁴¹ Nine states were classified as "Basic," meaning facility information was disclosed on a PDF or Excel spreadsheet, regulatory enforcement was unavailable, and a Freedom of Information Act Request was required to get information about the facility.¹⁴² Fourteen states were classified as "High," and seven were deemed "Moderate."¹⁴³

Notably, Missouri had one of the highest ratings for transparency—meeting all but one requirement¹⁴⁴—because it posted complaints, inspections, and results online, in a searchable format.¹⁴⁵ Massachusetts was listed as one of the worst—only meeting two transparency criteria¹⁴⁶—due to its complete lack of a database or

What Is Assisted Living?, PLACE FOR MOM, <https://www.aplaceformom.com> [<https://perma.cc/9LMV-VETG>].

136. *State Guide to Assisted Living Records & Reports*, PLACE FOR MOM, <https://www.aplaceformom.com/planning-and-advice/senior-housing-101/assisted-living-state-licensing> [<https://perma.cc/KP2G-6JHF>] (Apr. 2020).

137. *Id.*

138. *Id.* (defining "High" as "[h]as separate searchable databases for assisted living facilities and licensing and regulation data. May lack information about inspections and regulatory actions.").

139. *Id.* (defining "Moderate" as "[h]as directories of licensed communities online but does not have searchable dataset. May lack information about inspections and regulatory actions.").

140. The objective criteria included things such as: whether the state lists the assisted living facilities, whether records are updated frequently (within 60 days), whether the format of information is searchable, whether inspections and complaints are publicly available, whether the owner name is available, whether the facility can be fined, and whether facility pricing is available. *Id.*

141. *Id.*

142. *Id.*

143. *Id.*

144. Missouri was missing the requirement that the facility pricing data be disclosed online. *Missouri Assisted Living Records & Reports*, PLACE FOR MOM, <https://www.aplaceformom.com/planning-and-advice/senior-housing-101/assisted-living-state-licensing/Missouri> [<https://perma.cc/AU4G-SHHU>].

145. *Id.*

146. *Massachusetts Assisted Living Records & Reports*, PLACE FOR MOM, <https://www.aplaceformom.com/planning-and-advice/senior-housing-101/assisted-living-state-licensing/Massachusetts> [<https://perma.cc/EDT8-JZPW>] (Jan. 2018).

online resource for facilities within Massachusetts, and individuals are required to submit a FOIA request to receive information.¹⁴⁷

In sum, the federal government has a very limited role in the regulation and oversight of assisted living facilities.¹⁴⁸ While states are expected to comply with limited CMS requirements, they are the primary regulatory authority of the assisted living industry.¹⁴⁹ As discussed, states vary considerably with respect to (1) defining critical incidents, (2) inspection and reporting surrounding critical incidents, (3) staff training surrounding critical incidents, and (4) public disclosure requirements of facility information.¹⁵⁰ In turn, the combination of limited federal regulation and underdeveloped state regulatory regimes has created an industry that falls short of protecting America's elderly population.¹⁵¹

II. THE THREAT OF UNDERREGULATED ASSISTED LIVING FACILITIES

Although assisted living facilities are growing in popularity among America's elderly population, they remain largely unregulated and unmonitored by the federal government. This leaves states as the sole hope for assisted living facility residents' health and well-being. Without heightened state regulation of abuse and neglect within assisting living facilities, the risk to residents' health and well-being will persist as illustrated in the alarming 2018 GAO report.¹⁵²

This Part will show that the combination of minimal federal oversight and inadequate state regulation of assisted living facilities leaves the health and welfare of assisted living residents unprotected. First, this Part will expand on the inadequacy of CMS's federal oversight of assisted living facilities, ultimately leaving a dangerous level of oversight to directionless state Medicaid agencies. Next, this Part will suggest such wide discretion and reliance on state Medicaid agencies results in unpredictability for potential consumers. This unpredictability stems from varying levels of regulation surrounding critical incidents, staff training with respect to critical incidents, and the necessity for public disclosure of facility information. Ultimately, this Part will illustrate the importance of heightened state legislation

147. *Id.*

148. *See supra* Part I.B.

149. *See supra* Part I.C.

150. *Id.*

151. *See infra* Part II.

152. GAO REPORT 2018, *supra* note 11.

and regulation of assisted living facilities for the sake of elderly safety and well-being.

A. CURRENT CMS FEDERAL OVERSIGHT OF ASSISTED LIVING FACILITIES DOES NOT GUARANTEE HEALTH AND WELL-BEING OF THE ELDERLY POPULATION

As discussed above, while CMS has *some* federal oversight of assisted living facilities,¹⁵³ the effectiveness of such oversight is plagued by gaps in state reporting¹⁵⁴ and unclear CMS expectations of state reporting.¹⁵⁵ In reality, this “oversight” results in states checking off boxes that guarantee the “health and welfare of Medicaid beneficiaries.”¹⁵⁶ This system falsely presents a high standard of federal oversight, while entirely leaving implementation up to state discretion.¹⁵⁷ Unsurprisingly, states fail to elevate deficiencies that may result in harm to beneficiary health and welfare to CMS’s attention.¹⁵⁸ The false security of federal oversight, combined with an ambiguous delegation to state Medicaid agencies, perpetuates a standardless industry for assisted living facilities.

Further, assisted living facilities lose accountability for resident health and well-being when state Medicaid agencies are at liberty to outsource facility inspections to other state agencies without adequate notification and review procedures of inspection results.¹⁵⁹ This shortcoming strips CMS of knowledge of not only minor complaints, grievances, and inspection results of participating facilities, but also more serious investigation of harm to resident health and well-being.

Moreover, the CMS requirements that *do* exist are merely prerequisites for approval and renewal of HCBS waivers to receive Medicaid funding.¹⁶⁰ In other words, CMS operates on a very high level of oversight that, in practice, is not conducive to defining, preventing, tracking, or disclosing abuse and neglect in assisted living facilities.

The insufficient CMS oversight system through Medicaid is directly connected to a lack of protection for the vulnerabilities of

153. See *supra* notes 62–68 and accompanying text (discussing CMS oversight).

154. See *supra* notes 76–78 and accompanying text.

155. See *supra* notes 69–72 and accompanying text (discussing ambiguity of CMS requirements).

156. See *supra* notes 80–86 and accompanying text (discussing states blindly checking off boxes).

157. See GAO REPORT 2018, *supra* note 11, at 27–29.

158. *Id.* at 29–30.

159. See *supra* notes 106–07 and accompanying text.

160. See *supra* notes 63–68 and accompanying text.

assisted living facility residents. Once CMS approves the HCBS waiver, CMS exercises little to no influence on the respective state Medicaid agency oversight until renewal of the waivers. The gap in time between initial HCBS waiver approval and the subsequent renewal periods¹⁶¹ acts as a symbolic punt from CMS to unchecked state Medicaid agencies to record, report, and remedy critical incidents as they see fit. As shown by the GAO's findings in the 2018 report, this has resulted in many states entirely neglecting to implement effective systems to track critical incidents.¹⁶² Thus, the current interplay between CMS and state Medicaid agencies is doing very little to ensure assisted living facility resident health and welfare in a climate of elder abuse and neglect.¹⁶³ Not surprisingly, elder abuse and neglect has negative effects on the quality of life, and can even substantially increase the risk of death,¹⁶⁴ among the nation's elderly population.¹⁶⁵

Despite CMS's increased state HCBS waiver requirements in 2014, CMS observed little to no oversight improvement.¹⁶⁶ This failure was the natural result of unclear CMS guidance on what states should deem a reportable "deficiency," lack of state obligation to provide

161. HCBS waivers—Section 1915(b) and Section 1915(c)—and Section 1115 waivers account for the majority of state waivers for assisted living facilities. GAO REPORT 2018, *supra* note 11, at 14 tbl.2. HCBS waivers account for 69% of programs in the GAO report and Section 1115 waivers account for 10%. *Id.* HCBS waivers are generally approved for three years, with five-year renewal periods, while Section 1115 waivers are generally approved for a five-year period, with a possible three-year renewal period. *Waivers, MEDICAID & CHIP PAYMENT & ACCESS COMM'N*, <https://www.macpac.gov/medicaid-101/waivers> [<https://perma.cc/EW8S-FJF9>].

162. *See supra* notes 97–102 and accompanying text.

163. *See supra* notes 1–7 and accompanying text (discussing severe elder abuse in assisted living facilities and the alarmingly high rate of such abuses). *See generally Elder Abuse: Key Facts*, WORLD HEALTH ORG. (June 15, 2020), <https://www.who.int/news-room/fact-sheets/detail/elder-abuse> [<https://perma.cc/H4C2-2YXG>] (explaining that pinpointing statistics for elder abuse in institutional settings, such as nursing homes, hospitals, and long-term care facilities, is extremely difficult due to the scarcity of data; however, elder abuse is a rapidly growing problem not only in the United States, but across the world, estimating that 320 million elders will be victims of abuse by 2050).

164. *Statistics and Data*, NAT'L CTR. ON ELDER ABUSE, <https://ncea.acl.gov/What-We-Do/Research/Statistics-and-Data.aspx> [<https://perma.cc/TMX6-WEUU>] ("Elders who experienced abuse, even modest abuse, had a 300% higher risk of death when compared to those who had not been abused.").

165. *Id.* (explaining that impacts of elder abuse can include psychological distress, higher rates of depression than those who were not abused, social isolation, decreased social identity, and economic exploitation).

166. GAO REPORT 2018, *supra* note 11, at 28.

information on critical incidents, and CMS's inconsistent enforcement of state annual reporting requirements.¹⁶⁷

Not only did CMS fall short in its recent attempt to strengthen assisted living facility oversight, the near future of CMS oversight of assisted living facilities is not promising to improve health and well-being of assisted living facility residents. As discussed above, the GAO gave three recommendations to CMS to improve oversight of assisted living facilities.¹⁶⁸ Importantly, CMS agreed with two out of the three GAO recommendations. Specifically, CMS indicated it would clarify requirements regarding monitoring and reporting of deficiencies in states' annual reports and further stated that it would reaffirm states' responsibility for filing annual reporting requirements on time.¹⁶⁹ However, CMS did not explicitly agree nor disagree with GAO's recommendation to provide states with standard requirements for reporting critical incidents annually.¹⁷⁰

The GAO report clearly outlines the glaring inadequacy of federal oversight. However, CMS's response lacks the necessary motivation to create broadscale regulatory changes to improve assisted living facility residents' health and well-being;¹⁷¹ rather, the recommendations

167. *Id.* at 28–33.

168. *See supra* note 87 and accompanying text.

169. GAO REPORT 2018, *supra* note 11, at 34.

170. *Id.* However, CMS has taken some action to indicate the importance of critical incident recording. *See, e.g.*, CTR. FOR MEDICARE & CHIP SERVS., HEALTH AND WELFARE OF HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER RECIPIENTS 2 (2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib062818.pdf> [<https://perma.cc/E9EJ-38PV>] (providing steps for states to consider for improvement of their critical incident reporting, including the suggestion that in the absence of a federal definition, states should define critical incidents to, “at a minimum, include unexpected deaths and broadly defined allegations of physical, psychological, emotional, verbal and sexual abuse, neglect, and exploitation”); CTRS. FOR MEDICARE & MEDICAID SERVS., INCIDENT MANAGEMENT 101, <https://www.medicaid.gov/sites/default/files/2019-12/incident-management-101.pdf> [<https://perma.cc/YZ5Y-CRPP>] (detailing the elements of an effective Incident Management System: “(1) [i]dentifying the [i]ncident, (2) [r]eporting the [i]ncident, (3) [t]riaging the [i]ncident, (4) [i]nvestigating the [i]ncident, (5) [r]esolving the [i]ncident, (6) [t]racking and [t]rending [i]ncidents”).

171. Recognizing this reality, several lawmakers have expressed intention to address legislation regarding federal regulation of assisted living facilities to improve the health and well-being of assisted living beneficiaries. For example, Senator Elizabeth Warren, one of the four senators who had requested the report in 2015, responded to the 2018 GAO report by stating, “I plan to pursue legislation to address these groundbreaking findings,” indicating that the GAO report “finds that thousands of seniors face serious health and safety risks in their assisted living facilities.” Lois A. Bowers, *Despite Headlines, GAO Report Does Not Portend Major Changes for Assisted Living, Industry Leaders Say*, MCKNIGHT'S SENIOR LIVING (May 13, 2018), <https://www.mcknightsseniorliving.com/home/news/despite-headlines-gao-report-does-not>

CMS adopted will merely require states to up their data reporting requirements to CMS.¹⁷²

B. INADEQUATE STATE REGULATION SURROUNDING CRITICAL INCIDENTS AND PUBLIC DISCLOSURE CREATES UNCERTAINTY AND DANGER FOR ELDERLY HEALTH AND WELL-BEING

As discussed, the past, present, and future of federal oversight of assisted living facilities is not promising for protection for assisted living facility resident health and well-being. Additionally, the threat to elder health and safety in assisted living facilities is likely much greater than suggested by the 2018 GAO report. First, this Section will illuminate the blind spots of the GAO report, ultimately suggesting that the current state of assisted living facility resident health and well-being is worse than projected. Then, this Section will illustrate the problem with the uncertain state definitions of “critical incident” (at least with respect to the most severe incidents), unreliable review of such critical incidents by state agencies, uncertain staff training surrounding critical incidents, and the states’ disjointed approaches to public disclosure of facility health and safety information.

Ultimately, this Section suggests that the current federal oversight regime of assisted living facilities is inadequate due to the large number of assisted living facilities that fall outside of CMS’s purview. Additionally, this Section opines that state uncertainty regarding the definition of “critical incident,” as well as how to track, report, prevent, and disclose such incidents is a threat to the well-being of America’s elderly population.

1. Illustration of a Larger Problem Revealed by Blind Spots of the GAO Report

The alarming statistics presented in the 2018 GAO report¹⁷³ very likely underreported critical incident numbers. First, the 2018 GAO report only included assisted living facilities that are Medicaid

-portend-major-changes-for-assisted-living-industry-leaders-say [https://perma.cc/E72V-WPUF].

172. Lilly Hummel, senior director at the National Center for Assisted Living, stated in an interview about the 2018 GAO report, “The recommendations have much stronger implications for the Medicaid state offices than for assisted living providers directly, because the recommendations are all aimed squarely at . . . the CMS oversight process and the reporting process. At this point, I’m not anticipating . . . broadscale changes for assisted living.” *See id.*

173. *See supra* notes 94–98 and accompanying text (providing statistics).

certified, which does not include all assisted living facilities.¹⁷⁴ Second, the 2018 GAO report does not tell the full story of critical incidents in assisted living facilities, due to the fact that only twenty-two out of the forty-eight participating states reported critical incident data.¹⁷⁵ Third, although many states have multiple programs that cover assisted living services,¹⁷⁶ the 2018 GAO report only requested state data on their largest HCBS program.¹⁷⁷ Shockingly, the HCBS waiver program is the program with the most stringent federal requirements.¹⁷⁸

In short, the GAO report is merely an illustration of the problem using a subset of assisted living facilities, rather than a comprehensive detailing of the number of elderly individuals affected by underregulated assisted living facilities. With the absence of meaningful and enforced federal standards for quality care in assisted living facilities to guarantee resident health and well-being,¹⁷⁹ residents are left looking to their respective states to protect their health and well-being at facilities.¹⁸⁰

174. See *How Medicaid Can Help Seniors Cover the Cost of Assisted Living*, AM. COUNCIL ON AGING, <https://www.medicaidplanningassistance.org/assisted-living> [<https://perma.cc/4QPG-LPCX>] (Jan. 7, 2020).

175. See *supra* notes 99, 101 and accompanying text (discussing why the other twenty-six states were unable to report critical incident data). Additionally, Louisiana, Kentucky, and West Virginia were left entirely out of the report because their Medicaid agencies do not cover assisted living services at all. See GAO REPORT 2018, *supra* note 11, at 12 fig.1.

176. See GAO REPORT 2018, *supra* note 11, at 13–14 tbl.2 (“The majority of states, 31 of the 48, reported administering more than one program that covered assisted living services.”). Also not included in the 2018 GAO report is data from private pay assisted living facilities. David Levine, *Does Long-Term Care Insurance Cover Assisted Living?*, U.S. NEWS & WORLD REP. (July 29, 2019, 1:26 PM), <https://health.usnews.com/best-assisted-living/articles/does-long-term-care-insurance-cover-assisted-living> (stating that the majority of assisted living residents rely on private pay and personal assets to afford living costs, while assisted living residents paying via Medicaid account for approximately one in six residents).

177. See GAO REPORT 2018, *supra* note 11, at 4.

178. *Id.* at 7.

179. See *supra* Part I.B. Despite the fact that the assisted living facility population experiences similar health and medical needs as the nursing home population, see *supra* notes 40–42, assisted living facility residents are not statutorily guaranteed the same quality of care afforded to nursing home residents. MOLLOT ET AL., *supra* note 121, at 5 n.2 (“The federal Nursing Home Reform Law states that each resident is entitled to services that help the resident ‘attain or maintain’ his or her ‘highest practicable physical, mental, and psychosocial well-being.’” (quoting 42 U.S.C. § 1395i-3(b)(2))).

180. This is not a new reality for assisted living residents. After the 1999 GAO report, the public began tuning in to the responsibilities of the states in protecting individuals in assisted living facilities. Advocacy groups and the media presented states as

2. State Discrepancies Surrounding the Understanding of “Critical Incidents”

As previously discussed, state Medicaid agencies are left with wide discretion to determine what constitutes a “critical incident” and what is worth reporting to CMS in annual reports.¹⁸¹ While states agree that physical, sexual, and emotional abuse constitute a reportable “critical incident,”¹⁸² there is a concerning amount of discrepancy among states regarding other categories of “incidents” that may affect elder health and well-being. For example, additional common incidents likely to cause harm to resident health and welfare include unexplained death, missing residents, police or doctor referral to Adult Protective Services, threat or attempt of suicide, unauthorized use of seclusion, injuries resulting in hospitalization, and unauthorized use of restraints.¹⁸³ While most states classify these occurrences as “critical incidents” worthy of reporting to CMS, the problem arises with the handful of states that do not.¹⁸⁴

With respect to incidents such as unexplained death and injuries resulting in hospitalization, the resident has suffered a significant, if not fatal, injury. Not classifying this as a “critical incident” is problematic because it is very possible the injury was a result of negligent or substandard care. These incidents should certainly be reported and investigated to ensure the safety of assisted living facility residents.

Similarly, not classifying incidents such as unauthorized use of restraints and unauthorized use of seclusion as “critical incidents” would ignore their inhumane, abusive nature. Again, this would be problematic for the well-being and safety of residents because it would ignore a very likely indication of negligent or substandard care in need of corrective action.

However, two of these incidents—attempted suicide and police or doctor referral to Adult Protective Services—are arguably not as serious. While tragic, these incidents are not necessarily indicators of

“doing a poor job of protecting consumers. The problem, many pronounced, was that assisted living had no uniform standards, beginning with its definition and its appropriate clientele base.” Keren Brown Wilson, *Historical Evolution of Assisted Living in the United States, 1979 to Present*, 47 GERONTOLOGIST 8, 19 (2007).

181. GAO REPORT 2018, *supra* note 11, at 27–28 (“[E]ach state Medicaid agency has wide discretion over the information it will collect and report to demonstrate that it is meeting the health and welfare requirements and protecting beneficiaries.”); *see also supra* Part I.C.1 (discussing states’ varying conceptions of “critical incident”).

182. *See supra* note 94 and accompanying text.

183. *See supra* note 95 and accompanying text (providing state statistics).

184. The number of states that do not classify these incidents as “critical” ranges between two and seven states. *See supra* notes 95–96 and accompanying text.

substandard or negligent care. Rather, an attempted suicide or referral to Adult Protective Services may, instead, suggest the need for resident access to mental health services. Despite this, not classifying these as “critical incidents” would allow for serious threats to resident safety and well-being to fly under the radar. These incidents deserve the highest level of consideration by states to ensure protection of America’s elderly population, even if the critical incident investigation ultimately reveals the incident was due to the need for mental health services.

In sum, lack of uniformity among states regarding the categorization of the above-mentioned more serious incidents creates dangerous uncertainty for the health and well-being of assisted living facility residents. These incidents may not be recorded, tracked, or taken as seriously as physical, emotional, or sexual abuse without classification as “critical incidents.” Differing state classifications of these more serious incidents would do a disservice to America’s elderly population, as well as their family members, because incidents that are reasonably expected to garner attention and investigation would be demoted to a low-level incident.

Beyond these incidents, there are also lower risk incidents discussed in the 2018 GAO report that are common in assisted living facilities. Specifically, these lower risk incidents include injuries needing medical attention (but not hospitalization), medication errors, discharge and eviction from the facility, physical infrastructure issues, suspected criminal activity by the provider, and minor injuries not requiring medical attention.¹⁸⁵

To the average person, these incidents may not seem life-threatening or worthy of being deemed a “critical incident;” however, these lower-risk incidents may quickly rise to “critical incident” nature if they occur even more than once in a short time span.

As an example of how a lower-risk incident may quickly rise to a “critical incident,” medication errors such as alterations of schedules and doses, forgetting doses, or taking the wrong medication can cause serious issues in elderly patients.¹⁸⁶ Such errors may result in side

185. See *supra* notes 95–96 and accompanying text.

186. *Overdosing, Wrong Medication and Nursing Homes Abuse*, NURSING HOME ABUSE CTR., <https://www.nursinghomeabusecenter.org/overdosing-wrong-medication> [<https://perma.cc/74HK-9N8S>]; see also *Avoiding Dangerous Side Effects of Medication in Nursing Homes*, HEALTH AGING BLOG (Aug. 7, 2018), <https://www.healthinaging.org/blog/avoiding-dangerous-side-effects-of-medications-in-nursing-homes> [<https://perma.cc/KYZ6-2S63>] (discussing various risks of medication errors in nursing homes, particularly with drugs commonly used by elderly patients); Breslow, *supra* note 29 (“[I]f you’ve got 93 medication errors, one of those or more will have a negative

effects with other drugs, render the medication ineffective, and create confusion and disorientation.¹⁸⁷ Thus, medication errors should be closely and effectively tracked and recorded because such incidents may have serious side effects for the resident rising to the level of a “critical incident.”¹⁸⁸

Additionally, lower-risk incidents such as injuries needing medical attention (but not hospitalization), suspected criminal activity by a provider, or discharge and eviction from the facility may hint at larger problems. Namely, effective tracking and recording of such incidents may reveal issues such as unqualified staffing, staff abuse, or staff neglect of residents.

However, the lower-risk incident of minor injuries not requiring medical attention is not likely worthy of the label “critical incident.” Residents in assisted living facilities are elderly and often frail, which makes minor injuries almost certain to occur.¹⁸⁹ Also, state classification of minor injuries not requiring medical attention as “critical incidents” would put significant strain on the state agency responsible for investigating more serious critical incidents.

Unsurprisingly, states vary significantly on whether they classify the above-mentioned lower-risk incidents as critical incidents worthy of reporting to CMS.¹⁹⁰ Giving states discretion on whether to classify these incidents as “critical incidents” is not as problematic to resident health and well-being as the first set of more serious critical incidents discussed. Instead, granting states discretion on how to classify these lower-risk incidents may allow respective states to consider their unique populations and the history of assisted living facilities operating within the state.

In general, federal inaction¹⁹¹ and state-by-state uncertainty (at least with respect to the more serious critical incidents discussed)

impact on the resident. And what you see is residents end up in the emergency room . . . or worst of all, they end up dead.”).

187. *Overdosing, Wrong Medication and Nursing Homes Abuse*, *supra* note 186.

188. An individual’s likelihood for medication dependency increases with age, especially considering the three most likely killers of elderly Americans: cancer, heart disease, and stroke, which all require medication. *Id.* Medication is required for various other common diseases and conditions among elderly Americans, such as high blood pressure, diabetes, Parkinson’s, and Alzheimer’s. *Id.*

189. *Cf. Avoiding Dangerous Side Effects of Medication in Nursing Homes*, *supra* note 186 (noting that many nursing home residents take medication that increases the likelihood of dizziness and falls).

190. The number of states that do not classify these incidents as “critical” ranges between seven and thirty-one states. *See* GAO REPORT 2018, *supra* note 11, at 42 tbl.10.

191. *But see supra* notes 169–70 (discussing recent CMS statements in response to the 2018 GAO report).

surrounding the categorization of these incidents presents a health and safety issue for current and prospective assisted living facility residents.¹⁹² The fact that states only exhibit uniformity among physical, sexual, and emotional abuse is at the root of the threat to elder safety and well-being. Without designation of incidents likely to cause harm to resident well-being as “critical incidents” and close tracking of lower-risk incidents, assisted living facility residents will continue to be in danger. Additionally, without knowing how states will handle and address these incidents, prospective residents cannot make an informed decision on a facility or state to reside in for their end-of-life care. These problems are certain to be exacerbated as assisted living facilities begin to grow in popularity,¹⁹³ medical needs of residents intensify,¹⁹⁴ and the population of elderly Americans booms.¹⁹⁵

3. State Discrepancy Surrounding Assisted Living Facility Staff Training Requirements

Compounding the problem of a state-by-state understanding of what constitutes a serious “critical incident,” states also vary on whether, and to what extent, they have initial and ongoing training requirements for assisted living facility staff that provide *direct care* to residents.¹⁹⁶ However, not all states require staff to be adequately trained on how to recognize and report such abuse and neglect.¹⁹⁷ Staff training requirements are a crucial regulatory area for assisted living facilities, because a trained, well-informed workforce has great

192. See generally John B. Breaux & Orrin G. Hatch, *Confronting Elder Abuse, Neglect, and Exploitation: The Need for Elder Justice Legislation*, 11 ELDER L.J. 207, 212 (2003) (“According to a study . . . older adults who were mistreated were 3.1 times at greater risk of dying within the next decade than those of the same age with no reported mistreatment.”); LONG TERM CARE CMTY. COAL., *supra* note 126 (recommending that states develop a consistent definition of what constitutes a “critical incident”).

193. See *supra* notes 34–39 and accompanying text (discussing increased popularity of assisted living facilities).

194. See *supra* notes 41–43 and accompanying text (explaining the typical medical needs of the assisted living population).

195. GAO REPORT 2016, *supra* note 32 (discussing aging population).

196. *Assisted Living Fact Sheet: Staff Training Requirements*, *supra* note 109; COMPENDIUM OF RESIDENTIAL CARE, *supra* note 110. See generally LONG TERM CARE CMTY. COAL., *supra* note 126 (recommending that all assisted living employees undergo training to recognize abuse and neglect, and that all staff that have direct contact with assisted living residents undergo annual training regarding abuse and neglect of residents).

197. However, other states do explicitly require staff training on abuse and neglect. For example, Alabama’s regulations state “[a]ll staff must receive initial and ongoing training on required topics such as . . . (2) identifying and reporting abuse, neglect, and exploitation . . .” COMPENDIUM OF RESIDENTIAL CARE, *supra* note 110.

potential to influence the health and well-being of assisted living facility residents.¹⁹⁸ The absence of federal regulation regarding staff training, and the obvious issue of uneducated staff, mandates the need for stricter state regulation to ensure elder health and well-being.¹⁹⁹ Without this, critical incidents will likely continue to go unnoticed.

4. State Discrepancy Surrounding Public Disclosure of Facility Information

Moving away from the classification and prevention of critical incidents, states also vary significantly on what information, if any information at all, is disclosed to the public regarding critical incident and general facility information.²⁰⁰ While not their first option, many elderly Americans are tasked with choosing a facility to spend most of their senior years when they are no longer able to care for themselves.²⁰¹ Unfortunately, this decision often comes with the added pressure of ailing health,²⁰² which places individuals in a vulnerable position to make a quick decision with minimal information.²⁰³

Even when consumers have the time to research facilities, the information available can be misleading and difficult to obtain.²⁰⁴ As discussed earlier, some states neglect to disclose critical incident data

198. *Id.* (“Staff training requirements are an important topic because a trained, qualified workforce can improve residents’ quality of life and care.”). Studies have shown that staff training requirements may benefit the health and well-being of residents at nursing homes, as well as assisted living facilities. *See, e.g.*, Brian P. Kaskie, Matthew Nattinger & Andrew Potter, *Policies to Protect Persons with Dementia in Assisted Living: Déjà Vu All Over Again?*, 55 GERONTOLOGIST 199, 202 (2015) (finding that states with specific staff training topics, such as aggression control, and more hours of required training were considered to have more rigorous care policies for dementia patients than states without such explicit training requirements).

199. LONG TERM CARE CMTY. COAL., *supra* note 126 (advocating for improved state regulation and assisted living facility staff training).

200. *See supra* Part I.C.4 (discussing critical incident disclosure).

201. *See Retirement Living, supra* note 10 (noting that most study respondents would prefer to age at home with a caregiver, but when facing failing health would consider moving into an assisted living facility).

202. Studies indicate that individuals seeking long term care often make decisions on a facility under “pressure of an imminent discharge from an acute care setting.” Catherine Hawes & Charles D. Phillips, *Defining Quality in Assisted Living: Comparing Apples, Oranges, and Broccoli*, 47 GERONTOLOGIST 40, 48 (2007).

203. It is also not unusual for family members to aid in decision-making alongside the prospective assisted living facility resident. *See, e.g., id.* at 48–49 (discussing the primary factors that guide prospective residents and family members in deciding on an assisted living facility).

204. Breslow, *supra* note 29 (explaining that due to the lack of state and industry standards in terms of which facilities can be labeled “assisted living,” the quality varies wildly).

and facility complaint data in any form,²⁰⁵ and of the ones that do, many do not provide information online.²⁰⁶ These states leave prospective residents in the dark surrounding critical incidents, complaints against a facility, and the respective facilities' response to such incidents.²⁰⁷ Alarming, only three states maintain websites that provide comparative ratings on facilities within the state, which makes it difficult for prospective residents to directly compare high- and low-quality facilities.²⁰⁸ Moreover, state websites presenting assisted living facility data also vary, with some states providing easily navigable and searchable documents,²⁰⁹ others declining to publish inspection reports online,²¹⁰ and several requiring a Freedom of Information Act (FOIA) request for individuals to obtain information on a facility.²¹¹ States that have unsearchable documents or require FOIA requests may create insurmountable difficulty for some elderly Americans. In particular, elderly Americans without tech-savvy family members or friends may struggle to obtain any facility information from these inaccessible disclosure formats.

205. GAO REPORT 2018, *supra* note 11, at 27 tbl.5.

206. Only ten states provide information on critical incidents online. *Id.*

207. This is not the case with nursing homes, as the federal government publishes a five-star nursing home rating system where individuals can easily compare the quality of nursing homes to inform their decision. *See Five-Star Quality Rating System, supra* note 123; Breslow, *supra* note 29 (explaining that the five-star system rates facilities on several measures of quality, including staffing, deficiencies in the facilities, and other quality indicators).

208. *See supra* notes 132–34 and accompanying text (discussing Arizona, Ohio, and North Carolina's assisted living facility rating systems); *see, e.g., Adult Care Licensure Section*, N.C. DIV. HEALTH SERV. REGUL. (Aug. 22, 2018), <https://info.ncdhhs.gov/dhsr/acls/star/search.asp#star> [<https://perma.cc/2ALP-BRT9>] (detailing North Carolina's "star rating" system based on the results of annual inspections conducted by the North Carolina Division of Health Service Regulation).

209. Alabama was rated as having "exceptional" transparency by A Place for Mom because the assisted living records are highly transparent, searchable, and records are available through an online health provider search. *Alabama Assisted Living Records & Reports*, PLACE FOR MOM, <https://www.aplaceformom.com/planning-and-advice/senior-housing-101/assisted-living-state-licensing/alabama> [<https://perma.cc/FKZ5-Y6XU>].

210. Illinois is one state that A Place for Mom rated as having "moderate" transparency because it does not publish assisted living inspection reports online. *Illinois Assisted Living Records & Reports*, PLACE FOR MOM, <https://www.aplaceformom.com/planning-and-advice/senior-housing-101/assisted-living-state-licensing/illinois> [<https://perma.cc/55PX-YCZL>].

211. Massachusetts is one state that A Place for Mom rated as "basic," because the state requires a FOIA request to receive information about assisted living facility inspection records. *Massachusetts Assisted Living Records & Reports, supra* note 146.

In addition to differing disclosures regarding critical incident information, states also differ on the required disclosure relating to other health and facility information.²¹² Unfortunately, with federal silence on state responsibility to publicly disclose assisted living facility information,²¹³ prospective residents have few resources beyond what the respective state provides to evaluate the quality of assisted living facilities.²¹⁴

To improve the health and well-being of assisted living facility residents, information such as critical incidents, grievances and complaints against the facility, and inspection results should be readily accessible. Additionally, people value different qualities and services when searching for an assisted living facility,²¹⁵ and prospective residents should have the right to make informed choices between high-quality and low-quality facilities that align with their personal interests.²¹⁶

212. For example, some states post data on frequency of inspections, whether the state may fine the facility, the price of the facility, violations, and so on. *Compare California Assisted Living Records & Reports*, PLACE FOR MOM, <https://www.aplaceformom.com/planning-and-advice/senior-housing-101/assisted-living-state-licensing/california> [<https://perma.cc/ZGR8-QDAF>] (describing how California provides transparent access to much of this information online), *with South Dakota Assisted Living Records & Reports*, PLACE FOR MOM, <https://www.aplaceformom.com/planning-and-advice/senior-housing-101/assisted-living-state-licensing/south-dakota> [<https://perma.cc/GGX4-RBAJ>] (describing how South Dakota requires a FOIA request to access similar information).

213. *Compare* Gleckman, *supra* note 31 (“While the federal government operates a website to allow consumers to compare nursing homes and home health agencies using a range of safety metrics, it operates no such service for residential care. And state information is often less-than-transparent or up-to-date.”), *with Five-Star Quality Rating System*, *supra* note 123 (illustrating CMS efforts to implement a federal rating system for nursing homes).

214. Breslow, *supra* note 29 (explaining that consumers have “practically nothing” to evaluate assisted living facilities, largely due to misconceptions about residents’ good health and autonomy).

215. Studies indicate that prospective assisted living residents differ on the importance of various facility factors, such as: location, price, physical appearance, amenities, staffing type, staffing levels, medication administration, communication with family members, and type of daily activities offered, to name a few. Hawes & Phillips, *supra* note 202, at 48–49.

216. *See generally* Breslow, *supra* note 29 (“We’re creating an industry with 1 million people in it who are becoming more frail, who are poorly regulated by the states, which already are stressed. They have fewer inspectors. They have fewer complaint investigators by a lot than we do in nursing homes That’s why I talk about it as a ticking time bomb, because we’re going to see more deaths, more injuries And families are going to be so shocked, because they think they’ve made . . . a safe decision, and they don’t understand . . .”).

In short, the combination of minimal federal oversight and inadequate state regulation of assisted living facilities is extremely problematic for ensuring the health and well-being of assisted living residents. Currently, the federal government and state Medicaid agencies lack the necessary standards and guidance to effectively regulate the industry.²¹⁷ This results in unpredictability for potential and current assisted living facility consumers with respect to elderly health and well-being.²¹⁸ This unpredictability largely stems from uncertainty in state Medicaid agency regulation surrounding critical incidents, staff training with respect to critical incidents, and the lack of uniform public disclosure of facility information.²¹⁹ To cure this problem, state legislatures, regulatory agencies, and delegated oversight bodies must take action to improve regulation and oversight of assisted living facilities, independent from the current Medicaid framework.²²⁰

III. STATE LEGISLATURES AND RESPECTIVE STATE AGENCIES SHOULD HEIGHTEN ASSISTED LIVING FACILITY REGULATION SURROUNDING CRITICAL INCIDENTS

This Part presents a solution to the increasing threat to America's elderly population through state action. First, this Part explains why state level regulation is superior to regulation at the federal level. Second, this Part proposes that states should enact legislation and regulation through the lens of critical incidents to increase awareness, prevention, and disclosure of elderly abuse and neglect within America's assisted living facilities. This legislation and regulation include a detailed definition of "critical incident," state mandated staff training requirements surrounding abuse and neglect, and facility disclosure requirements. Ultimately, this solution builds upon CMS regulatory efforts through state Medicaid agencies while simultaneously abandoning the uncertainty of CMS oversight. This is accomplished through designation or creation of responsible state agencies to oversee inspection, reporting, compliance, and enforcement of non-compliant assisted living facilities. In effect, the heightened regulation around critical incidents will provide states with an effective measure of assisted living facility quality and improve assisted living facility resident health and well-being.

217. See *supra* Part II.A.

218. *Id.*

219. See *supra* Part II.B.

220. See *infra* Part III.

A. HEIGHTENED ASSISTED LIVING FACILITY REGULATION SHOULD OCCUR AT THE STATE LEVEL

The call for increased assisted living facility regulation has primarily been directed at the federal government.²²¹ However, the superior option would be for states to enact comprehensive regulations that focus on defining “critical incidents,” increasing staff training surrounding abuse and neglect, and enhancing public disclosure of facility information.

States are better equipped to implement assisted living regulations because they are closer to their unique populations and better understand the priorities of current and prospective assisted living residents.²²² Notably, state governments also have the support of relevant voices in the assisted living industry, such as the National Center for Assisted Living and the Long Term Care Community Coalition.²²³ Allowing state flexibility, within the broader uniform changes, on regulation of its facilities allows states to address the needs and desires of their respective populations.

Due to the limited, although undeniably increasing, role of the federal government in assisted living facility funding through

221. GAO REPORT 2018, *supra* note 11, at 34 (recommending a course of action to CMS to address the problem of inadequate tracking of critical incidents in the assisted living industry); *see, e.g.*, Iain Johnson, Note, *Gay and Gray: The Need for Federal Regulation of Assisted Living Facilities and the Inclusion of LGBT Individuals*, 16 J. GENDER RACE & JUST. 293, 306 (2013) (calling for federal regulation of assisted living facilities alongside protection for LGBT residents); Patrick A. Bruce, Note, *The Ascendancy of Assisted Living: The Case for Federal Regulation*, 14 ELDER L.J. 61, 83–85 (2006) (calling for federal assisted living regulation); Bowers, *supra* note 171 (naming several U.S. senators who, in 2018, indicated interest in pursuing and advocating for federal assisted living regulations).

222. *See* Lois A. Bowers, *Renewed Calls for Federal Regulation of Assisted Living Countered by Some in Aging Services*, MCKNIGHT'S SENIOR LIVING (June 24, 2019), <https://www.mcknightsseniorliving.com/home/news/renewed-calls-for-federal-regulation-of-assisted-living-countered-by-some-in-aging-services> [<https://perma.cc/K3SA-BNP9>] (“[R]egulation should stay where it is, at the state level, closer to the assisted living communities, [NCAL] spokeswoman Rachel Reeves told the newspaper. States, she said, ‘can see what is best for residents and deal with those issues.’”); A.C. Thompson, *Elderly, At Risk, and Haphazardly Protected*, PROPUBLICA (Oct. 29, 2013, 10:56 AM), <https://www.propublica.org/article/elderly-at-risk-and-haphazardly-protected> [<https://perma.cc/BNQ6-2EDH>] (“Assisted living, the industry maintains, should be about flexibility: the ability to tailor, state by state, community by community, the kinds of residential settings offered and the levels of care promised. Assisted living facilities can run the gamut from private homes converted to care for a handful of residents to more institutional facilities as large or larger than traditional nursing homes.”).

223. Bowers, *supra* note 222; Thompson, *supra* note 222; *see also* About NCAL, *supra* note 27 (introducing NCAL).

Medicare and Medicaid,²²⁴ the federal government does not currently have the economic motivation needed to implement the long overdue regulations for assisted living facilities.²²⁵ Additionally, beyond the lack of economic motivation, the federal government does not appear to have the requisite political appetite to enact such broadscale regulatory change.²²⁶ Supporting this assertion is CMS's response to the 2018 GAO report, in which it hesitated to make changes necessary to protect the assisted living community.²²⁷ Particularly, CMS largely ignored the GAO's second recommendation to clarify and enhance state reporting obligations for critical incidents.²²⁸ Should the federal government recognize that the assisted living facility industry is an industry that deserves attention, America's elderly population deserves heightened protection now—not several years down the road.

Lastly, the current interplay between CMS and state Medicaid agencies provides minimal assistance in the attempt to ensure assisted living facility resident health and welfare.²²⁹ CMS's unclear guidelines for state Medicaid agencies, and their delegation of oversight authority to other state agencies without appropriate notification procedures, further illustrates the inadequacy of federal regulation.²³⁰ The federal CMS HCBS waiver system, and the investigation of state assisted living facilities upon renewal of HCBS waivers, does not offer a system conducive to increased, effective federal regulation.²³¹

In sum, the states are in a better position to heighten regulation and oversight for assisted living facilities. Thus, states should enact legislation surrounding critical incidents and create or designate particular state agencies or oversight bodies to review critical incidents

224. See *supra* Part I.B (discussing in detail the limited federal government involvement in assisted living regulation due to Medicare and Medicaid hindrances).

225. Breslow, *supra* note 29 (explaining that the federal government takes a “see no evil, hear no evil, speak no evil” approach to assisted living regulation due to the lack of economic involvement in the industry); see also *supra* notes 51–62 (discussing how the federal government is unable to regulate assisted living under Medicare, unlike nursing homes, and has limited ability to regulate through Medicaid, as not all facilities receive Medicaid waivers).

226. Breslow, *supra* note 29.

227. See *supra* Part II.A (explaining in detail CMS's response to recommendations in the 2018 GAO report).

228. *Id.*

229. See, e.g., GAO REPORT 2018, *supra* note 11, at 23 (noting that states varied in their ability to provide data on critical incidents).

230. See *supra* Part I.C.2 (discussing investigating and reporting of state Medicaid agencies and CMS).

231. See *supra* notes 160–63 (discussing the HCBS waiver renewal period and CMS oversight).

to heighten protection for America's elderly population. The details of this proposal are discussed below.

B. STATES SHOULD ENACT LEGISLATION SURROUNDING CRITICAL INCIDENTS TO INCREASE ASSISTED LIVING FACILITY RESIDENT HEALTH AND WELFARE

This Section will outline the three major components states should include in assisted living facility legislation and regulation surrounding critical incidents to ensure resident health and welfare. In a sense, these recommendations advocate for state "uniformity" to the extent that uniformity is necessary to protect resident health and well-being. To clarify, these recommendations also allow for levels of state discretion to the extent that it is necessary for states to cater to their unique populations without sacrificing resident health and well-being.

First, this Section recommends that states should enact new, comprehensive definitions of "critical incidents" so designated state agencies or oversight bodies can better track and investigate threats to resident safety. Second, this Section suggests that states should enact regulations surrounding staff training for recognizing and reporting critical incidents. Third, this Section calls for increased state disclosure to the public regarding critical incident data, and other facility data relating to resident health and welfare, to allow prospective residents and families to distinguish between high- and low-quality facilities. Ultimately, this Section argues that these three changes will help combat elder neglect and abuse in assisted living facilities, thereby improving residents' health and well-being.

1. States Should Amend or Implement Official Definitions of "Critical Incidents"

Uncertainty of state definitions of "critical incident"²³² (at least with respect to the most severe critical incidents) presents a significant threat to America's assisted living facility population.²³³ Uniform categorization of the obvious "critical incidents," such as physical, sexual, and emotional abuse,²³⁴ does not do enough to monitor the increasing and ever-prevalent threat to assisted living facility residents. Namely, states should enact legislation to officially define the term

232. See *supra* Part I.C.1 (discussing states' differing conceptions of critical incidents).

233. See *supra* Part II.B.2 (discussing the threat that non-uniform conceptions of critical incidents pose to the assisted living facility community).

234. See *supra* note 94 and accompanying text (discussing uniform categorization of these critical incidents).

“critical incident” to include not only the uniformly accepted forms of elder abuse, but also other serious incidents that occur in assisted living facilities that may present threats to health and well-being. Without near-uniform state definition of the most serious critical incidents, assisted living facility residents will not have the protection of state oversight of incidents any reasonable consumer would consider to be “critical.”

Opponents of this recommendation may argue that classifying all incidents in assisted living facilities, as mentioned in the 2018 GAO report,²³⁵ would result in an overflow of reporting and investigative duties for the responsible state agency, thereby resulting in decreased attention on the most serious incidents and decreased accountability for already low-quality assisted living facilities. To address this concern, states should implement a tiered approach to classifying critical incidents. However, even with this approach, the unavoidable increase in reporting and investigative duties for the responsible state agencies is necessary to protect America’s elderly population.

Particularly, states should classify critical incidents into two categories. The first category is incidents that resulted or are very likely to result in substantial harm to resident health and welfare. This category would require an automatic proposed label of “*critical incident for immediate state investigation*,” which should initiate priority review by the designated state reporting and investigative agency. Incidents in this category are physical abuse, sexual abuse, emotional abuse, unexplained death, unauthorized use of seclusion, unauthorized use of restraints, injuries resulting in hospitalization, missing residents, police or doctor referral to Adult Protective Services, and threat or attempt of suicide.²³⁶ Currently, most states already classify these incidents as “critical;”²³⁷ however, all states should ensure these incidents are included in their definitions.

The second recommended category includes incidents that indicate a substantial likelihood of harm to resident health and welfare if they occur more than once in a short time span or if they are not correctly addressed. This category would require a preliminary label with proposed language of “*critical incident requiring immediate facility monitoring*,” which should put facilities on high alert of potential harm to resident health and well-being. Examples of incidents in this

235. GAO REPORT 2018, *supra* note 11, at 34.

236. See *supra* notes 95–96 and accompanying text (discussing these incidents in the 2018 GAO report).

237. GAO REPORT 2018, *supra* note 11, at 25 fig.4 (showing that between two and seven states do not classify one of these as a “critical incident”).

category are minor injuries not requiring medical attention, discharge and eviction from the facility, physical infrastructure issue, medication errors, suspected criminal activity by provider, and injuries needing medical attention (but not hospitalization).²³⁸ As discussed, states vary significantly on whether these are classified as “critical incidents.”²³⁹ Important to note, under this tiered approach, these incidents are still classified as “critical” and states should still require reporting to the responsible state agency.

Despite their classification as “critical,” this second tier of incidents are a step down from “critical incident for immediate state investigation” and instead require strict monitoring by the individual facility to ensure internal investigation and corrective action is taken. If these incidents occur more than once in a short time frame, suggesting abuse or neglect of residents, they should be elevated to “critical incident for immediate investigation” status, which would then trigger review by the state agency or oversight body. These incidents have a seemingly lower risk of harm to resident health and welfare and may often be the result of an accident or a misunderstanding. However, that is not to say that these incidents cannot cause significant harm to resident health and welfare if they are not rectified or if they present as repeated incidents.²⁴⁰ Thus, initially classifying them as “critical incident requiring immediate monitoring” gives the facility the opportunity to conduct an internal investigation before they are elevated to “critical incident for immediate state investigation” status.

As discussed *infra*, state classification of these lower-risk (second tier) incidents may vary slightly depending on states’ respective populations. Additionally, states may vary with the history of their assisted living facilities that operate within the state, and some states may want to protect against particular incidents more than others. Because of this discrepancy, states should exercise discretion on these lower risk incidents and have authority on whether to classify them as critical or not. Further, discretion will allow states room to negotiate within the legislature to enact legislation surrounding lower-risk incidents.

In order for states to effectively monitor facilities that designate incidents as “critical incident requiring immediate facility

238. See *supra* note 96 and accompanying text (discussing these incidents in the 2018 GAO report).

239. GAO REPORT 2018, *supra* note 11, at 42 tbl.10 (stating between seven and thirty-one states do not classify one of these as a “critical incident”).

240. See, e.g., *supra* note 186 and accompanying text (discussing the risks an incident such as a medication error may present to an assisted living facility resident).

monitoring,” states must implement adequate tracking programs.²⁴¹ Particularly, states need systems that distinguish between provider types and track data such as types of incidents, frequency of incidents, the resident involved, staff member involved, and corrective action taken.²⁴² Currently, many state tracking systems fall short of these capabilities.²⁴³ By investing the resources to implement these systems, state agencies will be able to track critical incidents through the tiered approach and increase safety and accountability in assisted living facilities. There will likely be pushback against this solution due to both the current unregulated nature of assisted living facilities and the cost of developing and maintaining a database of this caliber. However, the importance of this oversight tool to assisted living facility resident health and well-being far outweighs the slight increase in cost.

As mentioned, despite the undoubted increase of responsibility on state agencies, states’ efforts to officially define critical incidents and the implementation of this tiered approach to handling critical incidents will draw the necessary attention to critical incidents and hopefully improve the safety and quality of assisted living facilities.

2. States Should Require Increased Staff Training Surrounding Critical Incidents

To implement an effective tiered approach to critical incident definitions, states must rely on assisted living facility staff to recognize and report such incidents. While some states explicitly require staff training on abuse and neglect, it is not the norm.²⁴⁴ States should implement regulations requiring that assisted living facility direct care staff be trained on recognizing, reporting, and preventing abuse and neglect among residents. All states should require training immediately upon hire and annually thereafter for all assisted living facility personnel that have direct patient contact.²⁴⁵ States should strive for eighty hours of training upon initial hire, which is what the state of

241. See *supra* Part I.C.2 (discussing inadequate state tracking systems revealed in the 2018 GAO report).

242. See *supra* notes 98–101 and accompanying text (listing these components as inadequacies of many states’ critical incident tracking systems).

243. *Id.*

244. MOLLOT ET AL., *supra* note 121 (noting that several states, including Alabama, Louisiana, Kansas, and Pennsylvania, all require staff training on certain critical incidents); COMPENDIUM OF RESIDENTIAL CARE, *supra* note 110 (discussing the variety of ways states approach training requirements, including enumerating specific topics).

245. COMPENDIUM OF RESIDENTIAL CARE, *supra* note 110; see *supra* note 117 and accompanying text (presenting data that forty states have orientation training requirements, and forty states have ongoing training requirements).

North Carolina requires.²⁴⁶ Similar to North Carolina, states could combine classroom instruction and practical experience training and mandate a comprehensive evaluation upon completion of the program.²⁴⁷ Additionally, states should specify minimum annual hourly requirements for staff training.²⁴⁸ Similar to Oklahoma, Montana, Pennsylvania, Virginia, and Wyoming, states should strive for at least sixteen hours of continuing education training per year.²⁴⁹ States can tailor their respective continuing education requirements to focus on their unique populations and problem areas. For example, if a particular facility had frequent critical incidents of medication errors, the facility could ensure that the continuing education training reiterates the protocol for medication administration. Then, to ensure that the staff understands the protocol, the facility could require staff to pass training modules or treat fictional patients. With these recommendations, states can be sure that facilities and staff are regularly reminded and educated on how to prevent future neglect and abuse. Through implementing these regulations, states will surely draw attention to critical incidents and decrease the rate at which they occur.²⁵⁰

Unfortunately, heightening state regulation surrounding staff training will impose increased costs on both the state and assisted living facilities which, in turn, may be passed onto the residents. This would make assisted living facilities less affordable to individuals who need it. To address this issue, states should retain discretion on how many initial and ongoing training hours assisted living facilities are required to provide to staff. This way, states can consider the reputation of the assisted living facilities within the state and determine, for their respective populations, the amount of staff training necessary to protect the states' elderly residents.

However, a slight increase in cost is likely still unavoidable if all states promulgate regulations that require both initial and ongoing staff training. Notwithstanding this, states should still require heightened direct care staff training. The benefit of adequately trained direct care staff equipped to prevent and report elderly abuse and neglect far outweighs slight increased cost.

246. See *supra* note 117 and accompanying text.

247. *Id.*

248. *Id.* (presenting data to suggest that states vary significantly with the number of hours required for initial training and ongoing training, with initial training ranging from one to eighty hours, and ongoing training ranging from unspecified to sixteen hours).

249. *Id.*

250. Kaskie et al., *supra* note 198 (explaining the correlation between states with specific training policies and increased quality of care).

3. States Should Require Public Disclosure of Critical Incident and Other Facility Related Data

Even after implementing regulations detailing a comprehensive definition of “critical incident” and requiring staff training on critical incidents, states have a duty to the public to ensure important facility information is disclosed.²⁵¹ Namely, states should give prospective assisted living facility residents and their families the resources to effectively evaluate the quality of a facility before making the hugely important decision on where to spend the remainder of their lives.²⁵² With access to critical incident data, such as the type, frequency, and corrective action taken, prospective and current residents will be able to determine the quality of facility they are, or may be, living in. Similarly, public access to information such as staff training will hold facilities accountable and reassure residents of the facility’s awareness of critical incidents.

Moreover, states should disclose other facility information influencing the safety and quality of assisted living facilities. Specifically, states should implement legislation and regulations that require disclosure of facility inspection results, complaints and grievances of family members and residents, staffing ratios, staff training requirements, facility pricing, facility ownership information, and whether the state has fined the facility for public health, building code, or various other violations.²⁵³

Finally, state agencies should work on creating a state-run website or database where facility information is easily accessible to individuals who seek it. An easily accessible site is one that has, at minimum, a searchable PDF.²⁵⁴ As discussed previously, there are currently only thirty-four states that have this feature.²⁵⁵

251. Hawes & Phillips, *supra* note 202 (listing different qualities and services people search for in assisted living facilities to fulfill their personal preferences). *Contra* Breslow, *supra* note 29 and accompanying text (discussing the “tall, thin blonde” problem of the assisted living facility industry).

252. See Breslow, *supra* note 29; *supra* note 214 and accompanying text (noting that individuals have very few resources to determine the quality of assisted living facilities, especially in comparison to nursing facilities).

253. See *supra* note 140 (discussing a few of the listed criteria).

254. See *supra* notes 138–43 and accompanying text (providing statistics on the number of states that did and did not have searchable databases). States with searchable databases were ranked as “high” or “exceptional” for disclosure rates, *id.*, which should be a goal for the assisted living industry.

255. *State Guide to Assisted Living Records & Reports*, *supra* note 136 (listing thirty-four states as “high” or “exceptional,” meaning that they publish a searchable database).

Unsearchable documents and requiring FOIA requests in order to obtain information on a particular facility is a level of concealment that states should prohibit among assisted living facilities due to the hindrance it puts on the public's ability to assess facility quality.²⁵⁶ Ideally, states should organize a website for prospective and current assisted living facility residents to compare assisted living facilities. In particular, states should maintain facility records in a searchable PDF format. Even better, states should expand these searchable PDF facility ratings to model the resources of Arizona, Ohio, and North Carolina²⁵⁷ through the use of a five-star uniform rating or ranking system similar to the one used for skilled nursing facilities.²⁵⁸

The above recommendations for new state legislation present a common issue: the necessity of attention from state legislatures as well as an increased expenditure of funds dedicated to regulating assisted living facilities. Reiterated, states will require increased funding for maintaining an oversight authority to review critical incidents, implementing facility staff training programs and requirements, and developing a public disclosure resource for facility data. It is to be expected that the political appetite and availability of state funding for these recommendations will vary greatly by state. For example, states with high percentages of elderly populations, such as Florida, Maine, West Virginia, and Vermont, may have greater ambition for this type of legislation than states with lower percentages of elderly populations, such as Alaska, Utah, Washington, D.C., and Texas.²⁵⁹ On a related note, jurisdictions that have high elderly poverty levels, such as Washington, D.C., Louisiana, and Mississippi, may have different motivations and considerations than states with low elderly poverty levels, such as Alaska, Connecticut, and New Hampshire.²⁶⁰ Lastly, state demographics differ on the number of elderly residents with self-care

256. *See id.*

257. *See supra* notes 132–34 and accompanying text (discussing Arizona, Ohio, and North Carolina's assisted living facility rating systems); *Adult Care Licensure Section*, *supra* note 208 (linking North Carolina's website on inspections of adult care facilities).

258. *See supra* note 123 (discussing CMS's "Five-Star Rating System" for nursing facilities).

259. ARI HOUSER, WENDY FOX-GRAGE & KATHLEEN UJVARI, AARP PUB. POL'Y INST., *ACROSS THE STATES: PROFILES OF LONG-TERM SERVICES AND SUPPORTS*, at A-10 (2018), <https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf> [<https://perma.cc/LB8C-5CN5>] (breaking down state populations by age).

260. *Id.* at A-21.

difficulties²⁶¹ or cognitive impairments,²⁶² which will also influence state legislature considerations when deciding whether to enact the above-recommended legislation and regulations surrounding assisted living facilities and to what extent.

Unfortunately, because this Note recommends regulation at the state level, there is not an authority that can punish states for noncompliance. However, these recommendations offer flexibility when possible, such as the definition of “critical incident” and state training requirements and topics, so states can tailor regulations to the specific needs of their populations and demographics. By encouraging states to tailor legislation to their own populations, the hope is that state legislatures can accomplish the most critical parts of these recommendations for their own respective populations to ensure the safety and well-being of elderly Americans. Additionally, as states begin to enact legislation surrounding critical incidents, staff training, and public disclosure of facility data, advocacy groups including the National Center for Assisted Living,²⁶³ Long Term Care Community Coalition,²⁶⁴ and A Place for Mom²⁶⁵ will continue to track and draw attention to state dedication (or lack thereof) to ensuring elderly health and well-being. This reality of social pressure could also help persuade states to enact the above-recommended legislation and regulations. Lastly, these recommendations are extremely timely for state legislatures, as the COVID-19 pandemic²⁶⁶ has drawn enormous attention to assisted living and nursing home facilities and the need to protect America’s elderly population.²⁶⁷

261. Mississippi, California, and West Virginia have the highest percentage of people over the age of 65 with self-care difficulties, while Colorado, New Hampshire, and Montana have the lowest. *Id.* at A-22.

262. Mississippi, West Virginia, and Alabama have the highest percentage of people over the age of 65 with cognitive difficulties, while Minnesota, North Dakota, and Vermont have the lowest. *Id.* at A-23.

263. See *supra* note 27 (discussing the National Center for Assisted Living).

264. See *supra* note 28 (discussing the Long Term Community Care Coalition).

265. See *supra* note 135 (discussing A Place for Mom).

266. *Coronavirus (COVID-19)*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/coronavirus/2019-ncov/index.html> [<https://perma.cc/8GTC-GYGZ>] (explaining facts, symptoms, and considerations regarding the COVID-19 pandemic).

267. See, e.g., *Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 29, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html> [<https://perma.cc/W2TH-T8Z6>]. But see Andy Markowitz, *AARP Answers: Nursing Homes and the Coronavirus*, AARP, <https://www.aarp.org/caregiving/health/info-2020/nursing-homes-coronavirus-faqs.html> [<https://perma.cc/69Q8-QR5C>] (Sept. 2, 2020) (“[T]he CMS rules on disclosing [nursing home] COVID-19 cases to residents and family members

CONCLUSION

Assisted living facilities are on a steady incline of increasing popularity. Despite industry growth, adequate regulations to monitor and protect the vulnerable consumers of the industry have not followed. The alarming 2018 GAO report is the tip of the iceberg with respect to the number of elderly people suffering from abuse and neglect in assisted living facilities.

This Note advocates for state legislation and regulation of assisted living facilities through the lens of critical incidents. With development of state legislation and regulation of assisted living facilities, states can eliminate the threat of abuse and neglect among residents. Namely, this Note calls for state legislatures to: (1) enact tiered definitions of “critical incidents,” with differing oversight efforts given to each tier, (2) require initial and ongoing staff training requirements for direct care workers addressing abuse and neglect, and (3) increase requirements for public disclosure of facility information. This proposal is not only a viable option for states, it is the best option to protect America’s elderly population due to the lack of federal action and states’ unique understanding of the populations that they serve. Assisted living facility legislation and regulation must be improved to reflect the devastating reality of increasing elder abuse and to protect our loved ones from an industry ill-equipped to look out for their health and well-being.

do not apply to assisted living facilities. They are licensed by the states, many of which have not issued disclosure orders, and regulation varies by state.”).