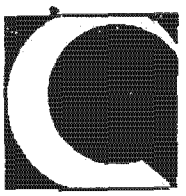
Adult Homes Serving Residents with Mental Illness:
A Study of Conditions, Services, and Regulation

A Report



by the New York State Commission on Quality of Care
for the Mentally Disabled
and the Mental Hygiene Medical Review Board

Clarence J. Sundram

Irene L. Platt
James A. Cashen
COMMISSIONERS

October 1990

PREFACE

Adult homes licensed by the Department of Social Services (DSS) are the largest single congregate residential option in the community for people with mental illness. With approximately 9,000 of the 25,000 beds in adult homes serving this population, they play a larger role than residential programs certified by the Office of Mental Health (OMH) like supervised community residences (3,881 beds), Residential Care Centers for Adults (620 beds), supported apartments (1,794 beds), and family care homes (2,828 beds).

Although intended primarily to provide residential services, personal care and supervision for the frail elderly, adult homes have also served patients discharged from psychiatric hospitals, many of whom are also frail and elderly. In recent years, a greater number of younger patients discharged from psychiatric hosptials in urban areas have been placed in adult homes, usually because other housing alternatives, including OMH-sponsored community residences and apartments, are not available to them.

Such placements have occurred as psychiatric hospitals struggle to avoid overcrowding by discharging patients who have been stabilized. The pressure under which psychiatric hospitals operate, and the high demands for admission,* prompt discharges into adult homes, often with insufficient scrutiny of whether such homes are "adequate and appropriate" settings (MHL Sec. 29.15) in which to meet the needs of the discharged patient for safe housing, personal care, supervision, and access to ongoing treatment and psychiatric rehabilitation.

This study of adult homes serving significant numbers of residents with mental illness was requested by the legislature to examine not only the conditions in such homes but also whether laws governing the regulation and inspection of these homes by DSS and OMH, enacted a decade ago, are being appropriately implemented.

As documented in this report, in the course of the study the Commission found many adult homes that provided adequate and, at times, exemplary care and supervision for their residents, at a modest cost (19 homes serving 21 percent of the sample population). At the same time, we found a significant number of homes (14 homes serving 45 percent of the sample population) with seriously deficient conditions that adversely affected the day-to-day living conditions, safety, supervision and health of the residents.

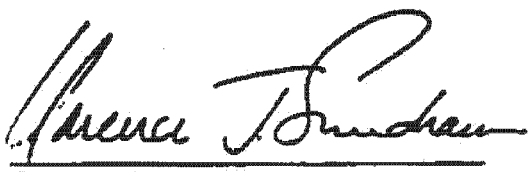
**Admission and Discharge Practices of Psychiatric Hospitals: A Report to the New York State Legislature Pursuant to Chapter 50 of the Laws of 1987*, NYS Commission on Quality of Care, April 1988.

As this latter part of the adult home industry exists at present, it does not serve the interests of the residents who live in deplorable conditions. These residents, often suffering from mental illness and other infirmities, are too afraid of jeopardizing their "home" to complain, and often lack advocates to forcefully and effectively press their concerns. They must rely upon state regulatory agencies to ensure that operators provide them with care and services that meet minimum standards. However, as the Commission found, the existing regulatory structure does not consistently provide such an assurance. In many instances, the seriously deficient conditions observed by Commission staff had existed for some time and had been cited by DSS inspectors during their visits, but had remained uncorrected or had recurred repeatedly.

The conditions in these homes will not change without a significant change in the effectiveness of enforcement of the laws and regulations already on the books. The Commission believes that this requires a strong commitment from both OMH and DSS to the correction of entrenched problems that have persisted in the decade since the enactment of the legal reforms. In particular, the Commission believes that the long-term viability of adult homes serving significant numbers of residents with mental illness is contingent upon more consistent assurances that the needs of patients discharged from psychiatric hospitals can be met with the level of care provided by adult homes. Equally important, appropriate and effective outpatient mental health services must be available to meet their needs for treatment and psychiatric rehabilitation.

The Commission is gratified to note that, following the circulation of a draft of this report to OMH and DSS, a Task Force on Enforcement, convened and chaired by the Deputy Secretary to the Governor for Human Services, has been formed to coordinate agency efforts to correct the deficient conditions at the adult homes with the most serious problems. The Commission will be participating actively with OMH and DSS in this effort.

The findings, conclusions and recommendations contained in this report represent the unanimous opinions of the members of the Commission. A draft of this report has been reviewed by DSS, OMH and the State Office for the Aging. Their responses to our recommendations are appended to the report.



Clarence J. Sundram
Chairman

Irene L. Platt
Commissioner

James A. Cashen
Commissioner

ACKNOWLEDGEMENTS

The assistance of many persons and agencies were critical to the Commission's completion of this study. Throughout the course of the study, the Commission received the cooperation of the Division of Adult Services of the Department of Social Services. The Division made available information that was requested by the Commission, entered into a memorandum of understanding to facilitate the gathering of data directly from the homes, and interceded promptly to resolve the few problems with access to the homes as they arose.

The Commission is also grateful to the operators, staff, and residents of adult homes who accommodated our visits, answered our questions, and generally helped us to understand both the strengths and the limitations of adult homes serving persons with mental illness. The Commission would especially like to thank the number of long-time advocates for persons in adult homes, including representatives of the Coalition for the Institutionalized Aged and Disabled and Mobilization for Youth Legal Services, for their insights and for their assistance in arranging informal forums for the Commission with residents of adult homes.

STAFF

Project Directors

Nancy Ray, Ed.D., Walter Saurack, Betty Jane Chura
Thomas Harmon, Marcel Chaine

Research Coordinators

Victoria Rinere, Karen Myers, Pamela Finton,
Gerald Montrym, Sylvia Wheeless

Counsel Staff

Paul Stavis, Jerry Luhn

Fiscal Analysts

John Rybaltowski (Coordinator), Michael Kester,
Richard Cicero, Michael McCarry, Robert McCausland,
Robert Myers, Anne Salemme

Site Visit Team Leaders

Crystal Bass, Mindy Becker, Barbara Beebe,
Stephen Hirschhorn, Cheryl Ouimet, Harriet Rubenstein,
Natalie Russo, Laurie Trojnor

Site Visit Staff

Gladys DeJesus-Aponte, Raymond Barron,
Anne Budin, William Combes, Catherine Frangella,
Jacqueline Garcia, Leslie Gleaner, Loretta Goff,
Debra Johnson, Mark Keegan, Paul LaFleur,
Robert Melby, Katherine McCormick,
Corinne Romanotto, Kathy Serino,
Pat Sherman, Janet Uhlin, Laura Woodward,
Robin Worobey, Victoria Zambardino

Support Services

Kathleen Runkle and Joyce Salazar (Publishing Editors),
Gail Fetsko, Geraldine Kirpens, Sylvia McLemore,
Joanne Miecznikowski, Linda Peterson, Leon Robinson

TABLE OF CONTENTS

LISTING OF FIGURES

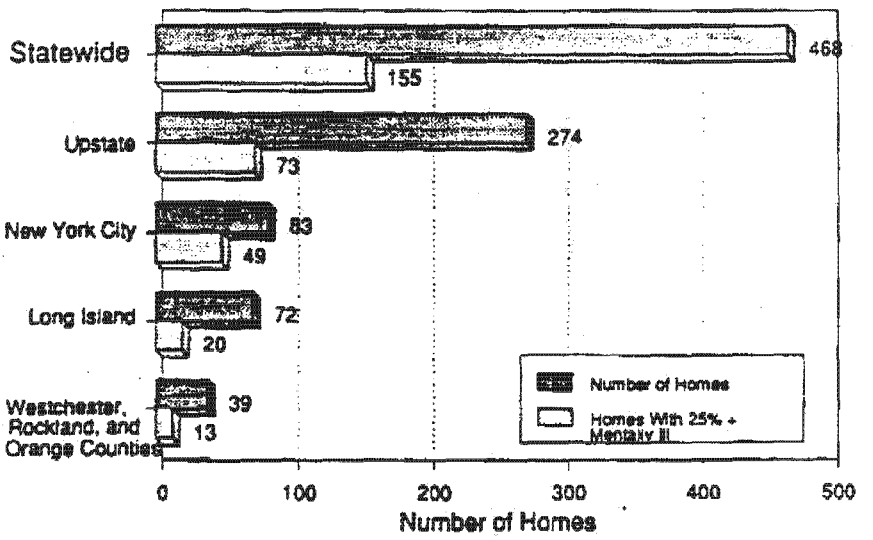
LISTING OF FIGURES
(Continued)

Introduction

In the wake of reports by Special Prosecutor Charles Hynes on conditions in adult homes,* the Legislature enacted Chapter 669 of the Laws of 1977. Recognizing the special needs of the residents with mental disabilities in these homes, this law requires the joint visitation and inspection by both the Department of Social Services and the then Department of Mental Hygiene of adult homes in which a significant number of residents have a mental disability. It also allows the Department of Mental Hygiene to propose supplementary standards for these homes. In September 1978, the Department of Social Services promulgated regulations (18 NYCRR §485.5) which further authorized the Offices of the Department of Mental Hygiene, including the Office of Mental Health, to carry out these responsibilities.

In the spring of 1989, the Legislature asked the Commission to review such adult homes and the effectiveness of the implementation of this program of joint visitation and inspection by the Department of Social Services and the Office of Mental Health in regulating and monitoring these programs. As a backdrop to this request, it is important to point out that adult homes are a major supervised housing resource for persons with mental illness in New York State. (Figure 1) As of July 1989, approximately 155 of the 468 adult homes statewide report that at least 25 percent of their resident population have a significant mental illness.**

Figure 1: Number of Adult Homes in NYS Serving Many Persons With Mental Illness



*_Private Proprietary Homes for Adults, An Interim Report_, Charles J. Hynes, Deputy Attorney General, March 31, 1977.

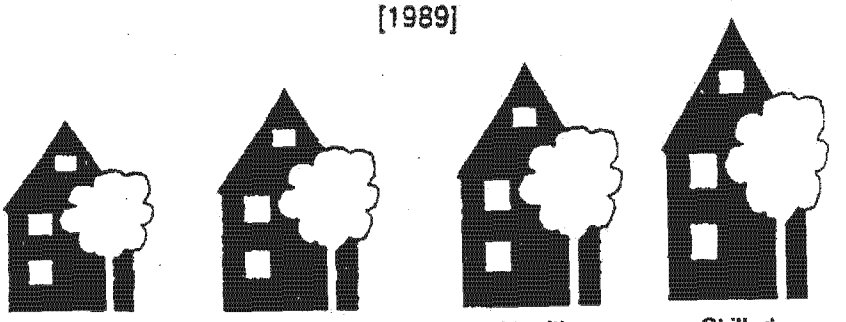
Private Proprietary Homes for Adults, Charles J. Hynes, Deputy Attorney General, March 31, 1979.

**The July 1989 _DSS Congregate Care Facility Directory_ identifies 155 adult homes whose resident population includes at least 25 percent persons with mental illness. In 1988 DSS reported data indicating that 150 adult homes statewide met this criteria. As most fiscal data presented in the report covers the period 1986-1988, the most recent period for which financial data were available, these sections of the report focus on these 150 homes, and especially the 147 of these homes where financial statements were available.

From another perspective, the nearly 9,000 persons with mental illness living in adult homes statewide comprise over one-third (36 percent) of the total 25,000 residents of adult homes. By comparison, approximately 9,500 persons with mental illness are afforded supervised residential care in the Office of Mental Health's community residence, apartment, and family care programs.

It is also important to note that funding for adult homes, limited to the residents' Supplemental Security Income (SSI), Social Security Disability (SSD), Home Relief (HR), and Social Security Assistance (SSA) payments, is markedly lower than for other publicly subsidized supervised facilities, like nursing homes, health related facilities, and the Office of Mental Health community residences. The standard SSI amount for the support of a resident in an adult home for one year is approximately $8,500;* for a resident in a community residence for the mentally ill for a year, public funding is approximately $24,300. The public costs of care in health related facilities and skilled nursing facilities are even higher at approximately $27,800 and $43,000 annually per resident, respectively. (Figure 2) While many adult homes serving persons with mental illness often have few private-pay residents, the Department of Social Services' data indicate that only 10 percent of the residents in these homes are private-pay residents.

Figure 2: Average Annual Per Resident Public Funding to Supervised Residential Care Settings*
[1989]



*Public funding excludes residents' personal allowance.

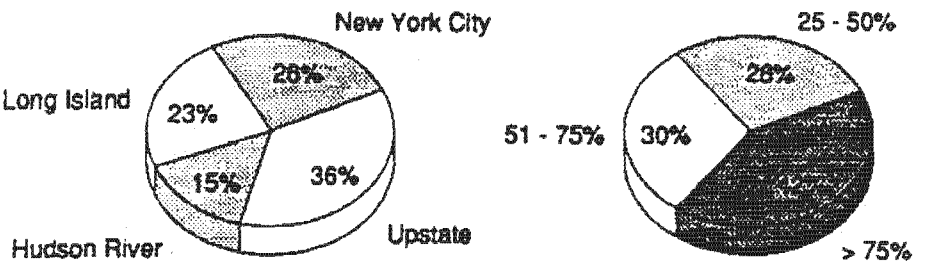
*As of January 1, 1990, an individual residing in an adult home in New York City, Nassau, Suffolk and Westchester Counties is entitled to a yearly Supplemental Security Income (SSI) benefit of $9,852, and in the rest of the State, $9,492. Of these respective amounts, the adult home operator receives $8,832, or $8,472 for residential care, and the resident receives $1,020 ($85 per month) allowance for his/her personal needs. The public portion of SSI payments may be reduced by "countable income" received by a recipient during any calendar quarter from earnings or unearned sources (e.g., public or private pensions), but the home receives such income up to the standard SSI amount. Homes may also receive payments above the SSI amount from "private-pay" residents who have income or resources that make them ineligible for SSI benefits.

Methods

Consistent with their lower level of public funding, the expectations and requirements imposed upon adult homes are different and generally less demanding than upon facilities with higher levels of reimbursement. Unlike skilled nursing facilities, health related facilities and community residences, adult homes are not a treatment facility and are required neither to have a professional staff (e.g., nurses, psychologists, therapists, etc.), nor to provide nursing, medical, or habilitative services. Rather, they are expected to provide room and board, limited personal care, case management and supervision, and assistance to residents in attending to their own needs and in accessing and using appropriate community services.

The Commission made unannounced inspections to 47 of the 155 adult homes which serve many residents with mental illness. This sample of 47 adult homes represented a diverse group of small, medium, and large homes, and homes located in cities, in suburban neighborhoods, and in rural areas. The Commission also shaped its sample to be geographically representative, including more homes downstate, where adult homes serving the largest numbers of persons with mental illness are located. We also visited homes which almost exclusively served persons with mental illness and others which served a more integrated population. (Figure 3) During these inspections, Commission staff reviewed living conditions and services for residents. Photographs were taken to document observations and, where appropriate, the consent of residents was obtained. Additionally, written reports of the Commission's findings for each adult home studied were prepared and sent to the appropriate officials within the Department of Social Services and the Office of Mental Health, as well as to the adult home operators.

Figure 3: Characteristics of Adult Homes Visited [N=47]



During the on-site visits, the Commission also interviewed 144 mentally ill residents in these homes and reviewed their records, a random sample assuring a 90 percent statistical confidence level. Data related to the medical and mental health services afforded to these residents, as well as their daily living skills and social rehabilitation needs, were also obtained from interviews with the adult home administrator and/or other responsible staff persons in the homes.

From a fiscal perspective, financial statements for homes serving many residents with mental illness were requested, and available reports from 147 of these homes were obtained to examine the profitability, costs, and staffing of adult homes. The Commission also analyzed balance sheets for 20 of these homes to obtain a fuller understanding of the "profitability" of adult home operations with particular attention to the equity the operators had invested in the homes.* Additionally, fiscal staff conducted on-site reviews of financial records at ten adult homes to determine the reliability of the financial reports submitted.

Who Lives in Adult Homes?

The Commission recognized that fundamental to assessing the performance of adult homes serving many persons with mental illness was an understanding of the level of assistance, supervision, and services these individuals require. State regulations for adult homes, as well as public funding levels for these homes, assume that their residents are in need of basic custodial care, some assistance with personal care, moderate supervision and the support of appropriate community services, but that they are not in need of the more intensive services provided by the more expensive supervised models of care offered by the state, including mental health community residences, health related facilities, and skilled nursing facilities.

The Commission's sample of 144 persons with mental illness living in adult homes revealed that, while a diversity of men and women with mental illness reside in adult homes, both young and old, a significant percentage of these persons were substantially dependent on staff to perform daily living tasks and to obtain needed medical and mental health services.

---

*Pursuant to New York Social Services Law, §461-e, financial statements setting forth information pertaining to the operations of adult homes, including revenues, expenditures and other data, must be submitted each year to the Department of Social Services. Of the 150 homes whose resident population in 1988 included at least 25 percent persons with mental illness, three homes failed to submit financial statements during the three-year period. Balance sheets recording homes' assets, liabilities and operators' equity are not required to be filed, but the Commission requested these statements from the 47 homes in the site visit sample. Twenty (20) of the operators complied with this request.

SELECTED RESIDENTS* OF THE ADULT HOMES

Jack Canter is 62 years old, and he has been a resident of an adult home for eight years. Prior to this admission, Mr. Canter had been hospitalized in a state psychiatric center for approximately four years. Mr. Canter has a psychiatric diagnosis of schizophrenia, paranoid, chronic with acute exacerbations, and currently he is being treated with the psychotropic medication Moban. Reportedly, Mr. Canter has a fixed delusional system which causes him to be disoriented to time and place. Additionally, Mr. Canter suffers from several medical conditions including seizures, ulcerated legs, and arteriosclerotic heart disease. Due to his medical conditions, at times, Mr. Canter requires staff assistance to ambulate. According to adult home staff, Mr. Canter can be verbally abusive toward others. Adult home staff also reported that Mr. Canter has been awaiting placement in an HRF/SNF since February 1989.

Mildred Johnson is 82 years old and she has been a resident of an adult home for nine years. Prior to this admission, Ms. Johnson had been hospitalized in a state psychiatric center for over 35 years. Ms. Johnson is diagnosed as having schizophrenia, catatonic, in remission, and currently she is not being treated with psychotropic medication; however, she does attend a geriatric mental health program. Medically, Ms. Johnson suffers from anemia and hypertension.

George Edwards is a 57-year-old mildly retarded man and he has been a resident of an adult home for six years. Prior to this admission, Mr. Edwards lived at home with his mother. Since his admission to an adult home, Mr. Edwards had to be hospitalized in a state psychiatric center for a period of 35 days and was diagnosed as having atypical psychosis. Currently, Mr. Edwards is being treated with the psychotropic medication, Mellaril; however, adult home staff report that Mr. Edwards frequently refuses to take his medication. Reportedly, Mr. Edwards has poor personal hygiene skills, is assaultive toward others, and exposes himself. Mr. Edwards' careless smoking habits also reportedly pose a fire hazard to the home's residents and staff. At the time of the Commission's review, Mr. Edwards was being referred to a community residence. If this referral was not successful, the adult home administrator stated that he may be evicted from the home.

Joanne Day is 50 years old and she has been a resident of an adult home for approximately four years. Prior to this admission, Ms. Day lived with her husband in their own home. Ms. Day is diagnosed as having schizophrenia, paranoid type, and she is being treated with the psychotropic medication, Haldol. Reportedly, Ms. Day participates in both on-site and off-site recreational/leisure activities, and she regularly receives mental health services from the on-site mental health program. According to adult home staff, Ms. Day is fairly independent; however, she requires assistance with her personal hygiene care.

Daryl Tucker is 28 years old, and he has been a resident of an adult home for approximately four years. Mr. Tucker carries a joint diagnosis of schizotypal personality disorder and attention deficit disorder, and he is being treated with the psychotropic medications, Mellaril and Klonopin. Reportedly, Mr. Tucker has poor personal hygiene skills, exhibits bizarre and ritualistic behavior, and is an episodic alcohol abuser. According to adult home staff, several agencies have been involved in attempts to assist Mr. Tucker with his problems without success.

Arlene Davis is a 50-year-old articulate woman, and she has been a resident of an adult home for approximately two years. Prior to this admission, Ms. Davis lived independently in her own apartment. Ms. Davis has a psychiatric history of chronic depression and recurring psychosis, and she periodically hallucinates and evidences delusional thinking. Ms. Davis is currently being treated with the psychotropic medication, Haldol, and she attends off-site mental health clinic services. According to adult home staff, Ms. Davis spends her entire day in the home, but she will participate in several on-site groups during the week.

*All resident names have been changed to protect their confidentiality. Residents reflect a cross section of the residents in the Commission's sample.

Approximately two-thirds of the population was over 55 years of age, although the significant minority of younger residents under 35 (8 percent) often stood out to the casual visitor. Additionally, residents with mental illness in downstate homes tended to be significantly younger than residents of upstate homes. Whereas 39 percent of these residents in downstate homes were under 55, only 18 percent of these residents in upstate homes were under 55.

Almost all residents in the sample carried a major psychiatric diagnosis, and while few had signs or symptoms of acute psychiatric illness (e.g., a recent suicide attempt, dangerous or bizarre behavior, hallucinations, etc.) at the time of the Commission's review, more than one in three residents had been hospitalized for a psychiatric condition in the past two years. Additionally, all but a few residents were receiving at least one psychotropic medication and some outpatient mental health services to treat their ongoing mental illness. (Figure 4)

Nearly three-fourths of the residents (72 percent) in the sample also had a concomitant medical condition, including hypertension, heart disease, respiratory disease, diabetes, and genitourinary/gastrointestinal disorders. Most of these residents were scheduled to see a physician at least monthly, and the majority were also receiving medications for their medical condition(s). In contrast, reportedly only 5 percent of the residents in the sample currently had an alcohol or drug abuse problem, largely because most operators of adult homes refused admission to individuals with such problems.

Figure 4: Clinical Characteristics of Persons With Mental Illness Living in Adult Homes [N=144]

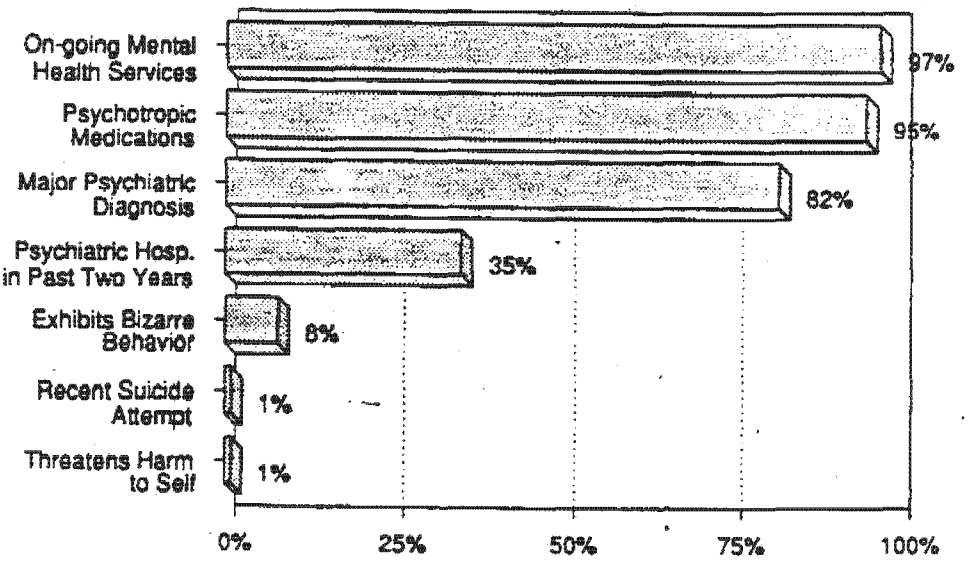
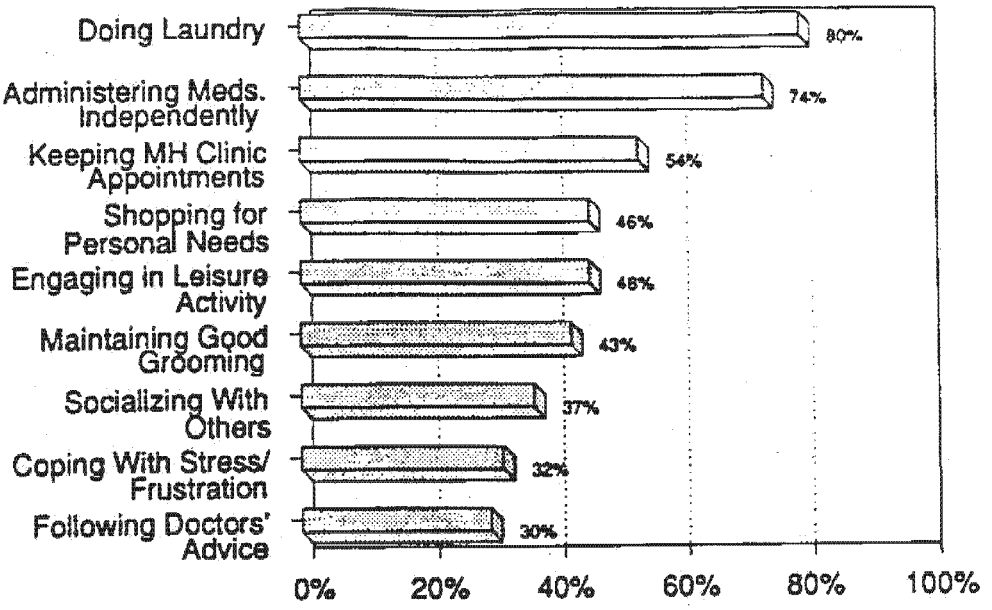


Figure 5: Skill Deficits of Persons With Mental Illness Living in Adult Homes [N=144]



The data also showed that most persons with mental illness living in adult homes had not lived independently for a number of years. Overall, 69 percent of the residents sampled had lived in the adult home for at least three years, and only 6 percent of the residents had resided independently immediately prior to moving to the adult home. More than half of the sample (54 percent) had previously been on an inpatient psychiatric unit, while another 27 percent had previously lived in another supervised care setting, like another adult home, a family care home, a community residence, or a health care facility.

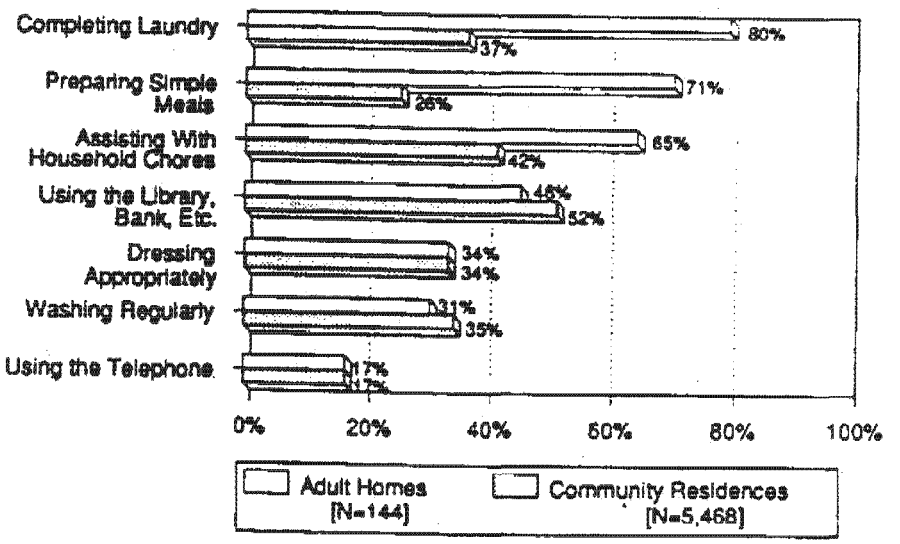
According to adult home staff, many of the residents in the sample also had deficits in basic personal care skills, like doing laundry, shopping for personal needs, and maintaining a good personal appearance. Over one-third of the residents were also described as having problems using community resources, managing their money, and advocating for their own needs. Most residents also required assistance with administering their own medications, keeping their mental health clinic appointments, and/or following through on doctors' advice. Many also had difficulty engaging in leisure activities, socializing with others, or coping with stress or frustration. Notably, in some cases it was not possible to determine whether the residents' difficulties in these areas were perpetuated because they had little opportunity to utilize these skills in the adult homes where they lived. (Figure 5)

By design, a part of the Commission survey tool used to review the 144 adult home residents with mental illness mirrored a portion of an Office of Mental Health's instrument, the Client Characteristic and Needs Survey, used by the agency to assess persons living in its community residence programs. Data from this section of the survey tool were used to compare the profile of residents with mental illness living in adult homes with residents living in the mental health community residence programs.

As shown in Figure 6, this analysis showed that residents of adult homes tend to be less likely to have signs of acute mental illness than residents of community residences. Simultaneously, however, residents of adult homes were more likely to evidence the debilitating signs of chronic mental illness, including significant deficits in basic daily living skills. For example, residents of adult homes were more likely than residents of community residences to be assessed by home/residence staff as unable to do their own laundry, assume responsibility for household chores, and prepare simple meals. In other basic skill areas, like washing regularly, dressing appropriately, and using the telephone correctly, the profile of adult home residents was remarkably comparable to that of community residence clients.

Other significant differences between residents of the two types of care facilities included age and length of stay. The sampled residents of adult homes were more likely to be over 55 (67 vs. 10 percent) and to have resided two years or longer in the adult home (69 vs. 24 percent) than their counterparts in community residences.

Figure 6: Skill Deficits of Persons With Mental Illness in Adult Homes vs. Community Residences



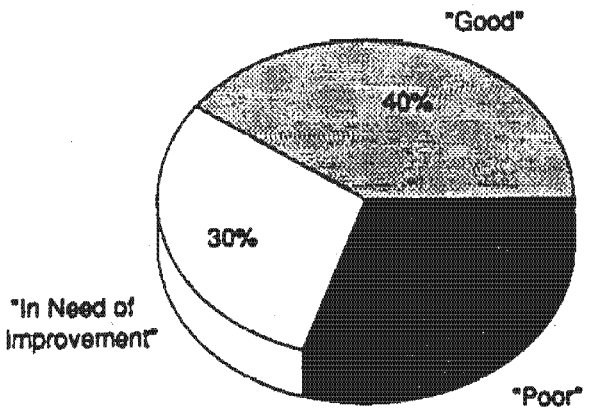
Inside Adult Homes

Homes with "Good" Conditions

As described earlier, the Commission's sample of 47 homes represented a geographically diverse array of homes of different sizes and resident composition. The diversity of the sample, however, hardly prepared us for the extent of variation in conditions we witnessed. (Figure 7) (See also Appendix A.) In 19 of the 47 homes, or 40 percent, conditions were very good, with few significant deficiencies, and 11 of these homes had no significant deficiencies in any of the areas reviewed. From their exterior maintenance to their inside environments, these homes evidenced the care and attention of their owners and staff. Furnishings were well maintained, comfortable, and attractive; housekeeping was outstanding; and staff conscientiously attended to fire and safety precautions. These homes were equally impressive in their attention to residents' personal care needs for proper hygiene, grooming, and dress, and in their attention to appropriate medication administration practices.

These homes also provided a variety of activities for residents and encouraged residents to use community resources. Most importantly, staff showed respect for residents, not only in ensuring basic residents' rights, but more obviously in their ongoing interactions with the people who lived in their home. These homes provided examples of the potential of adult homes to provide a safe, comfortable residence at a reasonable cost. Notably, they represented a cross section of homes across the state.

Figure 7: Conditions in Adult Homes Visited [N=47]



Excerpts From Homes With "Good" Conditions

"The common living areas and residents' bedrooms were very clean, odor free, well maintained and very attractively decorated, and the beautiful view of the woods and mountains from most rooms only added to the home's overall warm and comfortable atmosphere. The exterior of the home was also in very good repair, and the lawn and picnic/barbecue area were well maintained. . . . many caring and positive interactions among staff and residents, and the obvious efforts which had been extended to ensure that residents had a variety of activities and that their medical, mental health, and dental needs were regularly addressed."

(Evergreen Manor)

"Residents were well dressed and neatly groomed. Bedrooms throughout the home were generally neat, well kept, and individually decorated reflecting the residents' personal taste . . . Reviewers noted a mutual respect between staff and residents, and the administrator's avid advocacy for the residents' rights and well-being."

(Maple Manor HFA)

"There existed a good, free-flowing, supportive communication between staff and residents . . . never once did staff pass a resident, where the resident was not acknowledged. The physical environment of the home was immaculate... all areas were well maintained and nicely decorated. Each table was set tastefully, and the meal was hot, nutritious, and wonderfully appetizing. Residents were not only groomed and dressed appropriately, but many wore jewelry, scarfs, and other nice accessories. It was apparent that staff had made extra efforts to ensure that the residents received appropriate medical and mental health services, as well as enjoyable on-site and off-site activities."

(St. Zita's Villa)

"All areas of the home were clean, maintained, well furnished and attractively decorated. Residents were appropriately dressed and personal needs appeared to be well met. The residents were offered a variety of programming activities, and the activities taking place on the day of our visit were well organized and enjoyed by all. Finally, it was clear in observing staff serving meals, dispensing medications, shaving residents and assisting in activities. . . . that special care is taken in word and action to respect the dignity of the individuals in the home."

(Seaview Manor HFA)

"The interior and exterior environment were not only in excellent condition, but provided cozy, comfortable surroundings for the residents. In virtually every area it was apparent that the administrator and staff not only ensured regulatory compliance, but they also strove to achieve their own higher standards of excellence."

(Dawn Hill Adult Home)

"The most striking characteristic of the home was the careful and respectful attention staff paid to the residents. . . the hand-holding, hugs on the shoulders, and slow walks to the dining room were only a few of the acts of caring. The verbal communications were likewise affectionate, and not demanding. . . . questions answered clearly and directly."

(Bida HFA)

"A monthly activity schedule was posted in the main lobby and on all bulletin boards... Various activities were scheduled and included ceramics, sewing, Resident Council meetings, book club, shopping, movie night, and church services. . . restaurants, churches, and parks are easily accessible by walking. On the day of our visit, a cooking class and a van trip to observe the foliage were offered."

(DePaul HFA)

"Common living areas were very clean and attractively decorated with items reflecting the staffs' and residents' interests and tastes. The Halloween decorations and dried flowers throughout the home also reflected the many festive activities that are celebrated. These positive findings clearly reflected the staffs' efforts to assist residents in basic personal skills and ensure a wonderful warm and caring environment for everyone."

(Wiltshire House)

"By the time of our mid-morning arrival, the part-time housekeeper had already cleaned the home for the day. Bathroom fixtures had been scoured, and the baths were supplied with paper products and soap. Bedroom and common areas had been dusted and vacuumed. The home also provides the residents with excellent, home-cooked, well balanced meals. On the day of our visit, the residents spoke highly of the meals that the home prepares. They also reportedly enjoy the music concerts that are arranged on-site by the owner. These concerts have included classical and jazz recitals, and other musical offerings."

(Ridgeview Guest Home)

"The home was not only very clean, but it also provided a pleasant, comfortable atmosphere. Walls were wallpapered; the dining area had table cloths and flowers on tables; and bedrooms were also nicely decorated with curtains, pictures, matching furniture and personalized items. Common living areas, the dining room, bedrooms, and bathrooms all showed that regular attention was given to housekeeping. Fire extinguishers were recently inspected and properly mounted on walls. Fire evacuation procedures were posted on each floor, and staff indicated that all residents are capable of safely exiting the home during fire drills."

(Manor Haven Adult Home)

"The kitchen was clean and organized, and foods were appropriately stored. The menu and special diets were posted, and menu changes were added as needed. Snacks, especially fruit and fruit juices, are regularly provided to the residents as a part of recreational activities. Residents access. . . medical services by private physicians of the residents' choice in the community. Additionally, most residents participate in mental health programs or day programs for the mentally retarded in the community."

(Park Rest HFA)

"All areas were clean, well furnished, and in good repair. Meals were prepared with fresh ingredients, attractively served, and enjoyed by the residents. Recreational equipment was readily available. Staffing was adequate, and all staff-to-resident interaction was warm, caring, and attentive to the residents' personal needs. All residents interviewed also expressed satisfaction with the services offered."

(Johnson Adult Home)

Homes with "Poor" Conditions

In sharp contrast, however, 14 of the 47 homes, or 30 percent, had deficiencies in more than half of the areas reviewed. The widespread deficiencies in these homes were usually first signalled by poor exteriors and yard maintenance even before reviewers entered the homes. Once inside, the inattention to basic living conditions for residents was pervasive. Routine maintenance had apparently been neglected long term, and often serious, long-standing plumbing and roof leaks further contributed to poor conditions. The terrible odors of these homes were usually the first sign to a visitor of the serious underlying housekeeping problems. Bathrooms and resident bedrooms, as well as common living areas in many of the homes, clearly had not been attended to for long periods of time.

Furnishings in these homes were also often in disrepair, dirty, or broken. In other homes with poor conditions, furnishings were a mismatch of items, and in still others, institutional-like furniture arrangements -- chairs arranged in rows or on the periphery of large day rooms -- prevailed. Outside furnishings were often torn, broken and rusted.

These homes were also marked by inattention to residents' needs for assistance in dressing properly and maintaining good grooming. Medications were sometimes casually stored on open shelves, and more commonly, there was poor and unreliable documentation of staff assistance in administering medications to residents.

Fire safety precautions were also often lacking. Many instances of improperly stored flammable materials and storage of hazardous materials in resident living areas were noted. Additionally, some homes were so dimly lit that promptly exiting in an emergency would be difficult.

Homes "In Need of Improvement"

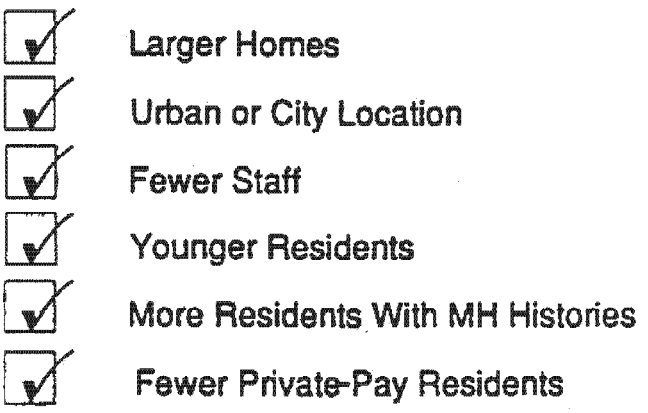
The remaining 14 homes fell somewhere in between the "good" and "poor" homes described above. These homes shared some of the positive features of the good homes, but in other areas significant deficiencies were evident. For example, at one of these homes which had arranged for on-site medical services by a general practitioner three times a week, and which offered a variety of nutritious, well-balanced meals and an array of recreational activities, little attention had been devoted to housekeeping, maintenance, or assisting residents with appropriate dress. Another home had a well-organized system for medication administration and held Resident Council meetings on a regular monthly basis, but had significant problems with maintenance, furnishings, and the care and organization of the residents' clothing.

At still another home, the environment was free of obvious fire/safety hazards, housekeeping was adequate, and recreational supplies were plentiful, but furnishings were in disrepair and mismatched, and worn and dirty carpeting signalled the inattention to routine maintenance. At a fourth home in this subgroup, the kitchen facilities and most bedrooms were clean, and the dining room was attractively decorated, but other areas of the home showed signs of long-term neglect, including major leaks, dim lighting, and cracked and crumbling wall surfaces.

Factors Related to "Good" Versus "Poor" Conditions

The Commission's study also revealed a number of factors which were statistically significant in predicting better or poorer conditions in the homes visited. (Figure 8) As a general rule, larger homes, homes located in urban areas, and homes located near or in New York City had poorer conditions. Certain characteristics of the resident population were also statistically associated with homes showing poorer conditions, including a greater percentage of younger residents, a greater percentage of residents with histories of mental illness, and a smaller percentage of private-pay residents. Homes with richer staffing coverage and higher resident revenues, indicating more private-pay residents, also tended to have better conditions.

Figure 8: Factors Significantly Related to Poor Conditions* [N=47]



*Significance Level < .05

Excerpts From Homes With "Poor" Conditions

" The grounds of the home were littered with garbage, the hedges needed trimming, and the walls on the side of the home were marred with graffiti. The interior of the home was dimly lit and poorly ventilated, with unattractive, damaged institutional furniture set on dark, buckled, and worn carpeting. One bathroom. . . had a large hole in the floor by the bathtub which permitted the viewer to see into the basement. Some residents. . . were poorly dressed in stained, ill-fitting, layered attire, sometimes without socks or stockings. . . many were dirty and appeared to require additional staff assistance in personal hygiene."

(Park Inn HFA)

" Throughout the house, cobwebs, dust and dirty flooring were noted. . . . Bathrooms had strong urine odors and poor ventilation. Resident bedrooms also had foul odors and were frequently cluttered and messy. Soiled and torn mattresses, ill-fitting, stained curtains, and soiled pillow cases, sheets and bedspreads were in the majority of bedrooms. Additionally, . . . dressers, beds, lamps and chairs were mismatched and old with peeling paint, chips and scratches. There were no. . . supplies and. . . resident bathrooms lacked toilet paper, paper towels, and soap. Many residents either carried a supply of toilet paper with them or had it hidden in their room. Approximately half of the residents spend a great deal of idle time in the dining/smoking area or in their rooms lying on their beds."

(Dawnview HFA)

" While some bedrooms were clean and the rugs vacuumed, many of the floors were littered with paper and cigarette butts and many smelled from cigarettes, body odor, or urine. . . . Bathrooms had dirt, stained tubs, sinks, floors, wall tiles, and mildewed shower curtains. . . . The TV room/common area was dirty and. . . the plastic modular chairs. . . were also dirty, approximately half lacking cushions, and many. . . were old, dirty and/or damaged. . . . There were roaches in the bathrooms, bedrooms, and medication/treatment room. . . . Most bedrooms contained old and worn furniture, including dressers with pieces chipped or broken, chairs with ripped cushions or missing armrests and old and worn curtains. . . . Of serious concern is the residents' disregard of the facility's policy prohibiting smoking in bedrooms and other specified areas, despite the presence of no smoking signs throughout the building. . . . Uncontrolled medications were not adequately secured, as medication vials were kept in plastic tubs. . . . in an open, movable cart."

(Wavecrest HFA)

" Outdoor patio furniture in the backyard was ripped, rusted and in very poor condition. . . . Floors and walls in the hallways and elevator were very dirty with built-up dirt. . . . Wall and floor tiles were mismatched and ungrouted in many places, and contained an accumulation of mold and mildew. . . . In the bathroom, medicine chests were rusted, and shower curtains were ripped and mildewed. . . . The majority of residents were poorly groomed and dressed in dirty, ill-fitting, seasonally inappropriate clothing. . . ."

(Park Manor Adult Home)

" . . . the grass needed cutting; bushes needed trimming; and, bags of garbage and assorted pieces of garbage seriously detracted from the home's appearance. Common living areas, dining area, bedrooms, bathrooms, and hallways were filthy; floors, windows, furnishings, and walls were very dirty; these areas were also infested with cockroaches. . . . broken furniture. . . . upholstered furnishings needed a thorough cleaning. The dining area had mismatched chairs and a few tables were slanted. . . . Several beds in bedrooms had very worn mattresses. . . . and, in one bedroom, the bed frame was broken, and the resident sleeps on a slanted bed. . . . Medications are securely stored and appropriately administered. . . . however, records lacked uniform documentation. . . . Residents appeared poorly dressed and groomed. . . . Many wore ill-fitting, dirty, and torn clothing and some lacked appropriate shoes."

(Anna Millssia Adult Home)

" Television rooms were dimly lit with worn furnishings, stained, cigarette-burned carpeting, . . . one TV room had food-spattered walls and cigarette ashes/debris on end tables. . . ceilings had an accumulation of dead flies. . . Most bathrooms showed maintenance deficiencies, with dirt-encrusted floor tiles, stained porcelain fixtures, and chipped woodwork or peeling plaster on walls and ceilings. . . Medication sheets. . . frequently lacked staff initials and no documentation was evident. . . to indicate the reasons residents had not received medications as scheduled. Limited numbers of staff are available. . . and in the event of an emergency, staff would not be able to locate and evacuate everyone from the floor. . . residents wore dirty, ill-fitting and inappropriate clothing and many needed help. . . Most residents were. . . idle, spending their time sitting in the lobby, TV rooms, or their bedrooms."

(Hunter House HFA)

" Housekeeping problems. . . litter, dirt, foul odors and heavy cigarette smoke were prevalent. The majority of beds were missing sheets/blankets and some were made with stained, dirty linens. In resident bathrooms, the floors, baseboards, toilets, and bathtubs were filthy, with built-up dirt, soap residue, mold, and mildew. . . The barber shop, the doctor's examining room, and the dentist's examining room. . . exceptionally dirty with shaving cream, debris, and dental molds scattered about. . . Furniture was spartan, and the majority of areas contained only metal folding chairs. . . old, rusted and stained. . . Residents smoke in all areas of the home and cigarette burns were noted. . . Many residents spend their day in bed. . . Staff are unable to accurately state how many residents are in the facility at one time. . . . The majority of residents were inappropriately groomed and dressed in stained and worn clothing. . . most did not have personal hygiene supplies."

(Leben HFA)

". . . old, rusted pieces of lawn furniture were in the front. . . Small flying insects were noted in every area. . . Smoking lounges were not adequately ventilated and cigarette butts littered the floors. . . Most bedrooms had stale and musty odors, carpets that were very worn. . . covered with butts, ashes, and dust. . . linens were either soiled or stained or completely lacking. . . Bathroom fixtures. . . countertops were worn and some had holes, baseboard heater covers were either broken or missing, and several toilets were not working properly. . . dirty and frayed/torn towels and washcloths hanging on towel bars or curtain rods. . . Dresser drawers were difficult to open and some drawers lacked knobs. Carpets were worn, raised or torn, causing a safety hazard to residents. Residents were smoking in non-smoking areas. . . Many residents were unkempt. . . and several wore no socks. . . Many supplies looked as though they had never been used, since they were covered with dust, mold or mildew. Medications were stored in a medication cart that had a broken lock and other medications were kept on top of the cart. . ."

(New Monsey Park HFA)

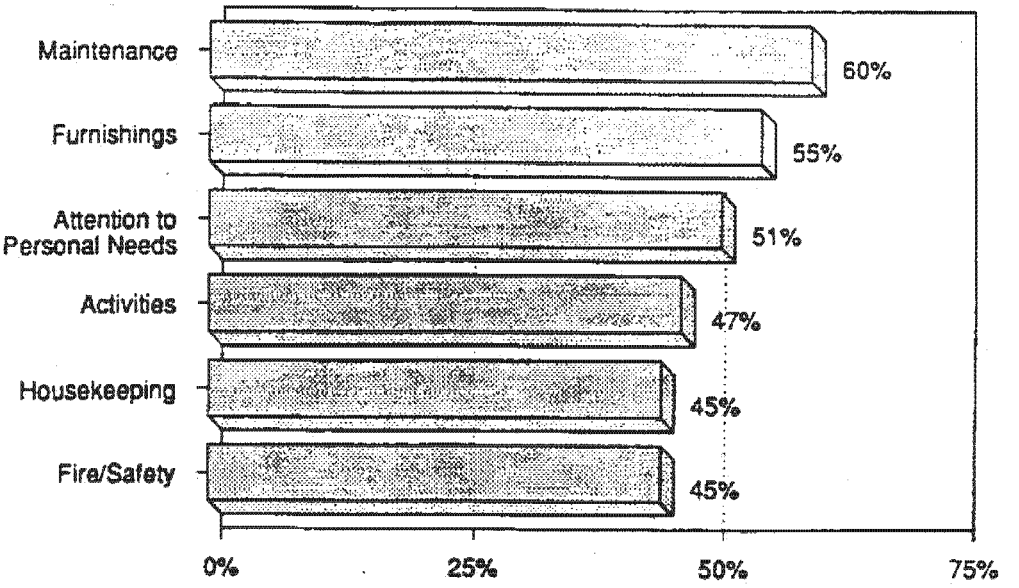
" Urine odors, body odors and grease smells pervaded the home. . . Large cockroaches were observed in the kitchen and dining rooms. . . When kitchen cabinets were opened, live and dead cockroaches were evident. The entire home was furnished with old, run-down, second-hand furniture. . . patio furniture was in dilapidated condition with broken springs and torn cushion covers. . . Residents' clothing was ill-fitting, old and dirty. . . Residents. . . use community bars of soap in the bathrooms. Medications were. . . on an open shelf in the living area next to roach spray. . . aftershave, deodorant and Monistat Vaginal Cream. The food appeared dried out . . . the only available drinking glasses were disposable plastic cups, reused multiple times."

(Babylon Manor Rest Home)

" Common living areas. . . were dirty and infested with cockroaches. . . A stale, musty odor was present. . . beds were unmade, and linens, blankets, and bedspreads were stained and dirty . . . Several bedrooms had only one dresser for two people, others had. . . broken, battered looking dressers. Several areas. . . in disrepair. . . a large hole in the ceiling. . . leaky roof. . . wires sticking out of the wall. . . floor tiles were broken and buckling. . . Residents wore soiled and stained clothing and one resident. . . belongings in plastic bags. . . Dining area is not large enough. . . some residents sat in TV room during mealtime. . . Medications were not securely stored and outdated medications. . . were stored in a medicine chest of a bathroom. . ."

(Mason HFA)

Figure 9: Significant Problem Areas Across Adult Homes Visited [N=47]



Trends in Conditions Across the Homes

Certain trends in problems across the 47 homes visited also were apparent. (Figure 9) Problems in environmental conditions, including maintenance and basic furnishings, and/or housekeeping were noted at most homes. These basic living condition concerns were especially prevalent in residents' bedrooms and bathrooms, although they often also extended to common living areas of the homes. Attention to residents' personal needs was also lacking in most homes. Many residents in these homes were shabbily dressed and poorly groomed, reflecting the homes' inattention to their responsibilities to provide personal care for residents.

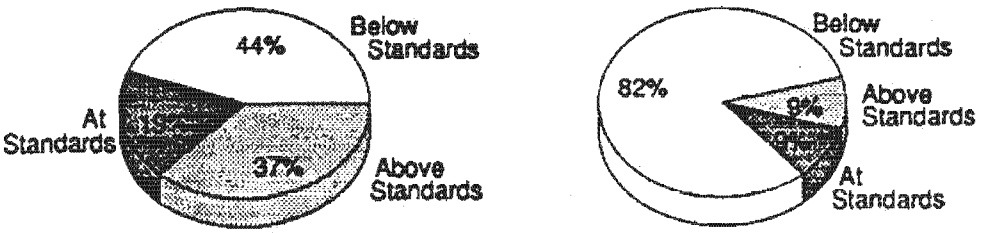
Fire/safety problems were also apparent in many homes, and they ranged from inappropriate storage which posed fire or evacuation hazards, to residents smoking in their bedrooms. Additionally, at many homes, some residents' physical, as well as mental, disabilities appeared to preclude them from exiting in a timely manner in case of an emergency.

Perhaps most evident to a visitor, however, was the pervasive inactivity of the residents in most of the adult homes visited. While adult homes usually had schedules indicating the potential provision of the minimally required 10 hours of recreational activities weekly mandated by the Department of Social Services' regulations, sometimes activities did not take place as scheduled, more often only a handful of residents participated, and in nearly half the homes, recreational supplies were not accessible to residents. In many homes, most residents spent their days sitting idly, or lying in bed, with little intervention or encouragement by staff to participate in scheduled in-home or community activities.

Underlying many of the problems noted across the homes were the few staff on duty. Review of the expenditure reports submitted by 43 of the 47 adult homes in the Commission's sample indicated that 44 percent of the homes failed in 1988 to provide the minimum staffing as required by Department of Social Services' regulations. Failure to meet minimum staffing requirements was especially prevalent among homes located in New York City, where 82 percent of the homes failed to meet minimum staffing requirements. (Figure 10)

Simultaneously, the Commission found that minimum staffing requirements were minimal indeed. For example, personal care staffing requirements provide only 32 minutes of personal care staff services a day per resident. Minimum night coverage requirements assure only one awake staff person for every 40 residents.

Figure 10: Compliance With DSS Minimum Staffing Requirements



Statewide [N=43*]

New York City [N=11]

* Of the 47 adult homes reviewed, four did not file a financial statement in 1988, from which staffing data on the homes were obtained.

Medical and Mental Health Services

Another component of the Commission's review looked at the accessibility of appropriate medical and mental health services to persons with mental illness living in adult homes. Here, the data indicated that all homes ensured access to outpatient mental health services to their residents, and that 64 percent of the 47 homes had made arrangements with at least one outpatient program for the provision of on-site services, weekly or daily. All homes also had arrangements with at least one local physician for medical services, and 70 percent of the homes had arrangements with a physician who made house calls. At many of the homes, podiatrists and laboratory technicians also visited the homes to provide services to the residents. (Figure 11)

Despite this accessibility to clinical mental health and medical services, however, many fewer homes made arrangements for the residents' needs for mental health rehabilitative and support services directed toward basic activities of daily living and vocational training. Whereas the Commission found that virtually all residents in its sample were seen by a clinician for individual therapy at least monthly and that many residents living in homes with on-site clinic providers were seen weekly or more frequently, only 32 percent were attending structured mental health day programs designed to address their substantial deficits in daily living skills, socialization, or vocational skills. Additionally, only 31 percent were receiving ongoing case management from their mental health provider. (Figure 12)

Follow-up discussions with Office of Mental Health officials confirmed that the Office has issued no guidelines specifying core services for on-site clinic providers and Community Support Services (CSS) teams in adult homes, and that these providers were largely on their own to determine what services to offer. Moreover, as many of these programs have historically operated as "satellites" of other larger programs, many have not been formally reviewed or individually licensed by the Office of Mental Health.

Another consequence of the "satellite" status of these programs is that the Office of Mental Health has no ready mechanism for keeping tabs on the costs of the programs. At the Commission's request, the Office of Mental Health did attempt to estimate total CSS funding spent for on-site service delivery to adult homes. In 1989, the Office of Mental Health estimated that approximately $4.3 million was spent for these services.

The Office of Mental Health could not, however, estimate the total public funds supporting on-site clinic or other licensed outpatient programs at adult homes, as many of these programs operate as satellite or outreach programs, and all services are billed through a licensed program of the umbrella provider agency at another location. State Medicaid files for 115 of the 144 residents in the Commission's sample, for

Figure 11: Mental Health and Medical Services at the Adult Homes Visited [N=47]

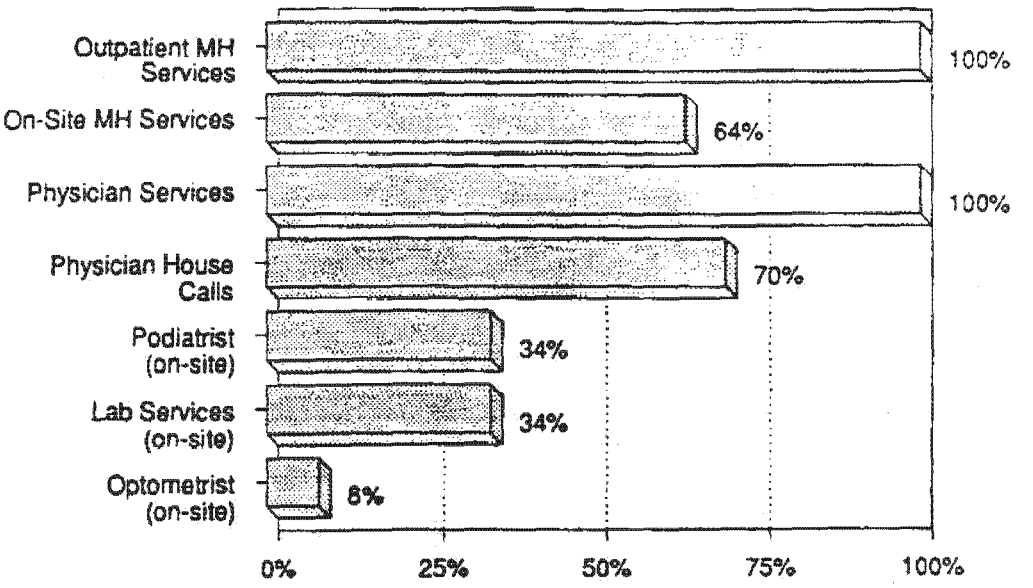
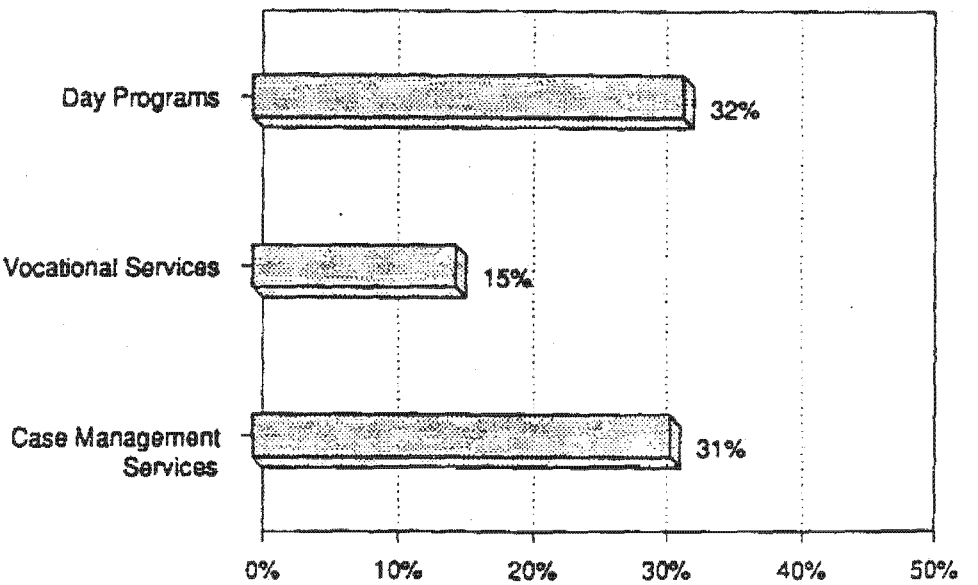


Figure 12: Receipt of Mental Health Rehab/Support Services by Residents With Mental Illness [N=144]



whom accurate Medicaid numbers were on file at the adult homes, indicated, however, that on average $2,500 per resident per year were billed for outpatient mental health services, excluding medications and transportation.

The Commission also noted that while most homes had ensured annual mental health and medical evaluation forms in the residents' records, rarely did these forms meet regulatory requirements of providing specific information about the residents' current status and treatment needs. More commonly, the professionals filling out these forms (developed and issued by the Department of Social Services) simply checked the few boxes and signed the forms, entering little, if any, narrative comment. Thus, it was not possible from these records to determine whether or how medical and mental health services were addressing the residents' evident problems.

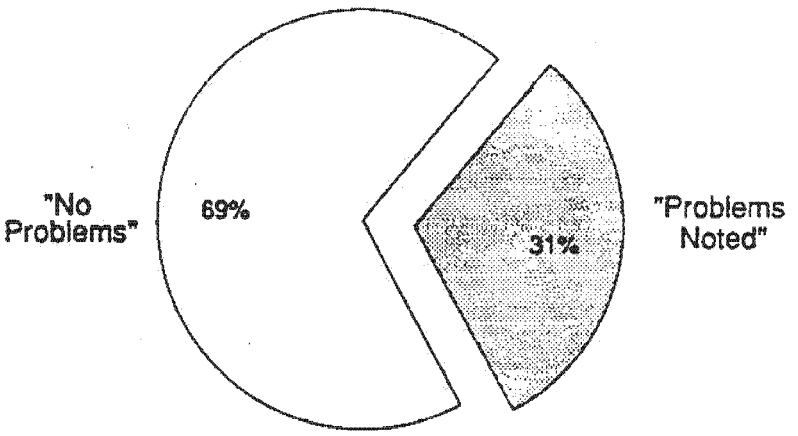
Medication Administration

Department of Social Services' regulations infer that all residents of adult homes must be capable of self-administering their prescribed medications, but they also state that adult home staff may "assist" residents in self-administering the medications. In practice, administrators at almost all of the homes visited (94 percent) stated that most residents were in need of significant or total assistance in this area. Commission staff found that adult home staff, at all homes visited, were assuming responsibility for the full range of medication storage, ordering, and administration tasks for almost all residents.

Despite their considerable responsibilities in these areas, however, these adult home staff often had little general education and little or no formal training in medication administration. In most cases, these staff knew very little about the medications they were administering or their intended or unintended adverse side effects, and at very few homes was there any supervision or oversight of medication administration by persons trained in these areas. Notably, the Department of Social Services' regulations place no training requirements on adult home staff performing these tasks. The seriousness of this oversight is reinforced by the literally hundreds of medications handled by staff at most homes daily, as many residents are receiving three or more prescribed medications.

At approximately one-third of the homes visited, the Commission's preliminary review evidenced obvious problems either in the careless and insecure storage of medications, the failure of staff administering medications to promptly and accurately document medications given to residents, or the lack of staff follow-up with residents who did not present themselves at medication administration times. (Figure 13)

Figure 13: Medication Management Deficiencies at the Adult Homes Visited [N=47]

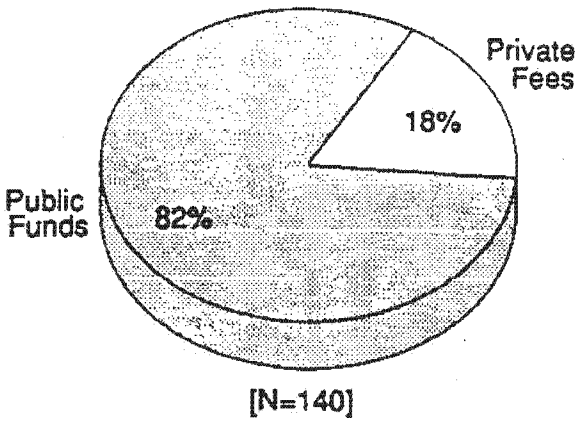


More in-depth follow-up of these issues at several homes indicated that anywhere from 10 to 75 percent of the residents missed doses of their prescribed medications periodically or regularly because home staff were not diligent in ensuring that prescriptions were refilled as needed or in following up with residents who failed to respond to general calls for medication administration.

The Cost of Care

The Commission was also interested in understanding the nature of the costs of operating adult homes, how the operators spent the revenue received, and the relative profitability of these homes. This analysis indicated that for the homes serving a significant mentally ill population, the majority of revenue comes from the federally administered SSI cash assistance program for persons who are disabled, aged, and/or have little income or resources. Eighty-two (82) percent of revenues received by these homes came from publicly administered funding sources, including SSI, HR, SSA, or SSD, while only 18 percent came from private fees of non-public-pay residents. (Figure 14) Notably, these public funds usually come to adult home operators through the "intermediary" of the resident, who typically signs over his/her monthly SSI, HR, SSD, or SSA check to the adult home operator. Residents on SSI receive a mandated portion ($85 per month) as a personal needs allowance.

Figure 14: Revenue Source of Adult Homes Serving Many Persons With Mental Illness [1988]



On the expenditure side, the Commission found that, over the three-year period 1986-1988, operators of the 147 homes filing financial statements reported total expenditures of almost $233 million.* Across the homes, 21 percent of this amount was spent on administration-related costs, including administrative personnel salaries, personnel fringe benefits, and overhead. Thirty-nine (39) percent was spent for occupancy costs including rent, mortgage interest, and utilities; and the remaining 40 percent was spent for resident services, including dietary, housekeeping, and attendant services.

Across the 140 homes, whose resident population included at least 25 percent persons with mental illness, and that had filed financial reports in 1988, per resident daily costs averaged $21.96, with a range of $31.68 to $13.50. Thirty-nine (39) percent of the homes had reported daily resident costs in

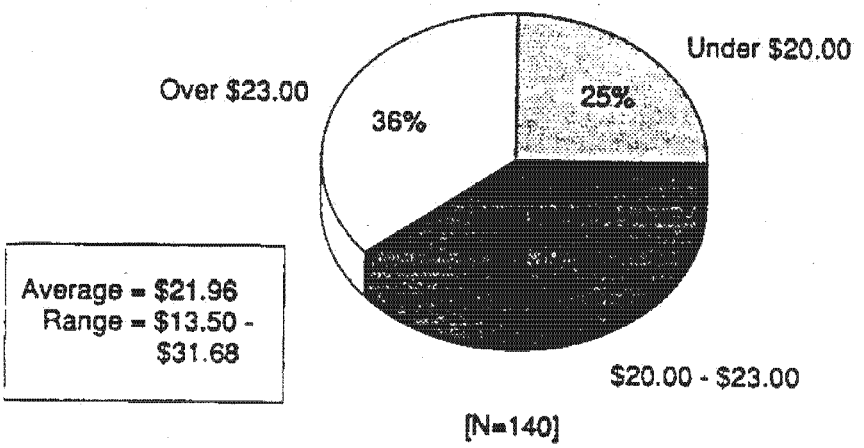
*In 1988 the Department of Social Services reported 150 adult homes whose resident population included at least 25 percent persons with mental illness. The Department of Social Services did not have available financial statements for 10 of these adult homes for 1988. Financial statements were not available for any of the years 1986-1988 for three of these homes.

the narrow range of $20.00-$23.00; another 36 percent had daily resident costs over $23.00; and, the remaining 25 percent operated at under $20.00 per resident day. (Figure 15)

Profitability

Recognizing that 91 percent of the homes whose resident population included at least 25 percent persons with mental illness are "for-profit," the Commission sought to examine the "profitability" of these businesses.* Reported pretax profits per resident averaged $2.20 per day across the 127 proprietary adult homes in 1988, with a range of a profit of $9.29 on the high end to a loss of $2.67 on the low end. Further analysis showed that 9 percent of the homes showed daily profits of over $5.00 a day per resident, 42 percent showed profits of between $2.00 and $5.00 a day per resident, and 34 percent showed profits of less than $2.00 a day per resident. Only 15 percent of the homes showed net losses on their expenditure reports. (Figure 16)

Figure 15: Reported Costs Per Resident Day of Adult Homes Serving Many Persons With Mental Illness [1988]



*Profit figures are "as reported" on the adult homes' financial statements. Adjustments were not made to reflect other than market transactions between related parties, expenses that do not pertain to the cost of resident care, or inflated salaries to the operator or family members. Adjustments for such items would raise the profits reported for adult homes.

Figure 16: Reported Profits Per Resident Day of Adult Homes Serving Many Persons With Mental Illness [1988]

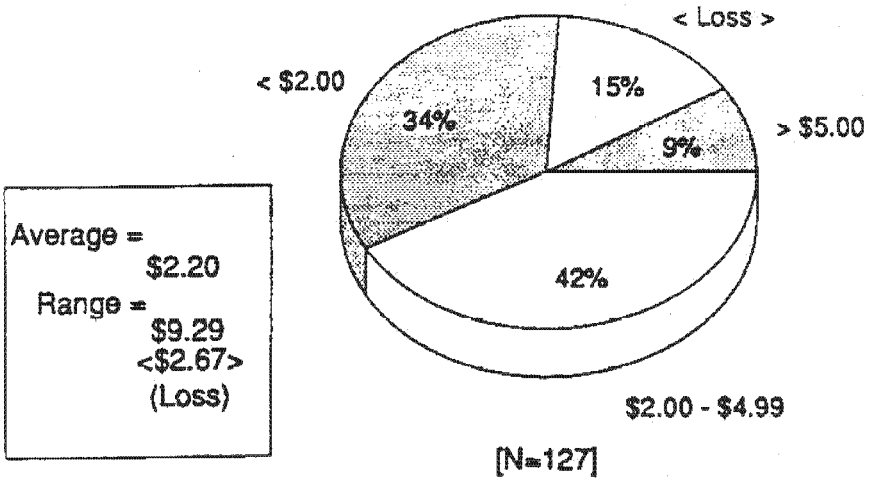
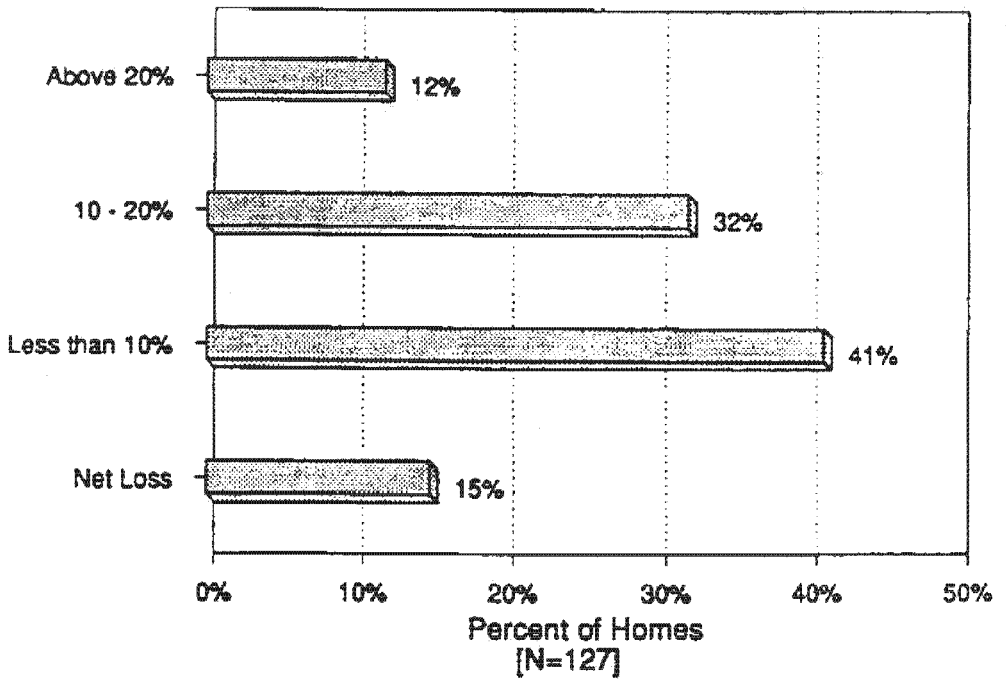


Figure 17: Reported Profits as a Percent of Revenue [1988]



Further analysis of the cost reports looked at reported profits of proprietary homes as a percent of the revenue received over the three-year period, 1986-1988. This analysis showed that 41 percent of the homes had a profit-to-revenue ratio of below 10 percent, while 32 percent of the homes had a profit-to-revenue ratio between 10 and 20 percent, and 12 percent had a profit-to-revenue ratio of above 20 percent. (Figure 17) Expenditure reports of only 15 percent of the homes showed net losses, and in these cases losses were either minimal or "explainable" based on unique circumstances such as low occupancy or questionable related-party transactions, which also cast doubt on the accuracy of the cost reports filed.

In 1979, Special Prosecutor Charles Hynes found that it was often the case that adult homes having poor conditions also had operators who were personally benefitting from monies that should have gone to pay for care and treatment of the residents. Despite new regulations, including the filing of facility cost reports, the Commission found similar fiscal abuses. (See shaded box, p. 26.)

The Commission believes that review and analysis of balance sheets, backed by comprehensive fiscal audits of the homes' finances, are essential to a full understanding of the "profitability" of this industry.

The Commission also sought to examine the profitability of the homes by obtaining balance sheet financial statements from the homes.* These statements, which record the total assets, liabilities and equity of a business, are not required to be submitted to the Department of Social Services, but are essential to evaluate the financial viability of a business. Only 20 of the 47 homes in our sample responded to the Commission's request for balance sheets. Among this limited group of respondents, the Commission found losses at four homes and returns on equity at eight homes with profits ranging from 7 percent to 165 percent.** (Figure 18)

For the remaining eight homes with profits, it was not possible to compute rates of return on equity, because the owners had withdrawn not only their annual profits and initial investments, but additional funds, effectively placing them into a negative equity position. Significantly, these eight homes with negative equity also showed profits, ranging from $80,000 to $1.7 million over the period 1986-1988. (Figure 19) The Commission believes that review and analysis of balance sheets, backed by comprehensive fiscal audits of the homes' finances, are essential to a full understanding of the "profitability" of this industry.

*The original (1978) Department of Social Services' financial requirements included a submission of balance sheets, but the adult home industry negotiated with the Department of Social Services to accept only a revenue and expense filing requirement.

**This yardstick of profitability was measured by dividing the 1986, 1987 and 1988 profits by the average equity (i.e., funds invested, earned, and retained in the home) for these same periods.

"QUESTIONABLE FINANCIAL PRACTICES"

Case Example #1

This case involves a 125-bed not-for-profit adult home located in New York City. Commission site visits to this home in 1987 and again in 1989 and 1990 revealed serious problems in basic living conditions and attention to residents' personal needs. A preliminary financial review by the Commission also revealed that the home was having severe financial difficulties, including a very poor cash position and a series of recent deficits. In recent times, the home's cash position had been so poor that many checks written to pay its bills were either post-dated or not mailed out at all, because there was not enough money in the bank to cover them.

Upon further examination, the home's poor cash position did not appear to be the result of inadequate income, but rather questionable management decisions regarding its disposition. In particular, there were a number of unusual transactions which seemed primarily to benefit the administrator of the home. For example, despite the not-for-profit agency's grave need for cash in recent years, it had loaned the administrator, interest-free, hundreds of thousands of dollars. By the end of 1988, the administrator still owed the not-for-profit agency nearly $160,000. In another questionable transaction, a $110,000 real estate tax refund to the not-for-profit agency was used to reduce the administrator's outstanding loan balance with the not-for-profit agency.

The most significant unusual transaction, however, involved the sale of the home by the not-for-profit agency to the administrator in 1985. The Commission found that the administrator purchased the building for $950,000 and then leased it back to the not-for-profit agency for approximately a quarter of a million dollars annually. These annual rental payments represented over 25 percent of the annual revenue of the home and are scheduled to increase progressively over the 11-year life of the lease. By the end of the lease term, the annual rental payment will be $390,000. Additionally, the lease between the administrator, who now owns the building, and the not-for-profit agency, which continues to operate the home, is a "net-net lease" arrangement, whereby the agency assumes responsibility for all expenses related to the operation of the home, such as maintenance and real estate taxes.

The home's administrator has steadfastly refused the Commission access to clarifying information, claiming that it is not relevant to the care the home is presently providing.

Case Example #2

Another large 181-bed home in New York City with poor conditions examined by the Commission staff also revealed a number of unusual financial practices. Unlike the home in the above example, this for-profit home had a relatively good financial profile with reported profits over the period 1986 - 1988 of $244,260 and an accumulated equity of $264,600. These funds suggest that, had the owner chosen, he likely could have afforded to replace the old and worn furnishings in the home or to have retained a contractor to repair the home's peeling plaster and to paint its dirty walls.

There were also large financial transactions of questionable necessity, which raised the possibility of whether some stated costs in the owner's financial statements might actually be hidden profits. For example, in 1984-85, the owner sold the home's lease for $181,000 and withdrew an additional $250,000 in cash, claiming he needed the funds to settle a labor dispute with the residence's former employees. No such settlement occurred and instead, the owner simply pocketed the $431,000, while the home's rent rose from $217,000 to $420,000 for no discernible reason.

Two other large questionable expenses on the books included an annual management fee of $110,000 to an employment agency, reportedly to ward off union problems, and an annual consulting fee of $28,000 to the owner's son for undocumented management services, which he allegedly provides to the home.

For 1988, questionable expenditures totaling $342,000 could have gone a long way toward making needed improvements in the home and its resident services.

Figure 18: Returns on Equity at Eight Adult Homes [1986 - 1988]

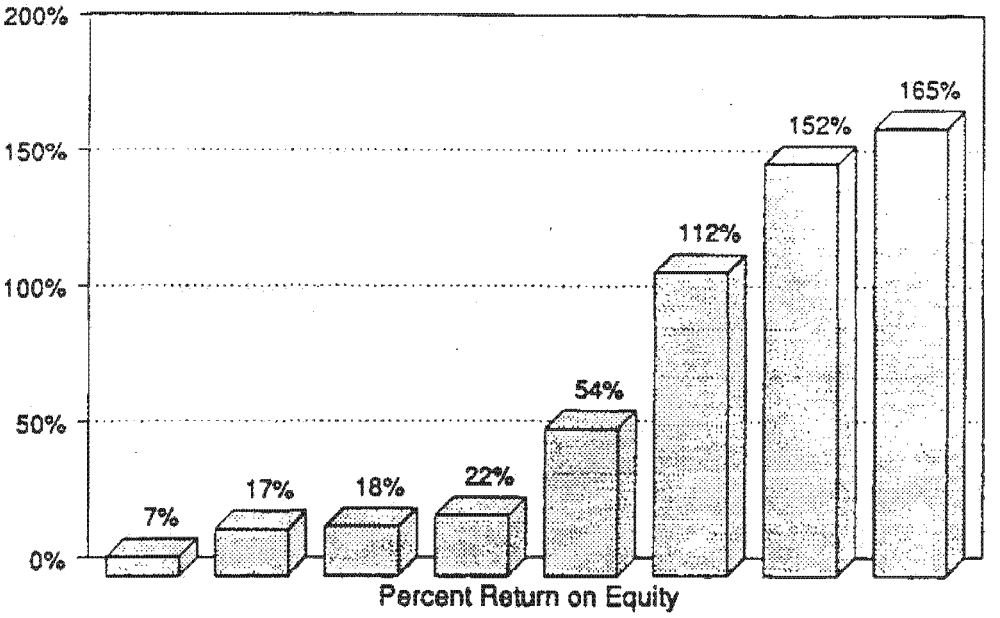
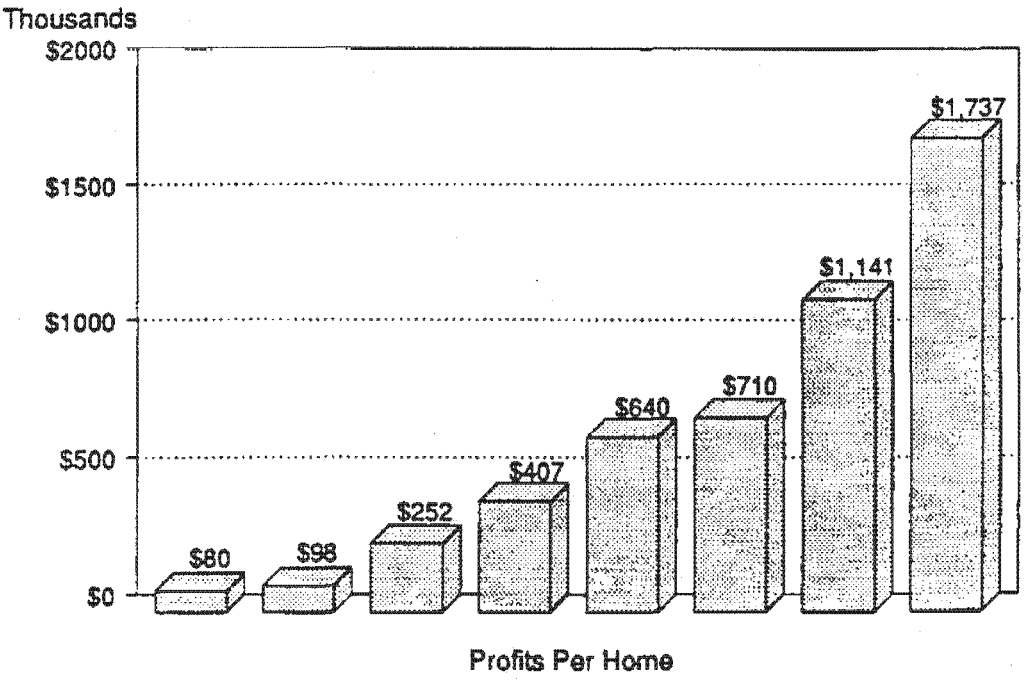


Figure 19: Profits Earned by Eight Adult Homes With Negative Equity [1986 - 1988]



Relationship of Costs to Quality

In examining the correlation between expenditures by the homes and their conditions, the Commission found little significant difference between overall expenditures at the homes with better or poorer conditions. Instead, the differences appear to be related with how the homes spend their money. The homes with better conditions spent significantly more on resident services and significantly less on occupancy. (Figure 20)

The Commission's review also revealed that the small percentage of not-for-profit operators of adult homes tended to have a different fiscal profile than the vast majority of adult homes which are for-profit businesses. Specifically, at the 13 not-for-profit homes whose resident population included at least 25 percent persons with mental illness, private-pay fees accounted for almost half of their 1988 revenues. Not-for-profits also tended to have lower occupancy costs, which included, among other items, rent, mortgage payments, interest, maintenance costs, etc., and simultaneously to spend a considerably greater percentage of their revenues for resident services, like housekeeping, meals, and activities. Not-for-profit homes also tended to more likely be at or above the Department of Social Services' minimum staffing requirements.

Figure 20: Expenditure Patterns of Adult Homes by Quality of Conditions [1986 - 1988]

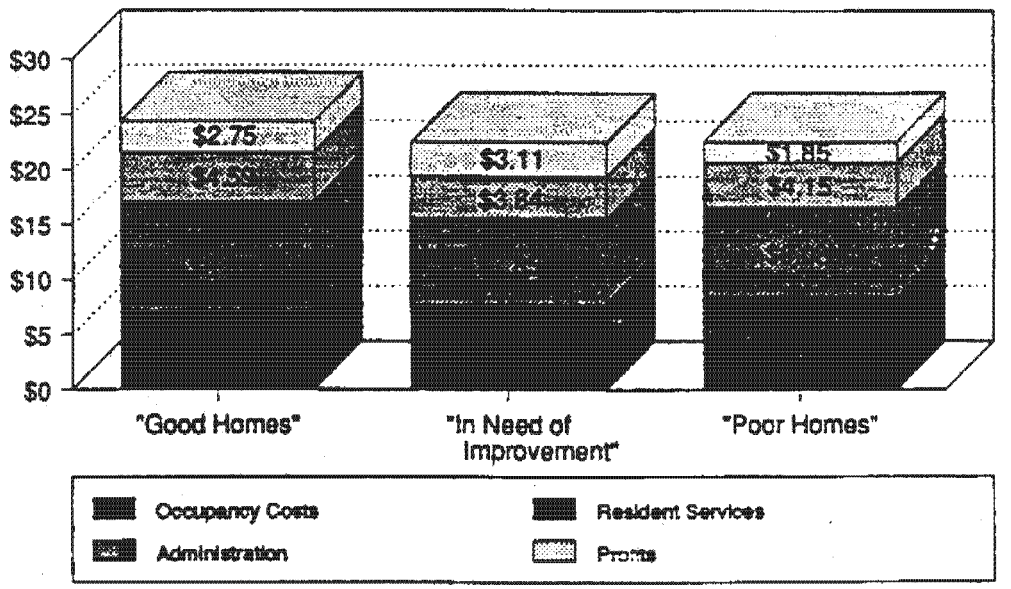


Figure 21: Government Agencies Inspecting Adult Homes Visited [N = 47]

• DSS	100%
• Fire Department	81%
• Department of Health	51%
• Building Department	34%
• NYS Ombudsman Program	28%
• Veteran's Administration	23%

Troubled Homes, Troubled Oversight

Of note, conditions in the four not-for-profit adult homes at which the Commission conducted unannounced inspections mirrored the variability in conditions in the 43 proprietary sample homes visited. Two of these four homes had good conditions, while the other two had poor conditions. Significantly, at the not-for-profit homes with poor conditions, expenditures for resident services were lower than expenditures at the not-for-profit homes with good conditions, but simultaneously virtually identical to those of proprietary homes with poor conditions.

Given the widely variable performance of the adult homes the Commission reviewed, and recognizing the broad discretion that providers have in how to spend public funds in a flat rate system such as adult homes, the role of the regulatory agency in establishing and enforcing standards and expectations is critical. In the case of adult homes serving the mentally ill, the principal responsibility for regulation lies with the Department of Social Services. While a number of other agencies also periodically visited the adult homes in the Commission's sample, the Department of Social Services was the only agency which maintained a regular presence in the homes. (Figure 21)

Additionally, although the law also contemplates a role by the Office of Mental Health in joint visitation and inspection of adult homes providing services to many persons with mental illness, the Commission found that the Office of Mental Health rarely inspected these adult homes. Furthermore, the on-site mental health service providers do not appear to play a consistent role as advocates for residents whose needs are not being met. Most rarely file complaints or seek correction of even the most apparent problems in the homes in which they are regularly present.

The Office of Mental Health has also not maintained consistent oversight of on-site mental health providers in adult homes. As a result, there is no uniformity in the core services these programs provide, and in practice most focus their service provision on individual therapy sessions to the neglect of rehabilitative and case management services which many residents need. The Commission also noted that in many cases cooperation and coordination of service provision between staff of the adult homes and mental health providers were limited.

Additionally, particularly in the New York City area, it was common for adult homes to be served by two on-site mental health providers, which further compounded the fragmentation of service provision and raised questions about the possible duplication of service provision. When questioned about this practice, Office of Mental Health officials acknowledged that they were uncertain of the rationale for this practice or its evolution in the New York City region.

The Department of Social Services' Role

These inspections appeared to have little impact on correcting conditions in the most seriously deficient homes.

In contrast to the Office of Mental Health's lack of inspection, the Department of Social Services had maintained a considerable presence in the adult homes visited, and most homes had four or more visits from the Department of Social Services' inspectors in the past year. (Figure 22) However, these inspections appeared to have little impact on correcting conditions in the most seriously deficient homes. Detailed historical reviews of the Department of Social Services' files of 8 of the 14 homes with the most serious problems revealed that, since 1986, none of these homes had demonstrated compliance or substantial compliance on a Department of Social Services complete inspection visit, and that they had well-documented histories of many problems in the Department of Social Services' files. (See shaded boxes, pp. 33 and 35.)

While most of these homes had also been repeatedly referred for "enforcement actions," usually fines, few enforcement actions had actually been taken against these homes, and few fines were actually levied although the serious problems recurred year after year. Only slightly over one-third of the homes with the most serious problems had paid any fines since 1986, and in total, these homes had paid fines of only $3,450 over the three-year period. Ironically, a higher percentage of homes with "good" conditions had paid fines since 1986, and the average fine, $2,900, was over four times the average fine paid by the "poor" homes. (Figure 23)

Figure 22: Adult Homes by Number of Annual DSS Visitations [N=47]

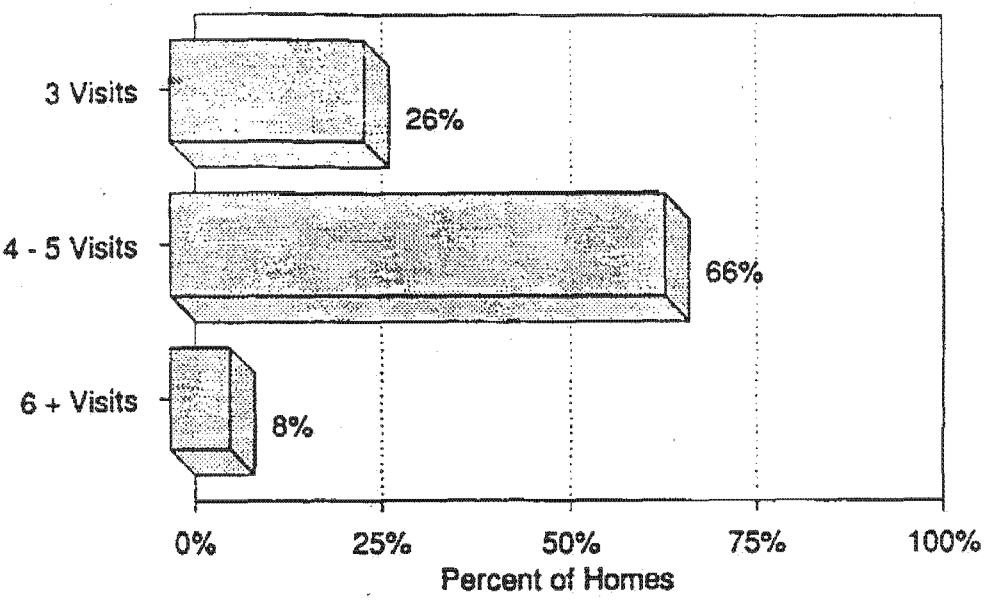
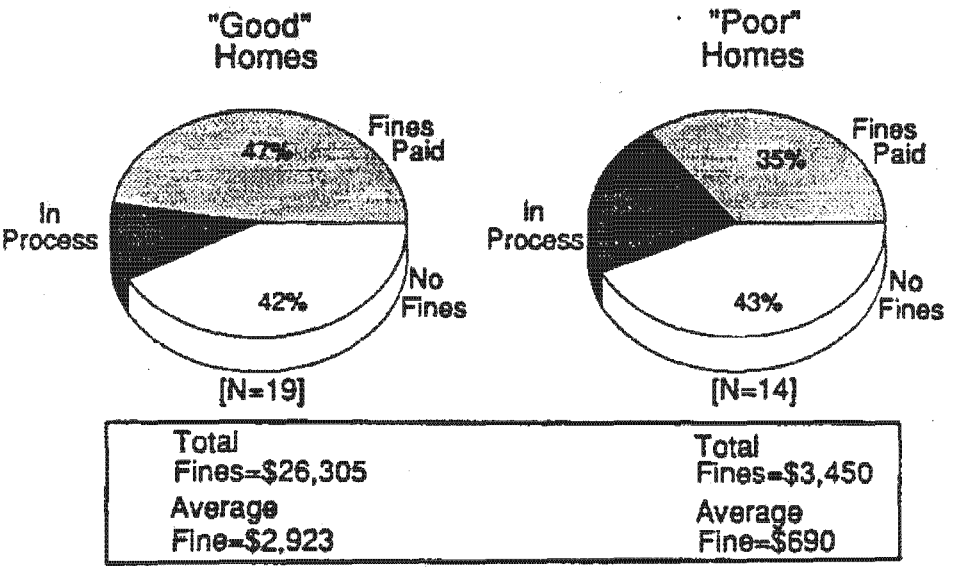


Figure 23: Fines Paid by "Good" Homes vs "Poor" Homes [1986 - 1988]



Anna Milissia Adult Home

The Anna Milissia Adult Home is located in Brentwood, Long Island, and it serves 19 men and women. According to the operator, half of the residents have a history of mental illness and many need help in managing their medications, arranging their medical appointments, maintaining adequate personal hygiene, and accessing community resources.

On the day of the Commission's visit, several of the residents were dressed in dirty, ill-fitting clothing; others appeared in need of a bath or shower; and many of the male residents needed a shave and/or shampoo. The majority of the common and resident living areas of the home were very dirty; most of these areas also had an overpowering odor; and many roaches were seen. Many of the walls throughout the home, as well as the furnishings, were in disrepair. Lighting was also very poor, reportedly due to electrical problems.

The exterior of the home was in an equal state of disrepair. The home needed painting; the grass needed cutting and the shrubs were overgrown; and the yard was littered with garbage and assorted discarded items, including an abandoned school bus. Additionally, the operator provided no regular schedule of activities for residents, and resident records were scant and in disarray.

A review of Department of Social Services' records for the home indicated that their inspectors had also cited the home for multiple problems over the years. In total, these records indicated that DSS inspectors had made 19 visits to the home in the past five years, in conjunction with seven complete inspections and 12 follow-up, partial, or complaint inspections. The Department had cited the home in non-compliance for six of the seven complete inspections and seven follow-up inspections over this period. Repeatedly, the home's operator had been cited for maintenance problems, fire safety problems, problems with the availability of hot water, and inadequate staff training. Additionally, the home had failed to submit annual expenditure reports, required by DSS regulations, in 1987 and 1988.

As of April 1990, despite this long record of poor performance, DSS has taken an enforcement action against the home only once since 1985. This action, taken in February 1988, resulted in a negotiated fine of $1,200, 10 percent of the originally assessed fine of $12,000. As of April 1, 1990, the operator has paid $700 of this assessed fine. DSS records also made no reference to attempts to discern the actual fiscal status of the operator or to exert concerted pressure to require the filing of annual expenditure reports.

In February 1987, the home was also referred for enforcement action due to "a lack of follow-through on required corrective actions, as well as a lack of supervision of employees assigned to various jobs;" but DSS officials reportedly did not move forward on this action. In June and August of 1987, DSS inspectors had also referred the home for enforcement, as a result of violations that remained uncorrected and that were deemed dangerous to the welfare of the residents. According to records and reports from DSS Central Office, however, the Department also took no action on these referrals.

Notably, the Moffitt Mental Health Clinic staff also visited the home weekly to provide services to residents. When the staff person providing these services was questioned about conditions in the home, she became very guarded and noted that she addressed all problems with the operator. According to DSS records for the past five years, the Moffitt Clinic has never filed an official complaint about the home.

Significantly, on April 6, 1988, the Department of Social Services renewed the certification of the Anna Milissia Adult Home for two years and nine months, noting that certification was contingent on "***continuing compliance of DSS regulations.***"

Mason Home for Adults

The Mason Home is located in Beacon, New York, and it serves 16 men and 4 women. According to the operator, 90 percent of the residents have a history of mental illness, and most also require assistance in many daily living tasks, in developing social relationships, and in using community resources.

At the time of the Commission's visit, many serious violations were noted at the home. Most areas of the home were dirty and roach-infested, and significant maintenance problems were evident both inside and outside the home. Several of the residents were poorly groomed and dressed in stained and soiled clothing, and many also lacked a toothbrush, toothpaste, shampoo, and/or a comb or brush. Serious problems were also noted with the home's practices for storing and administering medications to residents. The home also lacked a reasonably sized common living area for residents, and a number of problems with furnishings were noted throughout the home. An emergency fire exit was blocked by an assortment of stored furnishings (e.g., a mattress, a dresser, and a rolled up rug), and boards with sharp protruding nails were stored in the residents' smoking area.

A review of Department of Social Services' records revealed that the problems noted by the Commission were well-known to Department inspectors. Since 1986 when the current operator purchased the home, DSS has made 14 inspection visits, in conjunction with four complete inspections, seven follow-up inspections, and three complaint inspections. Over this period the home has never achieved compliance or substantial compliance on an annual complete inspection, and it has also been cited in non-compliance for two follow-up inspections.

Additionally, in all four DSS complete inspection reports since 1986, the home was cited for failing to ensure routine maintenance and for significant problems in medication storage and administration. Three out of four of these reports also cited the home for poor housekeeping, inadequate activities for residents, the lack of adequate staff, and the failure to provide staff with basic first aid training.

DSS records also indicate that the current problems with the Mason Home have a long history, pre-dating its current owner. From 1978 to 1986, DSS reports repeatedly cited the Mason Home for long-standing housekeeping and maintenance problems, serious problems with medication administration and storage, inadequate meal planning and preparation, insufficient staff, and the poor handling of emergency situations. In 1986 when the sale of the Mason Home to its current operator was pending, DSS recommended the change stating, "... the facility, which has been marginal in the past, was currently in enforcement and getting worse."

While DSS records also indicate that with the change in ownership some improvements were noted in the Mason Home, they also suggest that many problems have remained during the current owner's tenure. For example, an excerpt from one inspection report stated, "[With the purchase of the home] ... the owner/administrator consequently inherited a significant number of problems; ... [she] is trying to make improvements, but financial problems seem to slow improvements." Additionally, recent DSS inspection reports indicate many serious violations in environmental, programmatic, and medical care issues which were strikingly reminiscent of problems cited against the home's previous owner.

Despite these recurring problems and the current owner's three-year tenure at the Mason Home, DSS had remained remarkably tolerant of existing conditions. As of April 1990, DSS had not taken any enforcement action against the Mason Home. DSS officials do report, however, that based on inspections in the fall of 1989 and the winter of 1990 (subsequent to a formal Commission complaint), enforcement action will be taken *shortly*.

In short, the inspection history of the Mason Home over the past ten years is fraught with recurring deficiencies, suggesting years of neglect and a multitude of long overdue needed improvements. Ownership of the home has changed, the DSS inspection "slate" was wiped clean, and the potential for improvement reportedly existed, but few real changes in the quality of residents' lives have actually been achieved.

Additionally, while the law authorizes fines of up to $1,000 per day, there are less than a dozen citations in the regulations that warrant this. Most of the fines are less than $50 per day, and these are often compromised for 10 percent of the initial fine. Moreover, operators are often not fined for all citations. Thus, the bulk of the regulatory effort appears to rely on the coercive effect of token fines which, for the most deficient homes, are rarely imposed.

The Commission also found that while the Department of Social Services' inspection reports universally cited specific deficiencies, the current regulatory process does not focus on identifying underlying problems or requiring owners to correct systemic problems that result in recurring deficiencies. Operators at homes with the poor conditions appeared to take advantage of this regulatory approach, correcting only the specifically cited deficiencies and coming into "technical compliance" upon the Department of Social Services' follow-up visit, which itself focuses only on these deficiencies.

Thus, the bulk of the regulatory effort appears to rely on the coercive effect of token fines which, for the most deficient homes, are rarely imposed.

Regulation of "Poor" Homes

In reviewing the Department of Social Services' inspection files, Commission staff found numerous examples of homes with serious widespread problems where Department of Social Services' follow-up inspections had indicated compliance as the result of the operator's correction of a few specific deficiencies, although underlying problems and serious deficiencies persisted in many areas of the home. As a result, these poor homes are invariably cited for dozens of "new" but similar deficiencies in the next annual complete review, leading to a new cycle of specific corrections, while underlying problems remain beyond the reach of the regulatory process.

Additionally, the Department of Social Services sometimes allows operators of "poor" homes to avoid correcting problems by simply selling the home to another operator. The Department of Social Services views these transactions as a "quick fix" to the problem of a bad operator whose conduct cannot be corrected by the ponderous regulatory process. While in some cases, the Department reports that, following the sale, conditions in the homes were improved by the new operator, in other cases, such sales result in saddling the new operator with a home with a higher mortgage and little money left over to make the substantial renovations and improvements that are needed. At the same time, the home's official Department of Social Services' record is wiped clean. While this procedure satisfies regulatory needs and operators' interests, it sometimes provides little or no assurance to the residents that the living conditions they have had to endure will be quickly corrected.

New Queen Esther Home for Adults

The New Queen Esther Home for Adults is located in Rockaway, Queens, and it serves 46 men and women. According to the home's administrator, 90 percent of the home's residents have a history of mental illness, and most also need help in administering their prescribed medications, in arranging for medical and mental health services, in keeping their bedrooms clean, and in using public transportation.

The Commission made two formal site visits to the home in October 1989 and again in February 1990. Both visits revealed very dirty conditions in most areas of the home. Many floors were littered with cigarette ashes and other trash; bedrooms were in disarray, poorly furnished, and fouled by urine and body odors. The telltale signs of cigarette ashes, discarded butts, and burn marks on furnishings also indicated that many residents regularly smoke in their bedrooms, contrary to the facility's safe smoking policy. Bathrooms were equally dirty and poorly maintained, and few had toilet paper or clean towels for residents.

The majority of the residents were poorly dressed, and a few reportedly incontinent residents were found in urine soaked clothing. Some men were unshaven, and many men and women had dirty, greasy hair. The majority of the residents also had no personal hygiene items. The home also had only one clothes washer and no dryer. Reportedly, staff take residents' clothing to a local laundromat weekly, but many residents commented that laundry services were not available and that they washed their clothes out in bathtubs or took them to the laundromat themselves.

During its 25 inspection visits to the New Queen Esther Home over the past ten years, the Department of Social Services has also cited numerous problems at the home, with at least one inspection visit in nine of the past ten years citing the home in "non-compliance." The most recent DSS complete inspection report (October 1989) cited the home for 38 deficiencies which required immediate correction, and it concluded, "Due to the excessive amount of violations in both housekeeping and maintenance, the operator/administrator is [viewed as] not adequately supervising the facility." Subsequently in January 1990, DSS conducted a follow-up to this complete inspection and cited 17 continuing deficiencies, all of which were described as warranting immediate corrective action.

DSS inspection reports have also cited many recurring deficiencies at the home. For example, in eight of the past ten years, the home has been cited for various problems with bedroom furnishings, including deteriorated mattresses and box springs, no lamps, and broken dresser drawers. In eight reports, the home was cited for failing to provide in-service staff training and, in four of these reports, the citation specifically referenced the failure to ensure basic first aid training.

Despite this documentation of long-term poor performance, however, enforcement action was not taken against the home by DSS until June 1989. The resulting enforcement recommendation, which was issued in August 1989 and focused on food preparation, food storage, and the provision of balanced meals, was approved and a fine was recommended. As of April 1990, however, no specific fine amount had been assessed. According to DSS staff, the enforcement issues in the August 1989 action have been combined with new charges based on subsequent DSS inspections in a new statement of charges approved in April 1990. No action has been taken on this new enforcement action, however, as a hearing date (anticipated in May 1990) has not yet been set.

Although the New Queen Esther Home receives on-site mental health services from two providers, the New Hope Guild and the Creedmoor Psychiatric Center Adult Home Program, both of which are on-site at least three days a week, staff of neither of these programs have been aggressive advocates for improved conditions for the home's residents, and neither of these mental health providers has filed a complaint with DSS about conditions in the home since 1985.

In short, although the state has ensured regular inspection visits of the New Queen Esther Home, as well as the regular presence of staff from two mental health providers, including one state psychiatric center, its 46 residents have suffered long-term from poor conditions and services.

The Department of Social Services' oversight of the finances of adult home operators is also very limited, partly because the actual financial condition of the home has no bearing on the level of reimbursement provided in a flat-rate funded system. For example, while the Department of Social Services requires all adult homes to submit annual expenditure reports, no such reports had been filed by some homes for several years, and the Department of Social Services had not exercised its authority to conduct fiscal audits of a home's financial records since 1979. Moreover, the Commission discovered that essential findings of financial records submitted by adult home operators are not routinely shared with staff of DSS Regional Offices who conduct inspections of the homes. Without access to this information, inspectors are handicapped in their ability to assess the operator's actual investment in capital plant, maintenance, or furnishings, as well as compliance with minimum staffing.

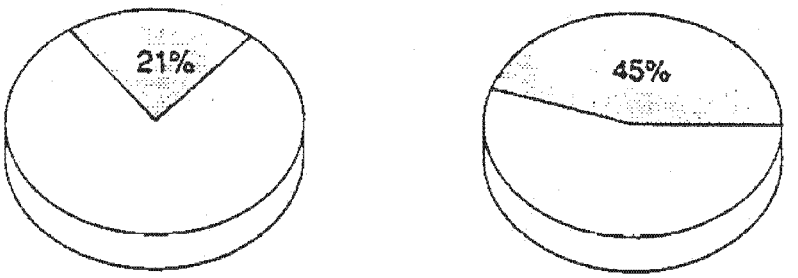
Finally, the Department of Social Services' scrutiny of the character and competence of potential operators applying for licenses to operate adult homes also seems limited. In two specific incidents in the past two years, identified by the Commission, operators and administrators of adult homes with long track records documented in the Department of Social Services' files of very poor conditions were approved to operate another home.

Conclusion

As reflected in this report, the Commission's study found that adult homes are a valuable resource in meeting the needs of persons with mental illness for low-cost supervised housing, and they are a resource worth preserving. At their best, homes operated and staffed by caring and committed people were found to provide pleasant residential environments, access to mental health services, and opportunities for normalizing social and recreational activities. Twenty-one (21) percent of the residents in the 47 homes in our sample lived in such homes. (Figure 24)

At their worst, however, homes operating under the same regulatory conditions offered dirty and dismal living conditions, a lack of personal care and supervision, and a persistent atmosphere that devalued the residents. Despite the availability of on-site mental health services, sometimes from multiple agencies, residents' rehabilitative and support needs were often not met. Forty-five (45) percent of the residents in our sample of 47 homes lived in such homes. The remaining one-third of the residents lived in homes that rated somewhere in between, which also evidenced significant problems in several areas.

Figure 24: Percent of Residents in "Good" vs "Poor" Homes Visited [N=3,460]



Although two state agencies, the Department of Social Services and the Office of Mental Health, share responsibilities for ensuring the quality of residential and mental health services, the Commission's findings clearly illustrated that the needs of residents often fell between the cracks in this fragmented system of service delivery and regulation. The Commission believes that the conditions in these homes will not change substantially without basic changes in the structure and regulation of the industry.

Appropriate Level of Care

The Commission believes there is a need to reevaluate the role which many adult homes are being called upon to play in serving a large population of people who are mentally ill. These residents often have a greater level of need for assistance than adult homes were designed to provide – with personal care, with medication administration, with supervision and access to rehabilitative services, and with training in daily living skills. The demands placed upon the homes, particularly in urban areas like New York City, to serve increasing numbers of younger patients who are discharged from psychiatric facilities as their symptoms of acute mental illness are stabilized, have not been accompanied by reexamination of the roles of and relationship between the Office of Mental Health and the Department of Social Services in ensuring that the needs of these residents can and will be met.

Indeed, in the decade since the enactment of Chapter 669 of the Laws of 1977, the two agencies have not yet developed a viable and workable partnership to carry out shared responsibilities. Despite the authority granted to it, the Office of Mental Health has not proposed any changes in regulatory standards for adult homes which serve a significant population of residents with mental illness. And the changes that the Department of Social Services has proposed in its new Residence for Adults Regulations would actually diminish the obligation of homes serving people with mental illness to provide personal care to residents.

The Commission believes it is time to confront directly the reality of the intensive needs of mentally ill residents of adult homes for substantial assistance to overcome their functional disabilities.

This fragmentation and the division of regulatory responsibility between the Department of Social Services and the Office of Mental Health dilute accountability by both entities and require correction.

While the state agencies and private providers have been relatively successful in making mental health services available and accessible to residents of adult homes, they have been less successful in ensuring that these services are targeted to assist residents with mental illness in developing the skills and competencies they require to live successfully in adult homes. The fragmentation of responsibility between the adult home provider, who provides room and board for $23 per day, and the outpatient mental health provider, who might earn $60 for a single half-hour clinic visit, often produces a tense and uneasy coexistence between these entities rather than collaboration in meeting residents' needs. This fragmentation and the division of regulatory responsibility between the Department of Social Services and the Office of Mental Health dilute accountability by both entities and require correction.

There is a need to integrate the currently fragmented efforts of the adult home operator and mental health providers to ensure the delivery of appropriate services, including rehabilitative and support services, supervision, and assistance with personal care and administration of medications. At the same time, there should be a single locus of regulatory responsibility with standards and expectations tailored to the real needs of the resident population. This may well require a different level of care, staffing and reimbursement than is currently provided for adult homes.

While there are persuasive arguments for maintaining this regulatory responsibility with the Department of Social Services, the important roles that the Office of Mental Health plays in funding and regulating outpatient mental health services, and in operating and regulating inpatient facilities which discharge patients to adult homes, suggest that this agency may be better positioned to comprehensively regulate the conditions that affect residents of these homes either directly or

under a delegation of responsibility from the Department of Social Services.* In addition, it should be noted that the Office of Mental Health currently has responsibility and experience with the regulation of other residential options for persons with mental illness.

Separate Homes for Mentally Ill Residents?

During the course of this study, the Commission repeatedly heard recommendations to adopt a formal policy of establishing separate adult homes for persons with mental illness. In some parts of the state and in many homes, this has become the de facto policy with 90 percent or more of the residents of adult homes having histories of prior inpatient psychiatric hospitalization. Furthermore, there appears to be a pattern developing that as residents with mental illness become a majority, the change in the overall composition of the home accelerates until it predominantly serves only these residents. As one state official put it, "These homes serve the mentally ill because neither they nor the residents have any choice."

Our study found that there is a strong correlation between poor conditions and a high proportion of public-pay mentally ill residents.

With that lack of choice, and with the diminishing ability of such homes to attract private-pay residents who often pay higher fees, an important "market force" for quality care is lost. Both the residents and providers are left solely to the influence of the regulatory structure to set and enforce standards (discussed below).

Although the Commission recommends confronting the existing reality that there are homes that predominantly serve residents with mental illness, we believe that there is a strong value in encouraging the preservation of mixed populations in adult homes that will continue to be regulated by the Department of Social Services, so that residents with mental illness are not segregated. Our study found that there is a strong correlation between poor conditions and a high proportion of public-pay mentally ill residents. Accelerating the concentration of residents with mental illness in adult homes will likely lead to deteriorating conditions of care.

*In assessing the feasibility of this shift in regulatory responsibility, it will be important to ensure that the residents' entitlements are not jeopardized by the classification of these residences as Institutions for Mental Disease under the Social Security Act.

One of the primary values of adult homes is that they are generic low-income housing available to people with a variety of needs. Recognizing that there is a need for additional development of adult homes, the Commission believes that the licensure of such new homes creates significant opportunities to avoid the trend toward segregation and to broaden the choices available to public-pay residents with mental illness who need such housing. We suggest that the licensure of new development be conditioned upon setting aside a portion of these new beds for such residents (e.g., 10-15 percent of the beds in a home).

Regulation/Enforcement

The system of inspection, regulation and enforcement for adult homes requires significant revision. The Commission learned that substantial efforts have been made over the past three years to bring order and regularity to the inspection process and to develop and implement a system of progressive fines which had been nonexistent. These measures have unquestionably had an effect upon a portion of the industry that has been prodded to correct regulatory violations.

More fundamentally, the threat of the imposition of token fines has been ineffective in prompting remediation of problems that would be expensive to correct.

However, this enforcement strategy appears to have had little effect upon larger, better financed and more recalcitrant providers who have successfully used the rigidity of the bureaucratic process to defeat efforts to correct egregious and long-standing deficiencies. More fundamentally, the threat of the imposition of token fines has been ineffective in prompting remediation of problems that would be expensive to correct.

Ironically, there appears to be considerable evidence that Department of Social Services' follow-up was more aggressive toward homes evidencing overall good conditions and services. This outcome appears to be the natural consequence of the Department's failure to differentiate its allocation of enforcement resources and efforts to homes with serious problems. Applying similar strategies and resources to homes with overall good and poor conditions and services, the regulatory system often missed the poorer homes, while operators of better homes often justly complained that they were fined for minor deficiencies that they would readily agree to correct.

The Department also rarely took advantage of the full arsenal of enforcement tools which the Legislature had put at its disposal more than ten years ago. Today, the Department has a variety of tools at its disposal, ranging from fines, to restrictions on operating certificates, to receivership, to court orders mandating compliance under penalty of criminal contempt. Yet, despite this enhanced capability, the Commission found that the Department continues to rely almost exclusively on token fines as its sole enforcement strategy. For example, the Department has rarely taken action to limit the operating cer-

tificates of poor homes in terms of their ability to admit new residents -- a penalty far more consequential than the relatively small fines that are imposed.

Simultaneously, the regulatory system exerts little attention to the critical importance of the character and competence of adult home operators in determining the overall quality of conditions and services. There was evidence that the Department had approved individuals to serve as "operators" of additional adult homes, even when there was substantial evidence that they had failed to assure basic regulatory compliance in the homes where they already served as operators. Similarly, the frequent selling and buying of adult homes with serious problems, sometimes encouraged by the Department, sometimes appeared to take place without a realistic appraisal of either the character or competence of the new operator or his/her financial capability or willingness to achieve the needed improvements in the home.

Homes with similar funding levels had a wide range of performance, ranging from excellent to abysmal.

In the recommendations that follow, the Commission offers several proposals to better target enforcement efforts on the relatively small number of providers who account for a large portion of the deficient beds, to broaden the arsenal of enforcement tools used and to sharpen the scrutiny of the character and competence of those who are licensed.

Funding/Incentives

There is continued debate about the adequacy of funding for adult homes. Homes with similar funding levels had a wide range of performance, ranging from excellent to abysmal. The Commission found no clear basis for recommending an across-the-board increase in the SSI reimbursement level, particularly as the existing levels have been set without reference to any reliable information on the actual cost of care.

What our study did find, however, is the absence of any positive incentives for improved performance. In the present flat-rate funded system, there is little incentive for providers to invest potential profits to enhance their operations, particularly since the regulatory system demands only minimal compliance. All of the reinforcers in the regulatory system are negative, and, as we have described, these don't work consistently and effectively to produce the desired results.

We believe there is a need for a Quality Improvement Program that will pay cash incentives for performance that exceeds minimal regulatory requirements in key areas affecting residents' daily lives -- e.g., physical environment, furnishings, quality of bedrooms and bathrooms, attractiveness of common areas and grounds, quality of meals and dining conditions, attentiveness of care plans to residents' needs, resident satisfaction, etc. The Commission recommends legislative authorization for the creation and funding of such a program.

Advocacy

Finally, the Commission was struck by the powerlessness of the residents of many of the homes over the conditins which determined the day-to-day quality of their lives. For most, the adult home placement was all that stood between them and homelessness. They were understandably wary of provoking the wrath of the provider and jeopardizing their "home." Hence, they file relatively few complaints despite the abundant egregious and persistent violations in some of these homes.

What is less understandable is that a host of medical and mental health professionals are in these homes regularly, and directly witness the significant problems which affect the daily lives of the residents they come to serve; yet they too, for the most part, remain silent. While many were vocal and vehement in decrying the conditions in some of the homes to the Commission, they rarely sought assistance from either the Department of Social Services or the Office of Mental Health in addressing the conditions which disturbed them. They too, it appears, were reluctant to jeopardize their relationship with the home or their continued role as a provider of medical or mental health services.

The Commission was struck by the powerlessness of the residents of many of the homes over the conditions which determined the day-to-day quality of their lives.

The Ombudsman Program for the Elderly, which is operated at a county level, has been implemented inconsistently and relies heavily on the efforts of volunteers. Only 28 percent of the sampled homes were served by the Ombudsman Program. Even where the Ombudsman Program exists, the volunteers recognize that their best chance of being effective in addressing residents' complaints is to develop collaborative working relationships with the adult home operator. Failing that, or confronted with provider intransigence, some of the ombudsmen report that they find the formal complaint mechanisms which exist in the Department of Social Services to be bureaucratic, time-consuming and ineffective.

The Commission believes it essential to ensure that mentally ill residents of adult homes have access to advocates whose primary mission is to advocate for their interests. We also believe it is important that volunteer ombudsmen have access to legal advocates whose efforts may be required to resolve problems that are not amenable to resolution otherwise.

Recommendations

Appropriate Level of Care

(A) The Office of Mental Health should conduct a careful assessment of the residents living in adult homes which have 25 percent or more residents with mental illness to identify the level of their needs for personal care, supervision, medical and mental health services, rehabilitation and support services, case management, and assistance with medications.

(B) Based on the preceding assessment, the Office of Mental Health should propose the development of a different level of care than the current adult home which, we believe, often fails to meet the needs of residents with mental illness of such homes. This new level of care should specifically identify the skills, qualifications, and staffing ratios required to adequately address the needs of the residents, as well as the level of reimbursement and the role of or relationship with on-site and off-site mental health providers to meet the residents' needs. This new level of care should be regulated by the Office of Mental Health, either directly, or pursuant to a delegation of responsibility from the Department of Social Services. The Department of Social Services and the Office of Mental Health should jointly decide what proportion of residents with mental illness would warrant moving a home to this new level of care.

(C) The Office of Mental Health should establish clearer standards and expectations for services from outpatient mental health programs which operate in adult homes to provide residents rehabilitation and support services, particularly in addressing their needs for personal hygiene and grooming, and activities of daily living.

(D) On an annual basis, the Office of Mental Health should certify whether an adult home whose resident population consists of more than 25 percent of persons with mental illness is an "adequate and appropriate" setting to meet the needs of persons discharged from inpatient psychiatric facilities (MHL ·29.15 subd. (h), para. 1.). This certification should be made following an on-site inspection, as well as a review of inspection reports prepared by the Department of Social Services. If any such home is deemed not adequate and appropriate for discharged patients,the Office of Mental Health should so advise the facilities it operates or certifies and simultaneously advise the Department of Social Services to bar further admissions of such individuals to these facilities.

Regulation/Enforcement

The existing system of certification, inspection, regulation and enforcement needs a critical evaluation and refocusing to ensure that it meets the objective of assuring the character and competence of providers, and fair, equitable and effective enforcement of the law and regulation. Accordingly, the Commission recommends:

The Department of Social Services should target a larger portion of its inspection and enforcement resources to addressing the need for corrections in homes which have serious and recurrent problems.

(A) The Department of Social Services should target a larger portion of its inspection and enforcement resources to addressing the need for corrections in homes which have serious and recurrent problems. Specifically, a select team of inspectors, auditors and attorneys should be created to ensure the identification and remediation of long-standing problems that affect the quality of life for residents in these homes.

(B) The Department of Social Services should broaden the focus of its inspection and enforcement efforts to not only identify specific deficiencies in the homes, but also the underlying causes of such deficiencies, and ensure that facility plans of correction correct not only the conditions but also the underlying causes. In this connection, the Department of Social Services should require that providers develop and annually update plans and schedules for maintenance and repair of the physical plant, and replacement of furniture and equipment.

(C) Since the current system of imposing fines as a means of promoting correction, particularly at homes with recurrent deficiencies, is ineffective, the Commission strongly recommends that the Department of Social Services utilize the broader range of tools provided by the Legislature, including suspension of admissions, limiting operating certificates, and seeking court orders and temporary receivership to assure remediation of serious problems which remain despite the payment of fines. At the same time, the Department of Social Services should use its discretion to provide technical assistance to homes which generally meet standards but which have had difficulty correcting specific violations.

(D) If the conditions of a home are such that a change of operator is deemed a viable solution, the Department of Social Services should ensure that major problems are corrected prior to a new operator receiving a full operating certificate. The Department of Social Services should consider utilizing its powers to place homes in temporary receivership to accomplish this objective, if necessary.

(E) In determining the character and competence of licensees, both upon initial application and upon renewal of licenses, there should be a more searching scrutiny of the licensee's historical performance in complying with laws and regulations relating to adult homes or other licensed care facilities, as well as independent fiscal audits of troubled facilities to examine how decisions on the disposition of available income have affected conditions at the facilities.

(F) The Social Services' Law and Regulations should be amended to ensure that providers annually submit balance sheets relating to the adult home. Such balance sheets are important to accurately determine the profitability of the home. The Department of Social Services should audit a sampling of such reports to assist in determining the need for adjustments in the level of reimbursement.

(G) The Department of Social Services should develop standard procedures whereby relevant findings identified through the review of adult home financial statements and balance sheets are routinely shared with inspectors and appropriately integrated in Department assessments of conditions, services, and required improvements in adult homes.

(H) Prior to transferring or renewing the operating certificate of an adult home, the Department of Social Services should solicit comments from residents, family members, mental health and medical providers, advocates and other community agencies which have a relationship with the adult home.

(I) The Department of Social Services should reassess its existing adult home inspection process to identify ways in which it can provide positive reinforcement to homes which are found to be in general compliance with regulations. Among the measures the Department of Social Services should consider are certificates of recognition, suitable for posting, as well as reducing the frequency of inspections at such homes.

We recommend that, in lieu of an increase in the SSI payment level, the Legislature authorize the creation and funding of a Quality Improvement Program.

(J) The Department of Social Services should enforce the staffing standards contained in its regulations.

(K) Fines collected by the Department of Social Services should be deposited in a special fund and made available for the purpose of providing training for the staff of adult homes and of the Division of Adult Residential Services and the provision of technical assistance to adult homes.

(L) The Department of Social Services and the Office of Mental Health should require annual in-service training of facility and on-site mental health staff of all adult homes.

Funding/Incentives

We recommend that, in lieu of an increase in the SSI payment level, the Legislature authorize the creation and funding of a Quality Improvement Program which provides financial incentives to providers to exceed minimum standards in delivering quality services to residents of adult homes. In essence, such a program would provide additional cash payments beyond the SSI rate for exceeding standards in specifically defined areas such as physical environment, resident participation in programs and activities, quality of personal care, resident satisfaction, etc.

Similar programs have been implemented in other states and have reportedly produced significant improvements in the conditions of congregate care facilities.

Integration/Separation

(A) As applications for new adult homes are considered by the Department of Social Services, approvals should be conditioned upon setting aside a percentage of the beds for residents with mental illness who receive SSI (e.g., 10-15 percent).

(B) At the same time, the Department of Social Services should consider encouraging more not-for-profit agencies to develop adult home beds and explore the feasibility of legislation authorizing the funding of construction costs through tax-exempt bonding.

Advocacy

(A) Funding for advocacy services for the residents of homes which predominantly serve mentally ill residents should be increased. In addition, Ombudsman Programs should be strongly encouraged to develop effective working relationships with legal advocacy programs that are available in their communities.

(B) Statutory and/or regulatory changes should be made to require mental health and medical professionals employed or retained by a mental health provider to provide services at an adult home to report to the Department of Social Services and the Office of Mental Health conditions and services that are harmful to residents and substantially adversely affect the quality of life in such homes.

APPENDIX A

PERFORMANCE RATINGS OF ADULT HOMES VISITED

Performance Ratings Of Adult Homes Rated "Good"* [N = 19]

	Housekeeping	Furnishings	Maintenance	Fire/Safety	Nutrition/Meal	Personal Care	Medication Srvs.	Medical/Mental Health Srvs.	Activities	Residents' Rights	Staff Interactio
St. Zita's Villa	○	○	○	○	○	○	○	○	○	○	○
Seaview Manor HFA	○	○	○	○	○	○	○	○	○	○	○
Dawn Hill Adult Home	○	○	○	○	○	○	○	○	○	○	○
Pines Rest Home	○	○	○	○	○	○	○	○	○	○	○
Academy HFA	○	○	○	○	○	○	○	○	○	○	○
Ridgeview Guest Home	○	○	○	○	○	○	○	○	○	○	○
Grantier Rest Home	○	○	○	○	○	○	○	○	○	○	○
Wiltshire House	○	○	○	○	○	○	○	○	○	○	○
Evergreen Manor	○	○	○	○	○	○	○	○	○	○	○
Maple Manor HFA	○	○	○	○	○	○	○	○	○	○	○
Bida HFA	○	○	○	○	○	○	○	○	○	○	○
Johnson Adult Home	○	○	○	○	○	○	○	○	◐	○	○
DePaul HFA	○	○	○	◐	○	○	○	○	○	○	○
Chai HFA	○	○	○	○	○	○	◐	○	◐	○	○
Holly Loch Rest Home	○	○	○	○	○	○	◐	○	○	◐	○
Manor Haven Adult Home	○	◐	◐	○	○	○	○	○	○	○	○
Martin Residence	○	○	○	○	○	○	○	○	◐	◐	○
Pines HFA	○	○	●	○	○	○	○	○	○	○	○
Park Rest HFA	○	○	◐	○	○	○	○	◐	○	○	○

Key:

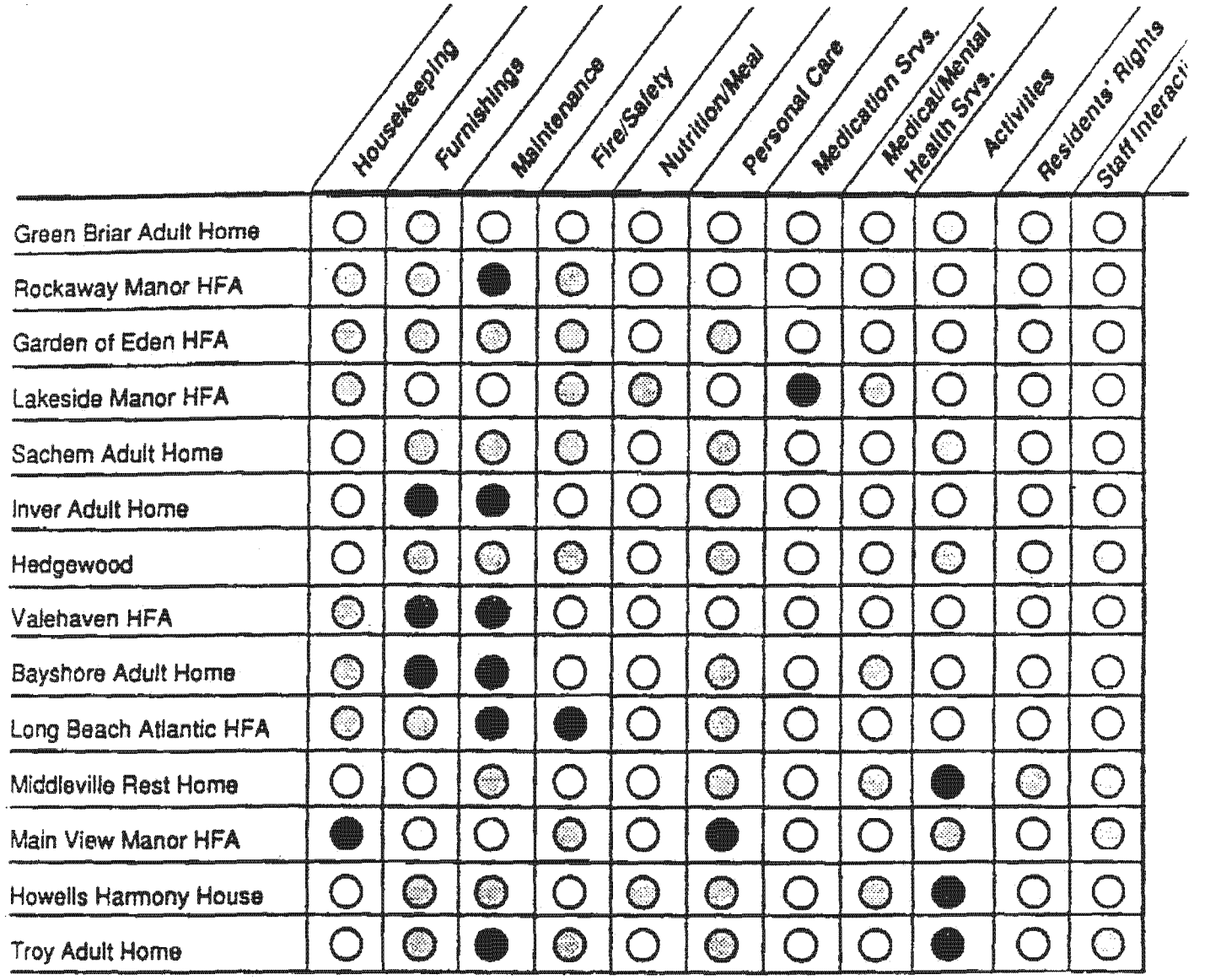
○ = No or Minor Problems

◐ = Some Significant Problems

● = Serious Problems

*It should be noted that conditions in adult homes fluctuate from time to time. These summary ratings represent a snapshot of these facilities at the time of the Commission's visit. For many adult homes visited, the operator and/or the administrator have planned or implemented corrective actions.

Performance Ratings Of Adult Homes Rated "In Need of Improvement"* [N = 14]

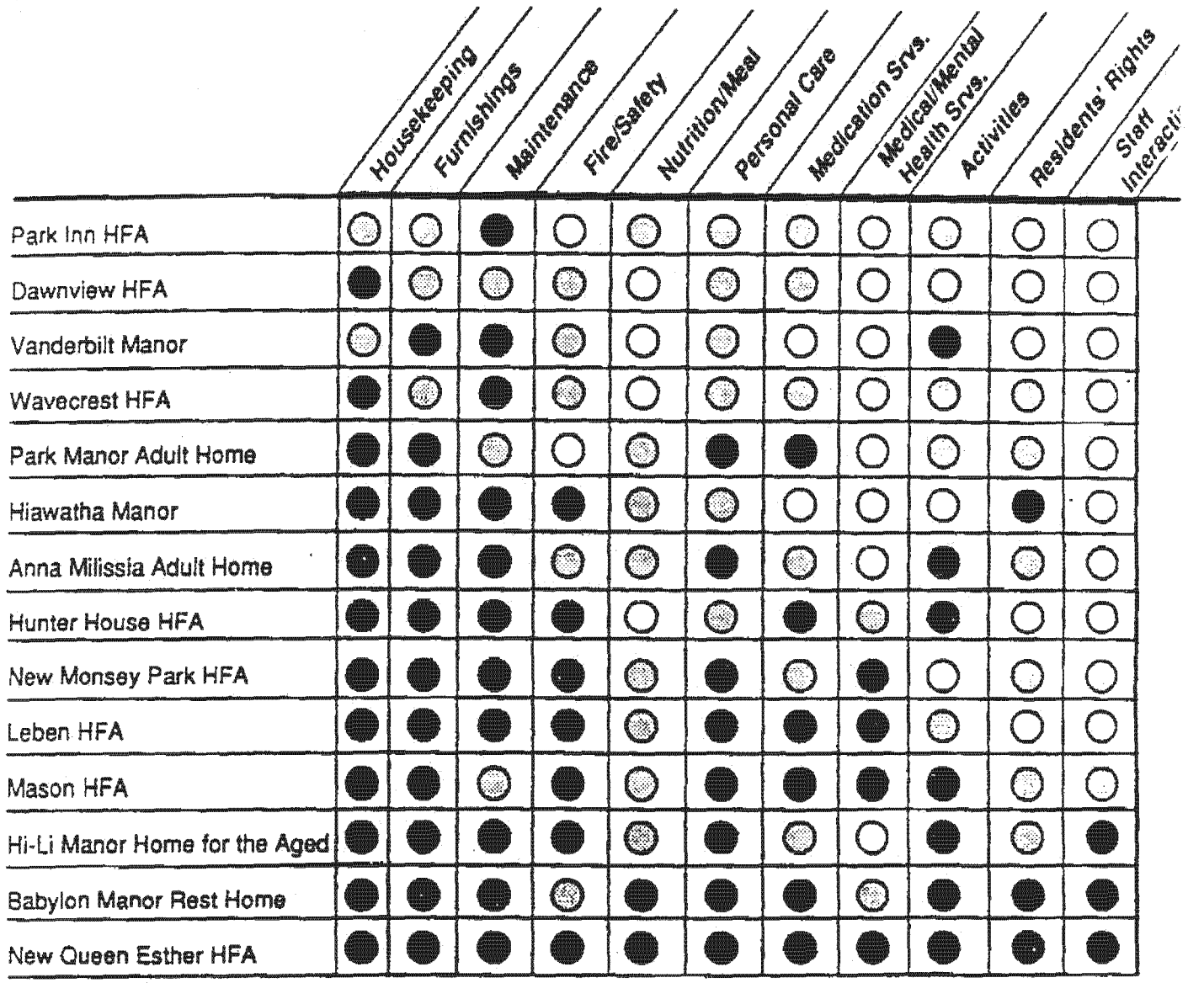


Key:

- ○ = **No or Minor Problems**
- ◐ = **Some Significant Problems**
- ● = **Serious Problems**

*It should be noted that conditions in adult homes fluctuate from time to time. These summary ratings represent a snapshot of these facilities at the time of the Commission's visit. For many adult homes visited, the operator and/or the administrator have planned or implemented corrective actions.

Performance Ratings Of Adult Homes Rated "Poor"* [N = 14]



Key:

- ○ = **No or Minor Problems**
- ◐ = **Some Significant Problems**
- ● = **Serious Problems**

*It should be noted that conditions in adult homes fluctuate from time to time. These summary ratings represent a snapshot of these facilities at the time of the Commission's visit. For many adult homes visited, the operator and/or the administrator have planned or implemented corrective actions.

APPENDIX B

RESPONSES TO THE DRAFT REPORT FROM

- Department of Social Services
- Office of Mental Health
- State Office for the Aging

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

CESAR A. PERALES
Commissioner

June 25, 1990

Dear Mr. Sundram:

The Department has concluded its review of the final draft of the report of the Commission's study of adult homes serving persons with mental illness. As requested, I have attached the Department's formal response to the study's findings and recommendations.

On behalf of the Department, I would like to express my appreciation for having had the opportunity to comment on the study.

Sincerely,

Cesar A. Perales
Commissioner

Att.

Honorable Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Suite 1002
Albany, New York 12210

A REVIEW OF NEW YORK STATE ADULT HOMES SERVING PERSONS WITH MENTAL ILLNESS

by

New York State Commission on Quality of Care
for the Mentally Disabled

COMMENTS FROM THE NYS DEPARTMENT OF SOCIAL SERVICES

EXECUTIVE SUMMARY

The New York State Department of Social Services (Department) recognizes that there has not been a major review of the adult home industry for over a decade. This review was requested by the Legislature and conducted by the New York State Commission on Quality of Care for the Mentally Disabled (Commission). The pressures created by limited resources and increasing demands for services will require state government to utilize creative approaches to service delivery and an increased collaborative spirit between State agencies.

While the Department may concur with many of the general observations and recommendations proposed by the Commission's report, there are some basic and specific issues raised by the report which require very careful consideration. The Commission report very clearly identifies the adult home as a valuable resource for individuals with mental disabilities. In addition, the report recognizes that the "state regulations for adult homes, as well as the public funding levels for these homes, assumes that their residents are in need of basic custodial care, some assistance with personal care, moderate supervision and the support of appropriate community services". Adult homes are not treatment facilities. As the report so accurately portrays, the quality of care received by the residents will be substantially compromised, when operators fail to target the limited Supplemental Security Income (SSI) and Public Assistance/Home Relief benefits to the needs of residents, when operators fail to manage admissions or when others make placements without a careful understanding of the service scope and capabilities of the facilities, and when the appropriate community services are not available.

The following comments address various specific issues that are raised within the body of the report.

Who Lives In Adult Homes?

The comparison of the residents of adult homes and community residences suffers by its failure to note the different focus and service ranges of the two types of facilities. It should be understood that on the basis of program intent and practice there are expected differences in the functional capacities of the residents. Residents of community residences are generally higher functioning and more capable of living independently. Community residences are promoted as transitional training environments for persons who are expected to make a transition to independent living within the near-term when provided with a program of rehabilitation and training. The adult home resident may have limited potential for independent living. Accordingly, the Activities of Daily Living (ADL) tasks with the greatest disparity (i.e. laundry, meals and housekeeping) must be provided for the residents of adult homes. In contrast, these same tasks are accomplished by the residents of community residences.

Medical and Mental Health Services

The report accurately indicates that adult home operators are required to ensure that access to outpatient mental health services be provided to their residents. Although the responsibility for making arrangements for services does rest with the adult home operator, the failure to provide out-patient mental health services is often caused by the lack of availability of such services and should not be attributed to any failure on the part of the operator.

Medication Administration

The report notes that adult home administrators claim that most residents are in need of significant or total assistance in the area of medication administration. It is the experience of the Department that many operators overstate the residents' need for assistance in the interest of comfortable central management and at the expense of individual resident autonomy and control. It is easier for the operator to do this because providing these services for the resident requires less resource time and energy. Therefore, overstating the residents' need for assistance is attributable to the operator rather than to a measure of the residents' actual abilities.

The Cost of Care

Supplemental Security Income (SSI) eligibility is based on categorical need and income, and not one or the other. Therefore, there should be a correction in this section which reads "...SSI cash assistance program for persons who are disabled or aged, and who have little income or resources."

RECOMMENDATIONS

Appropriate Level of Care

Although the Department is in strong agreement with the recommendations made in the report to conduct careful assessments of current residents living in adult homes which have 25 percent or more residents with mental illness to identify the level of their needs and to explore the possibility of new service configurations, we continue to disagree with the Commission's conclusion that the Department's new Residence for Adults Regulations would diminish the obligation of homes serving the mentally ill to provide personal care to residents. The Department supports the integration of persons with mental disabilities to the fullest extent possible. However, we recognize that there are adult homes which are capable of responding to the needs of a younger, more physically independent population than was ever envisioned in the regulations for adult homes. All of the references in the report, which indicate that operators are doing laundry, light housekeeping, etc., are a reflection of the original orientation of adult homes to serve a physically frail elderly population, rather than the younger mentally ill client that can perform these functions on their own.

As the report notes throughout, one of the greatest needs of the mentally disabled now living in adult homes is more support to overcome basic functional deficits that are a result of psycho-social

problems rather that physical limitations. The Residence Regulations do not reduce the obligation of the operator to respond to these needs, but will shift the focus from having the operator perform functions for the resident to assisting the resident with the actual performance of the functions. The Residence Regulations will also strengthen the requirements for closer integration and coordination among the adult homes and the community mental health providers. The Department strongly believes that these reasons provide sound justification that the Residence for Adults category is a viable point from which to begin to address the needs of many of the physically independent mentally disabled population.

Regulation Enforcement

A. The Department concurs with the Commission recommendation that more targeting of inspection and enforcement resources is required to address the need for correction in homes with serious and recurrent problems.

B. The Department requires operators to correct conditions through its inspection and enforcement process. We have encouraged operators to develop broader corrective action plans. However, the Department has implemented a process of issuing Conditional Certificates during the recertification period that will ensure in the future that operators adhere to plans of maintenance and repair of the physical plant, as well as correction of other violations.

C. The Department has a variety of administrative and judicial remedies available to it when pursuing enforcement of law and regulations. In choosing which option to employ, the Department assesses the specific circumstances, the strength of the evidence, and the particular goal of enforcement. When necessary, the Department does and will continue to use court orders, in those circumstances when it appears to be the most effective available remedy. We also provide technical assistance, both through the Regional Offices and with contracted sponsors; however, we agree that more training is necessary. In addition, as mentioned above, we have implemented a process of limiting operating certificates to compel operators to address remediation of long-standing problems.

D. The Department does consider and pursue receiverships where it feels that such extraordinary action is warranted. In the vast majority of cases, the Department has allowed the operator to sell a facility provided that the operator submits an approved corrective action plan at the time of change of ownership. Through this process we feel that we can accomplish the same results in a more effective manner with less disruption to residents.

E. The Department concurs that more scrutiny of a licensee's historical performance and character and competence is necessary. We have allocated our limited resources over the last few years into inspection and enforcement.

F. As mentioned above, the limited resources of the Department have been focused on the inspection process. We concur that more effort and resources in the area of auditing would be beneficial.

G. The Department concurs that financial reports can be a useful tool. Because of the time allowed the facility operator to file financial reports and for desk audits in the Department, the information is dated by the time it would be available to the inspector. The financial reports are not currently public information and we would either have to use extracts of the reports or possibly pursue a change in law if we were to distribute the report. Despite these problems, in some instances the inspectors have successfully used the information from financial reports as part of the inspection process.

H. The Department concurs with the recommendation to solicit comments from persons and entities which have a relationship with the adult home. However, it is sometimes impossible to prevent operators with a long-standing relationship from influencing the comments received.

I. The Department is currently reassessing its inspection process in order to reduce the frequency of inspections at homes found to be in general compliance with regulations, while increasing the Department's presence in those facilities with recurring regulatory deficiencies.

J. The Department concurs with the recommendation.

K. The Department has attempted to establish a special fund from the fines collected for the purpose of training and technical assistance to adult home operators. Unfortunately the pressures to reduce the State budget deficit have made this impossible.

L. The Department concurs with the recommendation to require annual inservice training of facility staff. Our regulations do require operators to complete 25 percent of the required 60 hours in mental health coursework every two years .

Integration/Separation

A. Regarding the Commission's recommendation that approvals of new applications for adult homes being considered by the Department should be conditioned upon setting aside a percentage of the beds for residents with mental illness who receive SSI, the Department believes that the goal is laudable. However, current statutory restrictions and the probable unavailability of community services presently make this recommendation ill-advised.

Advocacy

B. While the Department agrees that medical and mental health providers should be required to report conditions in adult homes which are harmful to, or adversely affect, the quality of residents' lives, we would not at this time endorse the recommendation that this be enforced through statute or regulation. The Department also believes that adult home operators should be obliged to report deficits in mental health services. The Department proposes that the development of procedures to encourage such reporting and to appropriately respond to those reports should be included in the agenda of the DSS/OMH joint work group.

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

June 26, 1990

Clarence J. Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Suite 1002
Albany, NY 12210

Dear Chairman Sundram:

Thank you for the opportunity to review the draft report summarizing the Commission's findings during visits to adult homes serving a large number of persons with mental illness. This report clearly illustrates the need for improvements in several areas of the operation and management of adult homes across the State. However, I was pleased to learn that the Commission agrees that adult homes are a valuable resource in meeting the needs of persons with mental illness for low-cost supervised housing, and that they are a resource worth preserving.

Despite the Office of Mental Health's (OMH's) shared recognition of the need to correct problems and improve conditions and services, we disagree with the CQC's proposed means to attain such remedies. The CQC's proposed remedies jeopardize mentally disabled residents' entitlements; encourage the development of large, segregated congregate settings to serve mentally disabled individuals; would statutorily impose a cumbersome "mandated reporter" reporting process regarding conditions in adult homes; and are unaffordable.

Alternatively, OMH suggests a five point plan directed at correcting problems and conditions within adult homes. This plan is detailed in the enclosed response to the Commission's report. We believe our response does not entail the risks inherent in the Commission's approach yet holds the promise of achieving the desired goal.

I look forward to our continuing dialogue and hope to have your support and advocacy for the changes needed to improve the services provided and conditions in adult homes.

Sincerely,

Richard C. Surles, Ph.D.
Commissioner

Enc.
cc: Cesar Perales

Commission on Quality of Care's
Review of New York State Adult Homes
Serving Persons with Mental Illness

OMH Response

The Office of Mental Health concurs with the Commission on Quality of Care (CQC) that there is a range of problems within adult homes serving a significant proportion (25 percent or more) of individuals with a history of mental illness. The problems in such homes, known as "impacted" adult homes, range from minor to very serious and warrant a jointly developed strategy from the Department of Social Services (DSS) and the Office of Mental Health (OMH). Consistent with the goal of the CQC's recommendation, this joint strategy should be aimed at improving the quality of residential and mental health services provided to the residents of "impacted" homes.

Despite OMH's shared recognition of the need to correct problems and improve conditions and services, we disagree with the CQC's proposed means to attain such remedies. The CQC's proposed remedies jeopardize mentally disabled residents' entitlements; encourage the development of large, segregated congregate settings to serve mentally disabled individuals; would statutorily impose a cumbersome "mandated reporter" reporting process regarding conditions in adult homes; and are unaffordable.

As the CQC acknowledges, adult homes provide a valuable, low cost, permanent housing option to mentally ill individuals capable of and having a right to live in a community setting. As such, it is a resource worth preserving. A history or incident of psychiatric inpatient care should not prohibit an individual from residence in an adult home or cause them to be identified as a life long OMH client. Currently, almost 9,000 individuals who have accessed mental health services reside in adult homes.

Development of separately certified, adult home settings to serve individuals with a history of mental illness, is not a program prototype that OMH wants to encourage. Furthermore, such an approach presents a risk of having such settings designated by the Federal government as Institutions for the Mentally Diseased. If so designated, residents' Federal Medicaid and SSI benefits are jeopardized.

As indicated, the OMH does agree that not all 9,000 residents with a history of mental illness are appropriately served in an adult home setting. Improvements in conditions and services are warranted. Both DSS and OMH need to improve and expand upon their respective quality assurance and enforcement practices within the adult home setting.

As an alternative to the CQC's proposal, the OMH recommends the following approach to remedy these issues:

1. Develop a joint MOU with DSS which defines appropriate, adult home admission and continuing stay criteria.

   DSS and OMH have established a joint work group to develop this MOU. The steering committee for the work group is jointly chaired by the DSS Deputy Commissioner for Adult Services and the OMH Senior Deputy Commissioner for Operations. The steering committee met in June and developed a time line for the work of this group which would require completion of this MOU by June, 1991.

2. Develop a joint MOU regarding a process by which the appropriate level of services would be determined and provided to residents who are mentally ill. It is expected that this work group will be making recommendations regarding the organization and coordination of multiple on-site mental health service providers. The steering committee established time line for this group is also June, 1991.

3. Finalize the existing, draft DSS/OMH MOU regarding joint inspections of adult homes. This document exists in draft and has been piloted in the Western and Central Regions. This document can be finalized by August, 1990 at which time a limited joint inspection schedule will be worked out between DSS and OMH regional offices. Both agencies recognize that this document may change based on the work of the admission/continuing stay and service MOU work groups. A more ambitious joint inspection schedule will be developed contingent upon the FY 1991-92 Budget approval of additional quality assurance staff reinvested from OMH facilities.

4. Provide training to facility staff in June, 1991, when the MOU work groups have completed their work. Training will be held for facility staff (adult home and State psychiatric center staff) to insure they share a joint understanding of appropriate admissions and continuing stay criteria. In addition, training for DSS regional and OMH regional quality assurance staff regarding appropriate level of services and enforcement of continuing stay criteria will be held. The steering committee set June/July, 1991 as the target training date for facility staff and July/August, 1991 for the target training date for the regional quality assurance staff.

5. Request regional resources to be dedicated to adult home quality assurance issues. The OMH has agreed to propose in its 1991-92 budget request the reinvestment of 10 staff from the facilities to the regional offices who would be dedicated to adult home quality assurance issues.

The OMH believes this approach will ensure individuals are appropriately placed and maintained in adult homes while simultaneously discouraging the development of new, separate congregate settings for the mentally disabled. Additionally, residents' entitlements will continue and development of a targeted quality assurance system is provided for.

The OMH's responses to the four areas (Level of Care, Regulation Enforcement, Integration and Advocacy) in which the CQC makes OMH specific recommendations follow:

1. Appropriate Level of Care:

   a. CQC: Assess mentally disabled residents of "impacted" adult homes to identify their health, medical and mental health needs.

      OMH: The Office's proposed regional office quality assurance presence will enable us to identify individuals whose mental health and related needs are unmet and access the needed assessment. This approach would be more targeted than a "blanket" assessment of all residents of "impacted" homes, thereby insuring it can be done with existing and requested resources and causing less intrusion into individuals' lives.

   b. CQC: Develop a different level of care to meet the needs of individuals inappropriately placed in adult homes.

      OMH: As indicated, OMH finds this recommendation unacceptable. Alternatively, the OMH proposes tighter oversight of admission and continuing stay criteria and the development of a process to determine the appropriate level of services to be provided to an individual resident.

   c. CQC: OMH should develop clearer expectations for outpatient mental health providers operating in adult homes.

      OMH: The Office agrees and feels the MOU regarding a process to determine the organization and level of services to be provided will meet this objective. As indicated, the projected completion date for this MOU is June, 1991.

   d. CQC: Annually the OMH should certify whether an "impacted" adult home is an adequate and appropriate setting to meet the needs of persons discharged from a psychiatric inpatient setting.

OMH: The Office agrees and feels the requested regional office adult home quality assurance presence will enable the Office to meet the goal of this recommendation.

2. Regulation Enforcement:

CQC: DSS and OMH should require training of facility and on-site mental health staff of all adult homes.

OMH: The OMH and DSS have agreed to develop joint training for adult home and State psychiatric center discharge and regional office quality assurance staff. Such training will focus on admission and continuing stay criteria and identification and referral of individuals in need of assessment for services and/or discharge from adult homes. As indicated earlier, this training will commence in June, 1991. It is the intent of both agencies to provide such training on a recurring, periodic basis.

Training of on-site mental health staff is not currently planned but may follow the development of the MOU on the process to determine the appropriate level of mental health services to be provided.

3. Integration:

A. CQC: Approval of adult home Certificate of Need (CON) applications should require providers to set aside a certain percentage of beds for individuals who are mentally disabled and receive SSI.

OMH: The OMH endorses the concept of setting aside beds in newly established adult homes for people with mental illness. This approach is consistent with the OMH goal of accessing integrated housing and creating adequate residential capacity in each region of the State. The legal implications of accomplishing this through the CON process must be reviewed.

4. Advocacy:

B. CQC: Medical and mental health providers should, by statute and/or regulation, be required to report conditions in adult homes which are harmful to or adversely affect the quality of residents' lives.

OMH: The Office of Mental Health agrees that medical and mental health providers providing services to residents of adult homes should be required to report conditions that are harmful to residents and substantially adversely affect the quality of life in such homes. However, the Office does not endorse the idea that such a requirement

be enforced through statute and/or regulation. Rather, such requirements should be enforced through the regionally based quality assurance staff which make periodic visits to each "impacted" adult home.

NEW YORK STATE OFFICE FOR THE AGING

Mario M. Cuomo, Governor 2 Empire State Plaza, Albany, NY 12223-0001 Jane G. Gould, Director

June 22, 1990

Mr. Clarence Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210

Dear Mr. Sundram:

Thank you for the opportunity to comment on the Commission's draft report: A Review of New York State Adult Homes Serving Persons With Mental Illness. The report is well done, and we generally agree with its findings, many of which confirm our own experience in the State Long Term Care Ombudsman Program.

For perspective, we want to note that the recommendations of this report not only focus on mentally ill residents and their needs but also are based on a small initial sample (47) and an even smaller number (12) of adult homes with serious problems. Therefore, readers should both understand this limitation (There are over 1300 adult care facilities in New York State, about 470 of which are adult homes with about 30,000 residents.) and not assume erroneously that the findings of poor care apply to all adult homes. Nevertheless, shortcomings in the current regulatory scheme do have negative effects on all adult home residents regardless of mental health status.

Here are our responses to the recommendations of the report:

Regulation Enforcement

We agree that the regulatory system, and enforcement in particular, needs significant revisions. The New York State Department of Social Services needs both the tools and the resources required to ensure quality care. Clearly, improvements in the administration of the regulatory system will benefit all residents of adult homes, not only those who are mentally ill. In addition, however, we would highlight the limitations on current enforcement options and recommend that the provisions of the Social Services Law also be strengthened.

For example, Section 460-d(7)(b)(1) of the Social Services Law prohibits the Department of Social Services from imposing penalties if the violation is corrected within 30 days of receipt of the inspection report, except in extreme circumstances. The result is that this law gives providers no incentives to deliver or maintain quality care. The only incentive is to correct a violation after the inspection report is issued. Thus, we recommend a thorough review of the enforcement provisions of the Social Services Law to identify and remove all barriers to ensuring quality care and to strengthen and expand the enforcement remedies available to the Department.

We would support the use on an interim basis of a select team of inspectors, auditors, and attorneys to target those adult homes with the greatest current problems. However, such an approach on a continuing basis should not be necessary in a well developed regulatory system.

We agree that the State Department of Social Services itself can take steps to improve its enforcement system. We suggest that they look to the New York State Department of Health which has a sophisticated, well-run nursing home enforcement system which has served as a model for other states. That system includes a wide range of mechanisms for promoting and ensuring compliance and can serve as a model for the State Department of Social Services.

In addition, in the Department of Health enforcement system, the State Long Term Care Ombudsman in the State Office for the Aging is notified of all enforcement activity. The State Ombudsman Program then informs the appropriate substate long term care ombudsman program which increases on-site monitoring of resident conditions. When enforcement actions are occurring, residents are especially vulnerable to inappropriate transfers, poor care, violations of rights, and abuse.

The State Long Term Care Ombudsman Program also represents the interests of residents during the State Health Department receivership process. The Ombudsman Program organizes and supports a temporary committee of residents, family members, and other concerned persons to interview prospective receivers and make recommendations to the Health Department. The Ombudsman Program also reviews prior complaint data, facility inspection reports, plans of correction, sustained findings of patient abuse, and other materials in reaching a recommendation regarding the proposed receiver.

We suggest similar State Long Term Care Ombudsman roles with the Department of Social Services and adult care facilities. In addition, because it is an appropriate role for the Long Term Care

Ombudsman to coordinate and support resident and family input into State Department of Social Services decisions, these roles should include the review of initial, transferring, or renewing operating certificates as suggested by the Commission's report.

Regarding operating certificates, we believe that the Department of Social Services must be required to issue a conditional, time limited operating certificate whenever the operator has a record of persistent violation, even if corrected within 30 days. Furthermore, we recommend much greater resident input into individual facility inspections.

We also strongly recommend that in reviewing applications for operating certificates the Department of Social Services carefully examine all business relationships which might present conflicts or improper relationships -- particularly leases, supply contracts, and human services agreements. These arrangements have significant effects on financing and the quality of services provided to residents.

We support the delivery of technical assistance to adult homes needing specialized assistance to correct violations. Ideally, this assistance would be provided via a specialized organizational unit. Therefore, we are strongly opposed to the use of Department of Social Services inspectors during the regular inspection process to provide technical assistance to help facilities improve their regulatory compliance. This situation would create a vested interest on the part of the inspector/advisor in the advice and the success of the recommended approach. Rather, the inspector must direct his or her attention to the desired outcomes and allow the facility to develop its own best solutions to its own individual problems. State inspectors must be experts in determining whether standards are being met, but they do not necessarily need to be experts in how best to meet those standards in the many hundreds of different circumstances they encounter.

We would support the Commission's suggestion that the "better" adult homes be inspected less frequently, if there were a strong Long Term Care Ombudsman presence in all adult homes. Long term care facilities routinely move in and out of compliance, sometimes from day to day. Our experience is that without the regular on-site presence of State inspectors or Long Term Care Ombudsmen, the quality of care inevitably declines. Administrators and staff tell us of the inestimable benefit of the presence of the Ombudsman, as a State authorized, impartial citizen advocate from the community. In addition, that regular Long Term Care Ombudsman presence not only reassures the residents, their families, and others that someone is there to advocate on their behalf but it also provides them with an expert avenue for addressing their complaints.

Advocacy

We agree that developing additional linkages between the Long Term Care Ombudsman Program and legal advocacy programs in the mental health field is a good idea, and we will pursue this. However, underlying this recommendation is the assumption that the Ombudsman Program currently is available to all residents of adult homes. Unfortunately, due to funding limitations, it is not.

The State Long Term Care Ombudsman Program originally was created to represent the interests of nursing home residents and to advocate on their behalf because the regulators and the providers were well represented in the regulatory system. However, when adult care facilities were added to the responsibilities of the State Ombudsman Program, no new funds were provided for this additional responsibility. The result has been the uneven coverage noted in the Commission's report.

The State Long Term Care Ombudsman Program is funded solely with Federal dollars which are extremely limited. Although it plays a key role in State quality assurance for residential long term care, the State Office for the Aging receives no State funds at all for the Ombudsman Program. Volunteer long term care ombudsmen should be available to the residents of all adult care facilities, including persons with mental illness. Thus, we strongly agree with the Commission's recommendation for funding for advocacy services.

Additionally, there is a need for State Ombudsman staff in the State Office for the Aging: (1) to be responsible for enforcement liaison with the Department of Social Services; (2) to monitor, review, and make recommendations on Federal and State laws, regulations, and policies regarding adult care facilities; and (3) to work with advocates, providers, and others to ensure that resident rights are protected and that the services delivery system meets their needs.

Of relevance to the Commission's recommendations on advocacy are the mandatory reporting requirements of the Public Health Law. These provisions would be a useful reference in addressing the Commission's recommendation that professionals be required to report harmful and substandard conditions in adult homes.

Level of Care

We generally agree with these recommendations, except for the development of a different level of care. Any split would be

arbitrary and essentially eliminate a response by the mental health system to those with mental health needs who reside in homes below the cut off.

Also, it is clear from the findings that, in addition to the regulation of adult homes, the actual delivery of mental health services needs improvement. We believe that the mental health system must take greater responsibility for ensuring adequate services for mentally ill persons in adult homes across the board in all homes regardless of the percentage of residents with mental health needs. Thus, we suggest that the delivery of mental health services, and the quality of case management in particular, needs further examination by the Commission.

In addition, it would appear that many residents in need of mental health services are inappropriately placed in adult homes. We are aware of many disturbing incidents including assaults, unprovoked attacks, and even homicides in adult homes with many mentally ill residents. Many adult homes are ill equipped to serve the mentally impaired, and these situations may jeopardize elderly adult home residents.

Funding/Incentives

We advise caution in developing incentives, and we need to be certain that the rewards elicit the desired outcomes. Too often, unintended consequences occur or mediocre performance is rewarded. We would expect that before any adult home could be eligible for a reward it would have to meet all regulatory standards on at least one or more complete surveys.

However, before the consideration of any incentives, our energy must be directed to improving the current regulatory system and to "cleaning up" the non-complying facilities.

Integration/Separation

We share the Commission's concern that suitable mental health services be available to the residents of adult homes, and we advise caution in determining the proportion of residents with mental illness for any individual adult home. The recommendation is not clear on the source or justification of the 10 to 15 percent figure; nor is it clear whether this is a maximum or a minimum. Appropriate proportions can be especially difficult to determine in both the smallest and the largest facilities and might not be the best approach. Further, there seems to be some inconsistency between the call for assessing homes with more than 25 percent of

residents with mental illness and the call for a new level of care. Regardless of any proportion, we are concerned on behalf of residents about at which point the character of an adult home changes to a mental health facility.

The Industry

Finally, we were disturbed by the focus of the Commission's report almost solely on the regulators of care and the slight attention given to the providers of care. It is true that both the Department of Social Services and the Office of Mental Health must improve their oversight. However, the report makes no recommendations specifically directed toward providers even though they are most directly responsible for the quality of care and services delivered to residents. The report well documents the shortcomings of many of the providers themselves, and we would support recommendations to improve the capacity of the adult home industry to deliver quality care to residents, such as professionalizing the staff through upgraded qualifications and training requirements, particularly for administrators and aides. Environmental standards also require considerable additional attention on the part of the industry.

Closing

The problems in the adult home regulatory system are several: limited staff, a lengthy and cumbersome legal process, excessive negotiations, minimal financial resources, and insufficient legal authority. These are compounded by providers in a service delivery system focused on collecting public funds for profit rather than on meeting the needs of frail people.

Under the present enforcement system, truly a paper one, it cannot reasonably be expected that the quality of care or the quality of life for residents in marginal or substandard adult homes will improve. Meaningless threats and frequent compromises have had little impact on chronically deficient facilities.

The current standards must be effectively enforced throughout the adult home system.

The State Long Term Care Ombudsman Program must be visibly present in all adult homes.

The Commission has completed an excellent report of findings and recommendations. The next steps are crucial. We believe that

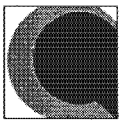
there is a need for a coordinated strategy for using the findings and recommendations for the benefit of residents, to define clear expectations for the adult home industry, and to set a course for the future of the industry. The Commission, the State Department of Social Services, the State Office of Mental Health, the State Office for the Aging, and the Executive Chamber should be included in that effort.

Sincerely,

Jane G. Gould
Director

cc: Michael J. Dowling
Cesar A. Perales
Richard C. Surles

The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities is an independent, New York State government agency charged with improving the quality of life for New Yorkers with disabilities, protecting their rights, and advocating for change.



New York State
Commission on Quality of Care and Advocacy
for Persons with Disabilities

401 State Street
Schenectady, New York 12305-2397

1-800-624-4143 (Voice/Spanish/TTY)

www.cqcapd.state.ny.us