

July 20, 2009

Dear Elected Officials and Citizens of South Carolina:

Thousands of South Carolinians with disabilities have no choice but to live in Community Residential Care Facilities (CRCFs).¹ Far too many of these individuals live in squalid and dangerous conditions because of inconsistent and ineffective oversight. The enclosed report, *No Place to Call Home: How South Carolina Has Failed Residents of Community Residential Care Facilities*, <http://www.protectionandadvocacy-sc.org/crcfreport.pdf>, clearly shows the need for increased, coordinated oversight of these poorly-regulated facilities. The facilities discussed in this report are those that serve residents with disabilities and low incomes, usually with government funding, including Supplemental Security Income, Social Security Disability Income, or veterans' benefits.

Protection and Advocacy for People with Disabilities, Inc. (P&A) has been inspecting CRCFs through its Team Advocacy program since 1986. In addition to our ongoing unannounced inspections of hundreds of these facilities, P&A has been closely involved in efforts to enforce existing regulations. This report describes the difficulties in enforcing resident protections at six of these facilities, including one that was required to close only after efforts by several agencies.

P&A found:

- Insect infestations
- Failure to deliver medication
- Lack of heat and air-conditioning
- Inadequate food
- Contaminated food
- Untrained staff
- Yards filled with garbage

The unsafe conditions in some of these CRCFs have continued for months or even years.

These appalling conditions exist now. Recent inspections and visits found that serious problems still exist at many facilities including: mouse droppings on the pantry shelves; roaches throughout the facility; electrical wires dangling from the ceiling; and numerous problems with medication administration, including staff giving medication without having washed their hands.

This report describes the fragmented system of oversight of CRCFs and the consequences for residents and makes recommendations to improve the safety and quality of care provided. An investigation of a CRCF may involve five or more agencies that have overlapping roles and responsibilities. Homes with even the most serious allegations against them can continue to accept new residents until the completion

¹ A licensed CRCF may also refer to itself as an assisted living facility.

of the investigation, which can take years. The Department of Health and Environmental Control, which regulates CRCFs, is seriously understaffed and frequently settles cases for a fraction of the assessed fines. Individuals have no easy way to find out whether a CRCF has had violations or been fined.

Residents of CRCFs often have no family or friends to speak for them. The facilities usually have little or no access to public transportation. The isolated residents are at high risk of abuse, neglect and exploitation. Stories such as those highlighted in the report are, unfortunately, far too common.

P&A recommends:

1. The statutes and regulations governing CRCFs should be revised to give licensing agencies **more enforcement options against frequently cited facilities and administrators**, such as:

- The power to **suspend new admissions to CRCFs with repeated, uncorrected violations** that significantly jeopardize residents' life or health while the appellate process to suspend or revoke a license is pending;²
- The power to **make suspension of operations automatic when a license has been revoked**, followed by an emergency hearing to determine whether the facility should remain closed during the appeal or be allowed to resume operations;
- The ability to **suspend the license of an administrator, prior to a hearing**, based upon frequent or egregious violations that significantly jeopardize residents' life or health;
- The creation of an **expedited appeal process** to review license suspensions or bars to new resident admissions;
- The **consideration** of information relating not only to the current licensing period, but of **all pertinent information regarding the facility and the applicant** when considering applications and renewals of licenses;

2. DHEC should **inform the public and concerned parties about problem facilities**. Facility inspection reports, including corrective actions, should be made available to the public on the agency's website (without any personally identifying information)³ and posted at the facility.

² Nursing homes that accept Medicaid payments are barred from accepting new admissions pending appeal of revocation of their operating license, 42 C.F.R. 488.414. Also, the statute could be expanded to include suspensions for prolonged periods of substandard conditions and repeated, uncorrected violations that present an unhealthy living environment. A third option would be to make suspensions automatic when a license has been revoked, followed by an emergency hearing to determine whether the facility should remain closed during the appeal or be allowed to resume operations. A fourth alternative would be to include an option for the licensing agency to request an expedited appeal process as well as injunctive relief pending appeal, if conditions so warrant. This injunctive relief could include a bar on the admission of new residents.

³ In its 2005 Annual Report, the Adult Protection Coordinating Council (APCC), a group created by the Omnibus Adult Protection Act, recommended that DHEC post inspection reports on its website.

3. The state should **create an Adult Abuse Registry** of individuals who have substantiated allegations of abuse or neglect of vulnerable adults against them. Facilities should be required to check the Registry before hiring a prospective employee.

4. The General Assembly should **fully fund enough DHEC inspection staff** to provide for periodic unannounced visits and full, timely investigation of allegations of regulatory violations.

5. The General Assembly should adequately fund the SC Department of Labor, Licensing and Regulation (LLR) to enable **prompt investigation of complaints against CRCF administrators.**⁴

Many CRCFs receive state funds to provide care for residents. The shocking and disgusting information in this report shows that the residents not only do not receive the services for which the state is paying, but do not benefit from state oversight.

P&A calls on the Governor, Lieutenant Governor, and members of the General Assembly to act on this issue in the coming legislative session. We ask the media to continue their coverage of deaths and abuses in the facilities, as well as the lack of oversight.

As recently as February 2009, a resident of a CRCF was run over by a truck after he went through an unsecured door.⁵ Similar incidents inevitably will continue to occur until CRCFs are effectively regulated and the public can learn about each facility.⁶

This report offers the information needed to begin making desperately needed changes. We are ready to assist in this process and await the opportunity to explore the next steps with all interested parties.

Thank you for working with P&A in our efforts to assure that all South Carolinians with disabilities have a place to call home.

Very truly yours,

Gloria M. Prevost
Executive Director

⁴ CRCF administrators are licensed by the Board of Long Term Health Care Administrators, located in LLR; complaints are investigated by LLR's Office of Investigation and Enforcement.

⁵ <http://www.wmbfnews.com/Global/story.asp?S=9893586>

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<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3163&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>