



FOLLOW-UP REPORT 2019 - ASSISTED LIVING REPORTING - 2020 INTERIM UPDATE

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: CLARE TOBIN LENCE

ISSUE BRIEF

Based on the [2019 Fiscal Note and Budget Item Follow-Up Report](#) (page 85), the Social Services Appropriations Subcommittee approved the following action in August 2019:

We recommend that DAAS [Division of Aging and Adult Services] and DFHP [Division of Family Health and Preparedness] report to the Social Services Appropriations Subcommittee during the 2020 Interim on the compliance rate for assisted living facilities reporting involuntary exits to the local ombudsman, the number of related citations and fines, and any recommendations to improve compliance with changing statutes.

DAAS provided the following update:

- “1. The Division of Aging and Adult Services (DAAS) and its Long-term Care Ombudsman program is not able to show facility compliance with the existing data in its control. While DAAS is able to report on the number of referrals it receives dealing with these discharges, it does not receive the total number of discharges that take place and therefore does not have a reference point for how many of these situations actually take place. If a facility does not report a discharge, DAAS is not in a position to know of it.
2. Given that DAAS does not receive reports related to noncompliance, it is not in a position to know if a facility should receive a citation or fine. Additionally, DAAS does not have a mechanism for citing or fining facilities. These actions would need to be carried out by another agency (presumably DOPL) or DAAS’ authority would need to be broadened to include these functions.
3. As noted in the responses above, we recommend additional reporting and coordination between the various private and government entities involved in these situations in order to more clearly understand the scope of the issue as well as to be able to gauge compliance. Additionally, resources for training facilities on this process and the need for reporting would help to support facility staff in these situations together with better meeting the needs of clients.”

DFHP provided the following update:

“Here is the info requested for the statutory change for assisted living facilities to report to the Ombudsman when there are facility initiated discharges. Since the statute took effect in 2018, the Bureau of Licensing and Certification has cited this issue three times:

- 1- 11/1/18 at Assisted Living of Orem South Villa - closed facility and did not notify residents, who did not have appropriate discharge. Fine - \$1400.
- 2- 4/3/19 at Country Lane of Payson - failed to give 30 day notice with Ombudsman notification. No fine.
- 3- 2/18/20 at Sunrise Park in Lewiston, Ut - failed to give Ombudsman info with facility initiated discharge. No fine.”

“Overall compliance is good based on the findings we have so far - only 3 instances of citing this situation in the last two years. The reason for the fine with one facility is that they were closing within days and were forcing people out of the facility, creating hardships for families and residents. We only issue fines when there is some sort of serious situation or immediate jeopardy to residents. There was in that case. The other cases were mistakes that did not cause harm or immediate threat to residents.”