TASK FORCE ON PREVENTING AND COUNTERING ELDER ABUSE

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Maryland Department of Aging

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TASK FORCE ON PREVENTING AND COUNTERING ELDER ABUSE

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April 30, 2024

The Honorable Wes Moore
Governor, State of Maryland
State Circle
Annapolis, Maryland, 21401

Dear Governor Moore,

The preliminary report of the Task Force on Preventing and Countering Elder Abuse (Task Force) is hereby transmitted to you. The Task Force, authorized by Chapters 706 & 707, Acts of 2023, has met in regular sessions and from an interdisciplinary subcommittees comprising of expertise and membership including: a member of the Senate of Maryland, a member of the House of Delegates, a member from the Office of the Attorney General of Maryland, a member from the Office of the Department of Aging, a member of the Baltimore City Fire Department, a member of CHANA, a member of the Maryland Medical Examiner, a member of Adult Services, a member of 2-1-1, a member of Mercy Medical Center, a member of the Maryland Long Term Care Ombudsman, as well as a representative of the Office of Health Care Quality, a representative of the Baltimore City Circuit Court Guardianship program, a representative of Maryland Legal Aid, a representative of Baltimore Senior Legal Services, a representative of the Montgomery County Department of Health and Human Services, a representative of the Maryland State Police, a representative of the Maryland Health Care

Commission, a representative of Maryland Children's Alliance, a representative of the Maryland Banker's Association, a representative of the Montgomery County Family Justice Center, and a representative of the Maryland Human Trafficking Task Force, compiled extensive information on priority issues, current laws, and administrative problems associated with the abuse and neglect of older adults, focusing on Maryland.

The proportion of senior Americans is rapidly growing. Based off the U.S. census, Maryland Department of Planning, it is expected that Maryland residents 60 and older will surpass the population of Maryland residents 18 and younger for the first time in the history of our state. With the expectation of serious mental or physical infirmity or dependence increasing with advanced age, there is reason to suspect that the incidence of abuse and neglect of older adults in Maryland will rise as their population increases. As we saw in 1986, when the last Task Force on Elder Abuse convened, the growing population faced Alzheimer's Disease and related disorders. Studying those issues provides a good example of the unsustainable stresses placed on family caregivers and the lack of support available to keep older adults in their home setting for as long as possible.

Maryland still seeks to ensure the most appropriate level of care for all its citizens. Our Task Force emphasizes expertise in the domains of the Collaborative Study of Maryland and Other States' Laws, Guardianship, Hospital Discharge and Long-Term Care Quality of Care, and Fraud, Scams, and Financial Exploitation. Based on the extensive expertise of the group that was comprised by Chapters 706 & 707, Acts of 2023, it is believed that these are the areas where abuse of older adults is the most prevalent and most preventable.

This report presents our findings and recommendations thus far. We plan to continue studying and expanding our recommendations on the key issues we have identified. The final report from this Task Force, due December 31, 2024, will include findings and further recommendations for any administrative and/or legislative action.

Sincerely,

Andrew Rabinowitz, Esq.
Chair

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Introduction

The Governor's Task Force was created to study the issues of the abuse and neglect of older adults. It was charged with making recommendations for implementing more effective and comprehensive responses to such abuse and neglect in Maryland. The Task Force members include representatives from the following entities and organizations:

A member of the Senate of Maryland, a member of the House of Delegates, a member from the Office of the Attorney General of Maryland, a member from the Office of the Department of Aging, a member of the Baltimore City Fire Department, a member of CHANA, a member of the Maryland Medical Examiner, a member of Adult Services, a member of 2-1-1, a member of Mercy Medical Center, a member of the Maryland Long Term Care Ombudsman Program, as well as a representative of the Office of Health Care Quality, a representative of the Baltimore City Circuit Court Guardianship program, a representative of Maryland Legal Aid, a representative of Baltimore Senior Legal Services, a representative of the Montgomery County Department of Health and Human Services, a representative of the Maryland State Police, a representative of the Maryland Health Care Commission, a representative of Maryland Children's Alliance, a representative of the Maryland Banker's Association, a representative of the Montgomery County Family Justice Center, and a representative of the Maryland Human Trafficking Task Force.

During the winter and spring of 2024, the Task Force held regular meetings and work sessions to review existing Maryland code, regulations, and procedures related to reporting, preventing, and responding to abuse and neglect of older adults. The Task Force broke into four committees, each charged with studying either an area where abuse of older adults is most prevalent or an area that can create change and prevention as well as prosecution. These four areas include, but are not limited to, the Collaborative Study of Maryland and Other States' Laws, the Committee on Guardianship, the Committee on Hospital Discharge and Long-Term Care Quality of Care, and the Committee on Fraud, Scams, and Financial Exploitation. Studying these areas and issues is believed to be the best option for identifying, classifying, preventing, and prosecuting abuse of older adults.

The Task Force was directed to produce a preliminary report identifying the four significant issues the Task Force recognized as areas that need to be studied. The abuse and neglect of older adults is a significant problem in Maryland. Identifying issues, public concerns, and potential responses are the goals of the Task Force.

Background on Maryland's history addressing Abuse and Neglect

Maryland has made commendable progress in enhancing its systems to address the abuse and neglect of older adults since the 1986 task force was convened. However, despite the efforts made then, many challenges persist today. A significant achievement of the 1986 task force was the establishment of dedicated support for Adult Protective Services (APS) laws. These laws mandate health practitioners, police officers, and human service workers to report cases of abuse,

neglect, self-neglect, or exploitation of vulnerable adults to the local Department of Social Services.

The reporting process remains largely the same as in 1986, with the Department of Social Services required to report to law enforcement agencies and the State's Attorney's Office for potentially criminal situations, especially those involving victims over 65. Today, there is a trend of State's Attorney's Offices and legal service providers establishing Senior/Elder divisions, such as the recently formed one in Baltimore City. Unfortunately, there has been a recent push to expedite guardianship procedures, reducing the notice period for a Petition for Guardianship and hastening a legal process that could take away one's legal decision-making authority.

For adults in nursing homes or related institutions, the reporting process is more intricate. Complaints about abuse are referred to law enforcement agencies, the Licensing and Certification Division of the Department of Health (MDH), or the Ombudsman Program of the Office on Aging. Typically, police conduct investigations with the assistance of the Department of MDH. The police must submit their findings in writing to the State's Attorney, the Ombudsman Program, and the facility's administrator within a set time frame after concluding their investigation.

Despite these developments, there remains a need to enhance coordination among the agencies involved in tackling abuse of older adults. Ongoing efforts aim to streamline reporting and roles, but greater coordination is essential to ensure effective collaboration among all agencies.

With a new administration leading Maryland, the goal of this Task Force is to build on the foundation laid by previous task forces. This Task Force aims to utilize this report to collaborate with community organizations, to create enhanced training for older Maryland residents, home health care workers, law enforcement officers, and family members. This report and its recommendations are designed to improve their ability to identify and report cases of elder abuse, exploitation, and fraud.

The Task Force's Target Population

As this Task Force was charged with examining the abuse and neglect of older adults, we have paid particular attention to that group. Importantly, adults are presumed to be independent unless proven otherwise. Their level of mental or physical dependence or infirmity determines their vulnerability to abuse. The changes of dependance or infirmity increase with age but are not presumed.

Definitions in Use

In Maryland law, the relevant legal definitions are:

Md. Code Ann., Health-Gen. § 19-347:
(a)(2)(i) "Abuse" means the non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce or resulting in mental or emotional distress.

(ii) “Abuse” does not include the performance of an accepted medical procedure that a physician orders.

Md. Code Ann., Fam. Law § 14-101:
b) “Abuse” means the sustaining of any physical injury by a vulnerable adult as a result of cruel or inhumane treatment or as a result of a malicious act by any person.

(l) (1) “Neglect” means the willful deprivation of a vulnerable adult of adequate food, clothing, essential medical treatment or habilitative therapy, shelter, or supervision.
(2) “Neglect” does not include the providing of nonmedical remedial care and treatment for the healing of injury or disease, with the consent of the vulnerable adult, recognized by State law instead of medical treatment.

(q) “Vulnerable adult” means an adult who lacks the physical or mental capacity to provide for the adult's daily needs.

The relevant existing statutes are:

MD CRIM LAW §3, Other Crimes Against the Person

Subtitle 6, Abuse and Other Offensive Conduct

§3-604 – Abuse or Neglect of Vulnerable Adult

(b)(1): Prohibits a caregiver, parent, or other person supervising a vulnerable adult from causing abuse or neglect that results in death, serious physical injury, or involves sexual abuse of the vulnerable adult.

(b)(2): Prohibits a household or family member from causing abuse or neglect that results in death, serious physical injury, or involves sexual abuse of the vulnerable adult.

§3-605 – Abuse or Neglect of Vulnerable Adults

(b): Prohibits the abuse or neglect of, or the intentional and malicious infliction of severe emotional distress on, a vulnerable adult by a caregiver, parent, household or family member, or other person with supervisory responsibility.

MD CRIM LAW §8, Fraud and Related Crimes

Subtitle 8, Financial Crimes Against Vulnerable Adults

§8-801: Prohibits a person from knowingly and willfully obtaining by deception, intimidation, or undue influence the property of a vulnerable or older adult with intent to deprive the vulnerable adult of that property.

MD EST & TRUST §13, Protection of Minors, Disabled Persons, Susceptible Adults, and Older Adults

Subtitle 6, Financial Exploitation of Susceptible Adults and Older Adults

§13-601:

(e) (1) "**Financial exploitation**" means an act taken by a person who:

(i) Stands in a position of trust and confidence with a susceptible adult or older adult and who knowingly obtains or uses, or endeavors to obtain or use, a susceptible adult's or older adult's funds, assets, or property with the intent to temporarily or permanently deprive the susceptible adult or older adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the susceptible adult or older adult, in such a manner that is not fair and reasonable;

(ii) By deception, false pretenses, false promises, larceny, embezzlement, misapplication, conversion, intimidation, coercion, isolation, excessive persuasion, or similar actions and tactics, obtains or uses, or endeavors to obtain or use, a susceptible adult's or older adult's funds, assets, or property with the intent to temporarily or permanently deprive the susceptible adult or older adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the susceptible adult or older adult; or

(iii) Knows or should know that a susceptible adult or older adult lacks capacity to consent and who obtains or uses, or endeavors to obtain or use, the susceptible adult's or older adult's funds, assets, or property with the intent to temporarily or permanently deprive the susceptible adult or older adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the susceptible adult or older adult.

(e)(2) "**Financial exploitation**" includes:

(i) Breach of a fiduciary relationship resulting in the unauthorized appropriation, sale, or transfer of property.

(ii) Unauthorized taking of personal assets.

(iii) Misappropriation, misuse, or transfer of assets belonging to a susceptible adult or older adult from a personal or joint account; and

(iv) Intentional failure to effectively use a susceptible adult's or older adult's income and assets for the necessities required for the susceptible adult's or older adult's support and maintenance.

(e)(3) "Financial exploitation" does not include an individual's good-faith use of a susceptible adult's or older adult's assets, including for the purposes of

establishing and implementing an estate plan intended to reduce taxes or to maximize eligibility for public benefits in order to preserve assets for an identified or identifiable person.

(k) "**Susceptible adult**" means an adult who is unable to perform, without prompting or assistance, one or more activities of daily living, is unable to protect the adult's rights, or has diminished executive functioning, due to:

(1) Advanced age.
(2) Mental, emotional, sensory, or physical disability or disease.
(3) Impaired mobility.
(4) Habitual drunkenness.
(5) Addiction to drugs; or
(6) Hospitalization.

§13-604: Provides cause of action for damages and other appropriate relief to susceptible or older adult subjected to financial exploitation in the State, or to a person acting on their behalf, against a person who has committed financial exploitation.

MD FAMILY §14, Adult Protective Services

Subtitle 2, Adult Protective Services Program

Subtitle 3, Investigation Provisions

§14-302: Provides requirements for mandatory reporting and report contents.

§14-303: Provides the timeline for investigation of received reports and the sharing of investigation information.

MD HEALTH GEN §19, Health Care Facilities

Subtitle 4, Home Health Agencies

§19-407: Provides for inspections of the operations of home health agencies at least every three (3) years.

Subtitle 9 – Hospice Care Facilities

§19-903: Provides regulations for the standards and practices of Hospice centers.

Subtitle 14, Nursing Homes

§19-1401:

(d) "**Deficiency**" means a condition existing in a nursing home or an action or inaction by the nursing home staff that results in potential for more than minimal harm, actual harm, or serious and immediate threat to one or more residents.

(f) "**Ongoing pattern**" means the occurrence of any potential for more than minimal harm or greater deficiency on two consecutive on-site visits as a result of annual surveys, follow-up visits, any unscheduled visits, or complaint investigations.

Subtitle 18 – Assisted Living Programs

MD FIN INST §1, General Provisions

Subtitle 3, Confidential Financial Records

§1-306: Abuse Report Requirements

(3) "**Elder adult**" means an individual who is believed to be:

(i) At least 65 years old; and

(ii) Residing in the State.

(4) "**Financial abuse**" means to take, appropriate, obtain, or retain, or assist in taking, appropriating, obtaining, or retaining, real or personal property of an elder adult by any means, including undue influence, for a wrongful purpose or with intent to defraud the elder adult.

(5) "**Financial exploitation**" means any action which involves the misuse of a customer's funds or property.

The Collaborative Study of Maryland and other States' Laws Committee

We have decided to use the more modern language of "older adults" rather than "seniors" or "elders/elderly," which are terms laden with inappropriate subjective precepts. Maryland's focus is on the umbrella term of "vulnerable adults," which eliminates protections for non-disabled persons who can care for themselves. Compared to the other jurisdictions, Maryland does not have comprehensive protections for older adults. The existing Maryland statutes are set out in this this preliminary report.

The final report will:

- Set out the applicable sections of law in the 4 States and compare.
- Identify missing protections in the Maryland statutory scheme.
- Recommend a statutory scheme that "hangs together" with a comprehensive view of necessary protections.
- Update working definitions – adding fuller definitions. Maryland needs to create uniform statutory definitions.
- Identify who is protected.
- Identify what is the conduct they are protected from.
- Ensure consistency. Terms are used in multiple code sections and need universal definitions.

This preliminary report will compare the States' statutes and definitions and will recommend next steps. It will address the Elder Abuse Judge's Bench Card, which is a resource used by Maryland judges. It needs substantial updating, e.g., to include definitional sections of the various laws. Specifically, the Bench Card needs:

- Provide specific definitions along with indicators – The card does not currently provide statutory definitions and should be updated to include the standardized definitions (below).
- Expand indicators – The list of situational indicators for abuse, neglect, or exploitation should be expanded.
- Update government and community resources – The list of available resources is incomplete and needs to be updated.

Establish a comprehensive statutory scheme, including modernizing important definitions, in order that the various community supports work together to investigate and protect older adult victims of abuse

The workgroup compared California, Georgia, Pennsylvania and Maryland statutes on abuse of older adults. Georgia, Pennsylvania and California have comprehensive statutory schemes. Maryland has more of an ad hoc approach by subject area, and not an inter-related scheme devoted to protection.

STATE COMPARISON OF TERMS

- **ABUSE**
  - MD: "**Abuse**" means the sustaining of physical pain or injury by a vulnerable adult as a result of cruel or inhumane treatment or as a result of a malicious act under circumstances that indicate that the vulnerable adult's health or welfare is harmed or threatened.

    "**Sexual abuse**" means an act that involves sexual molestation or exploitation of a vulnerable adult.

    "Sexual abuse" includes:
    1. incest.
    2. rape.
    3. sexual offense in any degree; and
    4. any other sexual conduct that is a crime.

  - PA: "**Abuse**" means the occurrence of one or more of the following acts:
    - (1) The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.
    - (2) The willful deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health.

- (3) Sexual harassment, rape or abuse, as defined in the act of October 7, 1976 (P.L. 1090, No. 218), known as the Protection From Abuse Act.

"**Sexual abuse**." Intentionally, knowingly or recklessly causing or attempting to cause rape, involuntary deviate sexual intercourse, sexual assault, statutory sexual assault, aggravated indecent assault, indecent assault or incest.

- GA: "**Abuse**" means the willful infliction of physical pain, physical injury, sexual abuse, mental anguish, unreasonable confinement, or the willful deprivation of essential services to a disabled adult or elder person.

  "**Sexual abuse**" means the coercion for the purpose of self-gratification by a guardian or other person supervising the welfare or having immediate charge, control, or custody of a disabled adult or elder person to engage in any of the following conduct:
  - Lewd exhibition of the genitals or pubic area of any person.
  - Flagellation or torture by or upon a person who is unclothed or partially unclothed.
  - Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is unclothed or partially clothed unless physical restraint is medically indicated.
  - Physical contact in an act of sexual stimulation or gratification with any person's unclothed genitals, pubic area, or buttocks or with a female's nude breasts.
  - Defecation or urination for the purpose of sexual stimulation of the viewer; or penetration of the vagina or rectum by any object except when done as part of a recognized medical or nursing procedure.

- CA: "**Abuse of an elder or a dependent adult**" means any of the following:
  (1) Physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.
  (2) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.
  (3) Financial abuse.

  "**Physical abuse**" means any of the following:
  (a) Assault, as defined in Section 240 of the Penal Code.
  (b) Battery, as defined in Section 242 of the Penal Code.
  (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.
  (d) Unreasonable physical constraint, or prolonged or continual

deprivation of food or water.

(e) Sexual assault, that means any of the following:

(1) Sexual battery, as defined in Section 243.4 of the Penal Code.

(2) Rape, as defined in Section 261 of the Penal Code, or former Section 262 of the Penal Code.

(3) Rape in concert, as described in Section 264.1 of the Penal Code.

(4) Incest, as defined in Section 285 of the Penal Code.

(5) Sodomy, as defined in Section 286 of the Penal Code.

(6) Oral copulation, as defined in Section 287 or former Section 288a of the Penal Code.

(7) Sexual penetration, as defined in Section 289 of the Penal Code.

(8) Lewd or lascivious acts, as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.

(f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:

(1) For punishment.

(2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.

(3) For any purpose not authorized by the physician and surgeon.

- **RECOMMENDED DEFINITION**: **Abuse** means:

(1) The willful infliction of physical pain, physical injury, sexual abuse, or psychological, emotional, or verbal abuse or anguish of an Older Adult.

(2) The unreasonable confinement or willful deprivations of goods or services necessary to maintain an Older Adult's physical or mental health.

(3) Sexual violence, abuse, harassment, rape, or threat thereof of any Older Adult.

(4) Stalking.

(5) Financial abuse – person of trust, deception, intimidation, undue influence.

(6) "Abuse" does not include an accepted medical or behavioral procedure ordered by a health care provider authorized to practice under the Health Occupations Article or § 13-516 of the Education Article acting within the scope of the health care provider's practice.

(7) Organizations and Business can be held to the abuse standard.

- **<u>RECOMMENDED DEFINITION</u>**: **Sexual Abuse** means:

  (1) Any act that involves sexual molestation or exploitation of an Older Adult.

  (2) The coercion for the purpose of self-gratification by a guardian or other person supervising the welfare or having immediate charge, control, or custody of an Older Adult.

- **NEGLECT:**
  - <u>MD</u>: "**Neglect**" means the willful deprivation of a vulnerable adult of adequate food, clothing, essential medical treatment or habilitative therapy, shelter, or supervision. "Neglect" does not include the providing of nonmedical remedial care and treatment for the healing of injury or disease, with the consent of the vulnerable adult, recognized by State law instead of medical treatment.

  - <u>PA</u>: "**Neglect**" means the failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health. No older adult who does not consent to the provision of protective services shall be found to be neglected solely on the grounds of environmental factors which are beyond the control of the older adult or the caretaker, such as inadequate housing, furnishings, income, clothing or medical care.

  - <u>GA</u>: "**Neglect**" means the absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a disabled adult or elder person.

  - <u>CA</u>: "**Neglect**" means either of the following:

    (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.

    (2) The negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise.

    (b) Neglect includes, but is not limited to, all of the following:

    (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.

    (2) Failure to provide medical care for physical and mental health needs. A person shall not be deemed neglected or abused for the sole reason that the person voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

    (3) Failure to protect from health and safety hazards.

    (4) Failure to prevent malnutrition or dehydration.

(5) Substantial inability or failure of an elder or dependent adult to manage their own finances.
(6) Failure of an elder or dependent adult to satisfy any of the needs specified in paragraphs (1) to (5), inclusive, for themselves as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

(c) Neglect includes being homeless if the elder or dependent adult is also unable to meet any of the needs specified in paragraphs (1) to (5), inclusive, of subdivision (b).

- **RECOMMENDED DEFINITION**: **Neglect** means the willful deprivation of adequate food, clothing, essential medical treatment or habilitative therapy, shelter, supervision, or interaction of an Older Adult. This includes the absence or omission of essential services such that it harms or threatens to harm the physical or emotional health of an Older Adult. … No Older Adult who does not consent to the provision of protective services shall be found to be neglected solely on the grounds of environmental factors which are beyond the control of the Older Adult or the caretaker, such as inadequate housing, furnishings, income, clothing, or medical care.

- **EXPLOITATION:**
  - Financial:
    - MD: "**Exploitation"** means any action which involves the misuse of a vulnerable adult's funds, property, or person

    - PA: "**Financial exploitation**." The wrongful or unauthorized taking or attempt to take by withholding, appropriating, concealing or using the money, assets or property of an older adult or care-dependent person, including any act or omission taken by a person, including through the use of a power of attorney, guardian, custodian, trustee, personal representative or conservator of an older adult or care-dependent person or by an individual who stands in a position of trust and confidence with an older adult or care-dependent person, including business transactions to:
      (1) obtain or attempt to obtain control, through deception, intimidation or undue influence, over the older adult's or care-dependent person's money, assets or property to deprive the older adult or care-dependent person of the ownership, use, benefit or possession of the older adult's or care-dependent person's money, assets or property; or
      (2) convert or attempt to convert money, assets or property of the older adult or care-dependent person to deprive the older adult or care-dependent person of the ownership, use,

benefit or possession of the older adult's or care-dependent person's money, assets or property.

- GA: “**Exploitation**” means illegally or improperly using a disabled adult, elder person, or resident or such individual's resources through undue influence, harassment, duress, false representation, false pretense, or other similar means for one's own or another person's profit or advantage.

- CA: "**Financial abuse**" of an elder or dependent adult occurs when a person or entity does any of the following:
  (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
  (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
  (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70.

  A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew or should have known that this conduct is likely to be harmful to the elder or dependent adult.

  For purposes of this section, a person or entity takes, secretes, appropriates, obtains, or retains real or personal property when an elder or dependent adult is deprived of any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative of an elder or dependent adult.

  For purposes of this section, "**representative**" means a person or entity that is either of the following:

  (1) A conservator, trustee, or other representative of the estate of an elder or dependent adult.

  (2) An attorney-in-fact of an elder or dependent adult who acts within the authority of the power of attorney.

- **<u>RECOMMENDED DEFINITION</u>**: **Financial Exploitation** means: The wrongful or unauthorized taking or attempt to take by withholding, appropriating, concealing or using the money, assets or property of an older adult or care-dependent person, including any act or omission taken by a person, including through the use of a power of attorney, guardian, custodian, trustee, personal representative or conservator of an older adult or care-dependent person or by an individual who stands in a position of trust and confidence with an older adult or care-dependent person, including business transactions to:

  (1) obtain or attempt to obtain control, through deception, intimidation or undue influence, over the older adult's or care-dependent person's money, assets or property to deprive the older adult or care-dependent person of the ownership, use, benefit or possession of the older adult's or care-dependent person's money, assets or property; or

  (2) convert or attempt to convert money, assets or property of the older adult or care-dependent person to deprive the older adult or care-dependent person of the ownership, use, benefit or possession of the older adult's or care-dependent person's money, assets or property.

  (3) The financial exploitation of vulnerable adults statute in Maryland (MD Code, Criminal Law, § 8-801) requires obtaining the property of a vulnerable adult, "by deception, intimidation, or undue influence." Without this element, we can only charge theft. So, for example, if a nurse's aide says, "loan me your debit card and I'll order you a pizza," but then proceeds to drain the resident's account, that's financial exploitation and theft. But if she simply comes into the room in the middle of the night, takes the resident's debit card, and drains the account, that's just theft. What we'd like to see is a change in the statute recognizing that people in a position of trust who violate that trust are guilty of exploitation. A nurse's aide who takes a debit card without using deception still only has access to the patient because she's exploiting her position of trust, and we think that should be sufficient to establish the crime. Similar provisions in the law exist for coaches and other school officials in their dealings with students.

- Trafficking:
  - <u>MD</u>: *Maryland does not have any Trafficking Statute.*
  - <u>PA:</u>

- GA: A person commits the offense of trafficking a disabled adult, elder person, or resident when such person, through deception, coercion, exploitation, or isolation, knowingly recruits, harbors, transports, provides, or obtains by any means a disabled adult, elder person, or resident for the purpose of appropriating the resources of such disabled adult, elder person, or resident for one's own or another person's benefit.

- **RECOMMENDED DEFINITION**: A person commits the offense of trafficking a disabled adult, elder person, or resident when such person, through deception, coercion, human trafficking, forced labor, domestic servitude, sexual and non-sexual exploitation, debt-bondage, isolation, knowingly recruits, harbors, transports, provides, or obtains by any means a disabled adult, elder person, or resident for the purpose of appropriating the resources of such disabled adult, elder person, or resident for one's own or another person's benefit.

DEFINITIONAL TERMS

- What age qualifies?
  - MD: 65 or 68, depending on statute
  - PA: 60 or older
  - GA: 60 or older
  - CA: 65 years of age or older; Dependent adult: a person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age
  - Recommended: To be determined.
- Is the specified age different across different offenses?
  - If so, should it be?

Other Common Crimes:

- Murder and Attempted Murder: CR §2-201- CR §2-206.
- Reckless Endangerment: CR §3-204
- Manslaughter: CR §2-207
- Rape & Attempted Rape: CR §3-303 & §3-304, CR §3-309 & §3-310.
- Sexual Offenses & Attempted Sexual Offenses: CR §3-305 - CR §3- 312.
- Theft: CR §7-104
- Bad Checks: CR §7-107
- Fraud in Procuring a Credit Card: CR §8-203.

- Identity Fraud: CR §8-301
- Credit Card Theft: CR §8-20.
- Assault in the first & second degree: CR §3-201-CR §3-203.

NEXT LOGICAL STEPS

1. Evaluate MD's needs.[1]

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[1] ***FOR CONSIDERATION---***

Decide where in the statutes should Older Adult Abuse live? Crim/civil/family/financial

- Cross-referencing definitions if various sections persist.
- Ensure consistent definitions.
- Should the new language be a self-contained Older Adult Abuse Act?
- Assess enhanced penalties for crimes against older adults
    - Create enhanced penalties for crimes against older adults.
        - Either a secondary add-on penalty
            - GA: "This article shall be cumulative and supplemental to any other law of this state."
        - *Or* Specific enhanced penalties in the Older Adult statutes

- Improve funding, training, and oversight of OHCQ and Long-Term Care.
- Closing a loophole in the law: Assisted Living Facilities that surrender their license with residents still in the facility has been a new trend over the past few years. Specifically, a facility operator either sells the operation to an unlicensed operator or decides they no longer wish to be in the business and surrenders their license. OHCQ interprets its power to hold these individuals to the regulations as tied to their license. However, once the Assisted Living Facility surrenders its license, OHCQ believes it no longer has authority to enforce the regulations regarding winding down the operation. As a result, residents are either left in the care of an unlicensed operator who bought the facility (while the licensing process proceeds) or are left without anyone (when the license is surrendered because the operator is getting out of the business). In the latter case, it falls on the state to come in and relocate the residents. Our suggestion has been to require some sort of bond to operate an ALF that would give the operator a financial incentive to do the right thing when closing-down and would cover some of the state's expenses in the event they're left to be responsible for the residents. Maryland has a similar requirement for gyms to avoid businesses that take members' money then close-down and skip town.
- Need regulatory body for Unlicensed Assisted Living Facilities.
- Improve reporting.
    - Improve consistency – information made available: from where, to whom, for what, when.
        - Are there notable exceptions? Should we (can we?) create standard reporting forms?
    - Consider inter-reporting among agencies.
        - Define which agencies get what, and when.
            - Which agencies are mandatory? Which agencies are conditional?
            - Are there any agencies specifically -not- included?
- Consider cascading effects of reporting, investigating, and litigating.
    - What protections for victims?
        - Information sharing
    - What should be the timing for reports to be submitted?
    - How quickly should an investigation commence?
    - What is the investigation turn-around time?
        - Is there a particular order in which the report needs to be provided to various agencies or other stakeholders? If so, why?
    - Who enforces timing? How?
    - Is there a statute of limitations?
        - Or should it be specifically extended for Older Adult abuse?

2. Add unintended consequences.
3. Find and address loopholes in the law.

Coordinating Resources

In addition to establishing a comprehensive statutory scheme, we recommend greater attention to existing resources available through the state and through public partners through a public awareness campaign and that state complete a comprehensive inventory of services and programs. Because older adults who rely on others are more susceptible to abuse, the state should provide more education, advocacy, and community engagement, the state to empower individuals and communities to recognize, report, and stop abuse of older adults in all its forms across these and community settings. These recommendations flow from the requirements of the law and embody the resources that preserve the rights of the person, create accountability in long term care, and strengthen the ability to prevent fraud, scams, and financial exploitation.

Establish a Public Awareness Campaign Supported by a Comprehensive Inventory of Services & Programs to Prevent Abuse of Older Adults

A public awareness campaign is needed to educate the public on the issue of abuse and neglect of older adults and the availability of resources and options for prevention and elimination of this growing problem. Through education, advocacy, and community engagement and assessment of existing resources, the state can empower individuals and communities to recognize, report, and stop abuse and neglect of older adults in all its forms and across various settings.

Public Awareness Campaign
There are several state agencies and non-profit organizations that provide services and information for older populations. These organizations have the expertise to guide this effort, and their leadership and participation are critical to the campaign's success. The overarching message is that older adults deserve to be treated with dignity and respect.

Community Engagement:
The state should lead in the following activities in order to engage the older adult community:
-Organize workshops, seminars, and town hall meetings to educate the public about the prevention of the abuse and neglect of older adults.
-Collaborate with local senior centers, libraries, and community organizations to reach a wider audience.
-Partner with law enforcement agencies, healthcare providers, legal organizations, and social service agencies to coordinate efforts in preventing elder abuse.
-Seek support from influential figures and community leaders to amplify the campaign's message.
-Seek collaboration and funding from financial institutions to raise awareness of common scams and strategies that contribute to financial abuse.
-Engage in live Q&A sessions and social media platforms

Education:
The state should review and update existing educational materials, including the utilization of

brochures, posters, and pamphlets outlining signs of the abuse and neglect of older adults and how to report it, how to talk with a healthcare provider and other mandated reporters, and services available to empower choice to prevent abuse, such as financial planning and establishing a power of attorney when appropriate.

Training Programs:
The state should lead in offering accessible training sessions for caregivers, healthcare professionals, and community members on identifying and addressing the abuse and neglect of older adults engaging professional speakers. In addition, the state should offer training modules for law enforcement personnel and legal professionals in order to improve the response and support for cases involving abuse and neglect of older adults. Finally, the state should develop (or promote awareness of) short online videos on how to identify deceptive practices/scams that lead to financial abuse.

Create Connection with Federal Agencies:
Establish awareness campaigns with the local Social Security Offices, and more robust education for both Rep Payees and SSA benefit recipients in general about financial exploitation, resources, reporting, prevention, etc.

Comprehensive Inventory of Services and Programs
The abuse and neglect of older adults often occurs where there are gaps in resources, resulting in unwanted institutionalization and other harms. We recommend that the state engage in an inventory of resources and work toward expanding services that promote the health and dignity of elders and the bridge and facilitating connections where greater efficiency would be beneficial.

Home and Community Based Services Waiver Expansion: Increasing access to care in the community empowers older adults to respond when care needs fail to be met in institutionalized settings. The state should assess expanding the Waiver program, including the utilization of the supports planners in facilitating the plan of service.

Helplines: Providing direct access to services greatly increases the prospects of a timely response. This subcommittee wishes to explore existing helplines, active shelters, legal service providers, and other entry ways for assistance and make recommendations about how such resources can be accessed and utilized.

Office of HealthCare Quality (OHCQ): OHCQ provides a vital accountability function in ensuring elders receiving care are afforded the care they are entitled to. This committee recommends that the Office receive the funding needed to fill vacancies and to utilize any and all resources from the federal government to address the current backlog of complaints alleged.

Designate Abuse Expert in State Agencies: 17 state agencies receive reports of abuse. Those state agencies should identify a staff member who would be trained in the abuse and neglect of older adults in to appropriately address and coordinate response and follow-up to the issue. If a report is made, there must be follow-up with the reporter and collaboration with the agencies involved.

Sustainability
Many programs and resources exist but operate in isolation. A state agency must be designated and resourced to maintain and update the inventory of programs and services and to sustain this enhanced and collaborative communication strategy, leveraging opportunities to expand the support available.

Preserving the Rights of the Person and Property and Utility of Guardianship

Guardianship involves the removal of a person's fundamental rights and liberties. "The typical [person subject to guardianship] has fewer rights than the typical convicted felon – they can no longer receive money or pay their bills. They cannot marry or divorce. By appointing a guardian, the court entrusts to someone else the power to choose where they will live, what medical treatment they will get and, in rare cases, when they will die. It is, in one short sentence, the most punitive civil penalty that can be levied against an American citizen, with the exception, of course, of the death penalty." -Former Congressman Claude Pepper (FL)

People with disabilities are more vulnerable to abuse, neglect, and exploitation generally. Guardianship itself can operate as a form of abuse when it is misused as a tool to control someone or their assets or isolate them from others. When a plenary guardianship is put into place without assessing alternatives to guardianship and limiting the guardianship to meet a person's demonstrated needs, the result may lead to negative health consequences, loss of sense of self and self-determination, deterioration, and poorer life outcomes. It is imperative that guardianship be utilized as a last resort, and when guardianship is unavoidable, the powers of a guardian be limited to what is necessary to meet a disabled person's unmet needs. What's more, adequate monitoring of both private and public guardianships must be in place to help prevent abuse of older adults under guardianships. We did not make preliminary recommendations about oversight of surrogate decision making under Md. Code, Health-Gen. § 5-605, and a later section describes recommendations for preventing fraud, scams, and financial exploitation.

Below are two issues critical to ensuring the safety of older adults subject to guardianship across the State of Maryland: 1) Assessing Alternatives Guardianship and 2) Enhancing Oversight over Guardians.

Assess Alternatives to Guardianship and Contracting Attorneys Skilled in Medical Assistance Planning to Serve as Guardian of Property

Guardianship is intended to be the option of last resort. It is not a discharge plan. It is not the answer in all cases that are filed. Even if an alleged disabled person is experiencing diminished capacity, that does not mean guardianship is the only option. Each case needs to be addressed with an individualized approach to ensure decisions are being made based on the alleged disabled person's demonstrated needs. There is no one-size-fits-all solution. When a guardianship is used for purposes of consenting to medical treatment or discharge or transfer from a hospital, the resulting guardianship is usually plenary in nature. The guardianship often remains in place despite the disabled person having recovered from the disability leading to the

appointment of a guardian. It is far easier to be put under guardianship than it is to get out of one. Appointing a guardian without assessing all alternatives and appropriate limitations stands to exploit vulnerability.

Many alternatives to a guardianship exist that require an inquiry to be made, e.g., whether the person has a healthcare or financial power of attorney or advanced directive, whether anyone is eligible and willing to serve as a surrogate decision maker, whether the person can designate an authorized representative for purposes of medical assistance planning pursuant to COMAR 10.09.24.04(F)(1) and, in the event financial institution records need to be accessed, which would require a court order,[2] is a specific transaction without the appointment of a guardian under Md. Code Ann., Estates and Trusts §13-204, thereby limiting a court's interference in a person's property rights, the more appropriate option? When a guardianship is shown to be the least restrictive alternative, a determination must follow as to who shall be appointed as guardian. Although the appointment of a guardian may be unavoidable, the inquiry cannot end without considering appropriate limitations on a guardian's powers.

Petitions for guardianship of person frequently include a request for appointment of guardian of property. Often, these cases are not merely about consent to medical treatment or discharge or transfer from a hospital or facility. There is a financial piece. Many guardianship cases involve low-income persons that require an application for medical assistance for discharge to a long-term care facility. If a person does not have capacity or a legal representative such as power of attorney, a guardian of property may be needed to complete a medical assistance application for long-term care benefits.

For guardianship of person, Maryland has a strong public guardianship system. There is no similar system for guardianship of property. Courts must turn to attorneys to serve as guardian of property when no one with a higher statutory priority is willing or eligible. Medical assistance planning is complex and attorneys skilled in this area are few and far between. The attorneys are expected to serve on a *low bono* or *pro bono* basis. There is no source of funding to pay them,[3] and attorneys are not lined up at the courthouse to provide this service. Courts across the state are at crisis points because there are not enough attorney guardians to do this work. The reality is that if a guardian of property is needed, until someone is willing to serve in that role, the person who no longer requires acute care is forced to languish in a hospital. This financial piece is often the crux of the issues presented in guardianship matters. It is vital that it be addressed.

MDH is the single state agency designated to administer the Medical Assistance Program. COMAR 10.09.24.02(B)(16). An application for Long-Term Care Medical Assistance may be

[2] Financial institutions often create barriers to accessing account records by requiring documentation that is inconsistent with Maryland law. The development of a guidance document for financial institutions that sets forth Maryland law as it pertains to guardianship and its alternatives may prove to be a useful tool to enhance communication with financial institutions.

[3] If assets are later discovered that would make a disabled person ineligible for long-term care medical assistance, or assets are available to pay an attorney guardian as part of a medical assistance spenddown, then the attorney guardian would be paid from the guardianship estate. *See* Md. Code Ann., Estates and Trusts §§ 13-218 and 14.5-708.

filed online through MDThink, in person at or by mail to a local department of social services, or the Bureau of Long-Term Care for certain jurisdictions. COMAR 10.09.24.04(A) requires MDH or its designee to determine initial and continuing eligibility for the Medical Assistance Program. The Division of Long-Term Services and Supports is the designee that reviews and determines eligibility for Long-Term Care Medical Assistance applications.

The priority here is to allocate resources for long-term care medical assistance planning for low-income disabled persons, which must include an appropriation to pay court-appointed attorney guardians to do this work. The Department of Human Services (DHS) has an infrastructure in place, i.e., its Maryland Legal Services Program legal services contracts [with attorneys who are appointed as counsel pursuant to Md. Code Ann., Estates and Trusts § 13-211(b)(3)] that may be adapted for court-appointed attorney guardians. It follows then that DHS would be the suitable agency to manage any appropriation for these services. A separate procurement process would be needed, and a new DHS unit would be necessary, including attorneys to serve as guardian and contract monitors, auditors, investigators, etc. to oversee the contract. Although Estates and Trusts § 13-211(b) provides the framework for DHS to be a contract administrator for court-appointed attorney guardians, the Statute will need to be amended accordingly.

Enhance Oversight of Private and Public Guardianships

Enhancing current monitoring practices will serve to prevent occurrences of abuse of persons under guardianship. A focus on the following key areas will help to improve oversight of vulnerable adults under guardianship in Maryland.

1. Monitoring – Evaluation of systems currently in place for private and public guardianships, including Adult Public Guardianship Review Boards. Maryland's Administrative Office of the Courts is the current recipient of a federal Elder Justice Innovation Grant, part of which involves evaluation of and strategies for providing adequate monitoring for persons under guardianship. Reappointment of counsel for disabled persons and the appointment of independent investigators are monitoring tools to ensure the safety of a disabled person and gather more information regarding the circumstances of a person under guardianship.

2. Information sharing - Public agencies currently collect and store information on clients they serve. The courts are exploring a similar system for data management in guardianship cases, in addition to MDEC. Information sharing between the courts and public agencies when a person is subject to a guardianship proceeding will help to protect older adults under guardianship, e.g., court access to NICS to better screen proposed guardians, receipt of notifications when a person under guardianship or a guardian is subject to an APS investigation, or when a guardian is convicted of a disqualifying offense post-appointment, and court access to vital records to help determine whether a guardianship should continue or a substitution proceeding should be initiated when a disabled person or their guardian is missing or has been reported deceased without supporting documentation would all trigger court intervention.

3. Access to counsel post-appointment for indigent persons under private guardianship – There appears to be a disparity in access to counsel for indigent persons under private guardianship versus indigent persons under public guardianship. It is necessary to obtain clarification from DHS to determine whether attorneys contracted to serve as court-appointed counsel for indigent persons in guardianship of person and/or property proceedings may be reappointed in post-appointment proceedings for indigent persons under private and public guardianships alike.

4. Training – Enhanced training of the judiciary and guardians will improve monitoring and compliance. It is important to be mindful not to create unnecessary barriers for persons serving as private guardians. The courts currently offer orientation and training programs and assistance for private guardians and persons wishing to become guardian of person and property.

Creating Accountability for Oversight Over Quality Long Term Care and Improving Hospital Discharges

Many older adults require assistance, and so their healthcare becomes integral with their housing. Sometimes older adults can maintain living in the community with supportive services for activities of daily living, but other times, more institutionalized medical care in a nursing home or hospital are required in order to achieve medical stability. In each setting, the consumer's goals and medical progress should drive the plan of care, yet thousands of elderly and disabled Marylanders reside and live in settings that vary widely in size, scope of services, and quality. When operated well, assisted living facilities and skilled nursing facilities can prevent hospitalization. Assisted living facilities play an important part in preserving independence, dignity, and the ability to participate the community. However, residents in assisted living facilities have the fewest protections. This year, the Maryland legislature passed amendments to Md. Code, Health-Gen. § 19-1805(A)(8) in SB0863/HB0723, "Rights of Residents of Health Care Facilities-Injunctive Relief" which is expected to become law effective July 1, 2024. The law will codify minimum basic rights of residents in assisted living facilities, to include the right to participate in decision making regarding transitions in care, including a transfer or discharge.[4] These rights are meaningless unless, like traditional tenants and residents of skilled nursing facilities already have, an appeals process is established.

Importantly, planning issues in transitions of care are not limited to assisted living facilities. In fact, there are common experiences that consumers of hospital, skilled nursing, and assisted living services face. For example, decision making capacity of older adults is often undermined and supports are not adequately considered, or surrogate decision making is very broadly implemented. In addition, service providers, particularly in skilled nursing and assisted living facilities where residency is often more prolonged, can pressure and take advantage of residents who rely on their support. Despite the "continuum of housing and health stability" that each environment provides, the regulations operate specific to each setting. As a result, this sub-committee recommends a

[4] Amended Md. Code, Health-Gen. § 19-1805(A)(8)(VI)

further study focusing on discharges involving these settings, particularly what constitutes a safe discharge and the requirements for facilitating a safe discharge.

The Sub-committee on Assisted Living, Nursing Homes and Hospitals has developed two broad recommendations:

1) Implement an appeals process for evictions from assisted living facilities given the fewer protections that exist for these residents.

2) In the year ahead ensure OHCQ is funded to fill vacancies and create a distinct Committee to study discharges of older adults from assisted living programs, nursing homes and hospitals, including standardized discharge planning requirements and processes for each provider setting.

Implement an appeals process for evictions for people in assisted living facilities

With regard to an appeals process for residents in assisted living facilities, understanding the role of medical settings is important. Specifically, hospitals are intended to provide acute, temporary care, and discharge planning is supposed to be established at the early stages of hospitalization, with the patient's input.[5] If medical attention is still required after stabilization is achieved, patients are often discharged to a skilled nursing facility, where Medicare covers a transitional period of going care. Once Medicare coverage ends, residents must decide what resources and coverage will facilitate ongoing recovery and stabilization. Many older adults decide to remain in skilled nursing care for the rest of their lives. Many elect to apply for coverage for services they could receive in an assisted living facility or other setting in the community. Discharges from a skilled nursing facility, when without consent, are limited to five specific situations, and the result of any discharge must be to a safe and secure location.[6] In contrast, discharges from an assisted living facility must be in accordance with the resident agreement.[7] In all of these settings, discharges without proper care can lead to repeated hospitalization and unnecessary suffering. Of particular concern, an eviction of a resident from an assisted living facility is based entirely on the resident agreement, without an opportunity to appeal before a court or administrative body and without a safe discharge requirement. While the State Ombudsman is usually one of the first to be notified when a skilled nursing facility or assisted living facility closes and has played a critical role in assisting with relocating residents, greater enforcement in statute and regulation would be helpful in preventing these unwarranted disruptions and emergencies.

The Maryland General Assembly recently took steps to codify minimum basic rights of residents in assisted living facilities in amendments to Md. Code Health-Gen §19-1805.[8] The Code will strengthen protections on paper, such as the right to participate in decision making regarding transitions in care but will have little meaningful effectiveness without an appeals process to

[5] Md. Code Regs. 10.07.01.27(C)
[6] Md. Code Regs. 10.07.09.11(C)(2)(b)
[7] Md. Code Regs. 10.07.14.33 (B)(1)
[8] HB 723 and SB 863 "Rights of Residents of Health Care Facilities- Injunctive Relief."

contest defective notice or process, including the reoccurring practice of assisted living facilities surrendering their license and relying on the Ombudsman to relocate residents-often without notice.

Although a process for exercising the right to appeal has not been implemented, a subset of residents in assisted living facilities, those who participate in Maryland's Home and Community Based Services Waiver ("Waiver") Program designed to keep residents needing nursing home level of care from institutionalization by providing services in the community, are currently entitled, under federal law, to receive the same protections as tenants.[9] In other words, Maryland is not in compliance with federal regulation. Specifically, a federal regulation that is commonly referenced as the Community Settings Rule states, *"[t]he unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law*." 42 CFR 441.530(a)(1)(vi)(A).[10]

Other states have implemented protocols limiting the reasons for an assisted living program eviction and providing appeal procedures. In California, an eviction notice is required to contain: 1) proposed date of eviction, 2) resources for finding alternative housing, 3) information to file a complaint to the state, and 4) obligation of the facility to file an unlawful detainer action and right to request a hearing.[11] In Utah, there are five delineated reasons a resident of an assisted living facility may be discharged, transferred, or evicted: 1) the resident poses a threat to the health or safety to self or others, or the resident's required medical treatment is no longer able to be provided, 2) the resident fails to pay for services, 3) the resident fails to comply with written policies or rules of the facility, 4) the resident wishes to transfer, or 5) the facility ceases to operate.[12] In Oregon, limited reasons for discharge are delineated with supporting documentation required and any notice of involuntary discharge must contain the rights to request an administrative hearing.[13]

There are advantages and disadvantages to processes that engage more strict landlord tenant processes v. administrative procedures, [14] and while we recommend that MDH implement an

[9] 42 CFR 441.530(a)(1)(vi)(A), referred to as the "Community Settings Rule", was published January 16, 2014, and became effective March 17, 2014. States were given until March 17, 2023, to comply with the Community Settings Rule. The Waiver program is authorized by §1915(c) of the Social Security Act

[10] Residents in the same facility who are not Waiver Program participants are not currently afforded the same protections under federal law, but Maryland should afford the right to an eviction appeals process to all residents of Assisted Living Programs.

[11] Cal. Health & Safety Code §1569.683.

[12] Utah Admin. Code 432-270-12

[13] Or. Admin. R. 411-054-0080

[14] Justice in Aging, March 3, 2023, "Implementing the HCBS Settings Rule: Protecting Consumers from Harmful Evictions" available at https://justiceinaging.org/wp-content/uploads/2023/03/Implementing-HCBS-Settings-Rule-3-30-23.pdf

appeals process facilitated and coordinated by the Office of Administrative Hearings (OAH), we recognize the importance of buy-in from the impacted communities and plan to hold at least one public hearing in order to facilitate a discussion about what appeals process would be most accessible and effective for those who would like to utilize the resource.

Regardless of the decided process, we recommend, as an immediate step, that an appeals process be implemented to ensure that residents in assisted living programs receive comparable rights as residents in skilled nursing facilities and renters subject to landlord tenant laws.

Ensure OHCQ is fully funded to fill vacancies in the year ahead and create a distinct Committee to study discharges of older adults from assisted living programs, nursing homes, and hospitals, including standardized discharge planning requirements and processes for each provider setting

Regardless of the setting, discharge planning is an ongoing concern and is often the reason for complaints filed against providers. In its 2024 Annual Report and Staffing Analysis for 2023, OHCQ, there were 4, 692 complaints and facility reported complaints from skilled nursing facilities, comprising 225 facilities. In addition, 1,349 complaints and facility reported incidents from assisted living facilities, comprising 1,721 facilities.[15] Only around half were investigated in each setting:

2024 Report Data

Type of Program	*Number of facilities*	*# of complaints*	*# of investigations*
Assisted Living Program	*1,721*	*1,349*	*661*
Skilled Nursing Facility	*225**	*4,692*	*2,855*

**Of note, only 42 facilities had an annual full survey to monitor compliance*

Many residents in each setting rely on OHCQ to address their complaints and concerns. They cannot withhold payment for poor care because they would be discharged or evicted. Rather, the state is charged to provide oversight to ensure residents do not develop severe bed sores and infections from remaining in soiled diapers, to ensure proper monitoring and correct medication is administered, and to ensure that facilities receiving money from the state and federal government are providing quality care. The lack of investigations and annual surveys is a significant concern to the committee, and we would be remiss not to acknowledge a proposal that came during the 2024 Legislative session that would give contract the state's responsibilities to local counties. The committee is concerned that such a result would lead to greater inequities, and strongly urges the state to request all available assistance (including assistance from the Centers for Medicare and Medicaid Services) in order to get caught up with annual surveys and investigations, and for the OHCQ to be fully funded to fill staffing vacancies.

In hospitals, case managers, nurses, and licensed social workers are often the people responsible for discharge planning. The roles do not always seem to work as an interdisciplinary team, which

[15] Office of Health Care Quality, Annual Report and Staffing Analysis, Fiscal Year 2024, p. 9 https://health.maryland.gov/ohcq/docs/Reports/Office%20of%20Health%20Care%20Quality%20Annual%20Report%20FY%202023%20-%20Letter%20and%20Report%20-%20Jan.%202024.pdf. In the Report, the Maryland Department of Health states that 2024 concludes the FY 2018 seven-year staffing plan, and that the Department is developing a staffing plan for FY2025-2029.

results in confusion and can disrupt potential viable community placements. For instance, the patient may have a case manager in the community or a housing application pending, but there is often poor coordination between hospital social workers and case managers in the community leading to duplication of work or a failure to utilize services that would have otherwise been in place. Similarly, in skilled nursing facilities, the social worker, case manager, and other healthcare professionals are responsible for discharge planning, but often do not engage in discharge planning until there is a problem warranting discharge. Residents are often not informed about Waiver services or other supports available in the community and because many people are unable to maintain their home, they become homeless once they recover from care.[16] In addition, while applications for Social Security benefits should be completed early in the admission process, they are often not provided with this assistance and left with no financial resources upon discharge. In assisted living facilities, the assisted living manager and delegating nurse are key staff who perform discharge planning. Sometimes, the same person performs both roles. With minimal guidance in the regulations protecting residents in assisted living programs, these residents are particularly susceptible to the cycle of displacement caused by inadequate discharge planning.

The subcommittee recommends education for anyone who is responsible for discharge planning in the three settings, noting that discharge planning is not taught in universities consistently and designees are often not given the training that is needed. The requirements for discharge planning should be determined by convening a Committee to review discharge practices in all three settings and making recommendations for education requirements and regulatory changes for professionals. This would help ensure that professionals that provide discharge planning are prepared and trained to provide this service to those that need it. The Committee would comprise consultation with the National Association of Social Workers (NASW), the Board of Social Work, Maryland Hospital Association (MHA), the professional board that will be licensing assisted living managers, and case management organizations that provide discharge planning to discuss discharge planning education and practices, and other advocacy groups. It is also recommended that we engage the Board of Nursing to discuss the role of the Delegating Nurse in discharge planning and what, if any training and educational requirements exist. Given the high rate of turnover in the field, it may be informative to consult with NASW and the Board of Social Work to discuss turnover rates in social work in health care settings and social work supervision as related challenges. And the Committee could study social issues that affect discharge planning, including available benefits, professionals, wait times for housing, etc. as well as gaps in services that could be addressed by legislation.

In essence, staff involved in the discharge planning process must be provided with ongoing training to include awareness of the social determinants of health and the resources and services available to address the specific needs of vulnerable populations (i.e., housing, behavior health services, caregiver support, DDA, TBI, substance abuse, financial support) and how to navigate through the system to obtain services to ensure discharge planners, residents, patients, and their support systems are aware of and connected to these services. They must also be equipped to assess, make recommendations, and plan for a discharge to an appropriate level of care, and obtain confirmation that the post discharge provider is licensed for the needed level of care.

[16] We also recommend expanding the HCBS Waiver program.

Preventing Fraud, Scams and Financial Exploitation

According to the World Health Organization, the current population of individuals aged 60 years and older will double from 1 billion in 2020 to 2.1 billion by 2050. As the quantity of older adults increases, so will the need for support.[17] This support that older adults need make them particularly vulnerable to exploitation. The mistreatment of older adults can be by family members, strangers, health care providers, caregivers, or friends. Abuse of older adults typically takes one of the following forms: physical abuse, psychological or emotional abuse, sexual abuse, stalking, abandonment, human trafficking, spiritual abuse, financial abuse, and neglect. The abuse of an older adult not only impacts the individual but also communities on many levels, including personal relationships, community engagement, public health, and economic domains.

Older adults are especially vulnerable to fraud and scams. Losing money or possessions to scams, fraud, and exploitation can be especially devastating to older adults, and older adults may be targeted at rates that outpace the services available to help the growing number of victims. Financial exploitation of older adults is costly, widespread, and results in a loss of billions of dollars each year.

Fraud, scams, and exploitation often go unreported and can be difficult to prosecute. One in ten community dwelling Americans aged 60 and older has experienced abuse, and one of the most frequent forms of abuse of older adults is financial exploitation. Older adults are more susceptible to financial abuse and exploitation and are perceived to be easy victims due to a variety of reasons, including cognitive and/or physical decline, an accumulated wealth in savings and asset accounts, and a greater reliance on family, friends, neighbors, and even strangers who can take advantage of them via the telephone, internet, or email to gain access to their personal information. These types of crimes leave older adults in vulnerable positions with limited ability to ever recover their losses in full.

To prevent older adults from becoming victims of fraud, scams and financial exploitation across the state of Maryland, this subcommittee determined prioritizing its focus on these two critical areas to be paramount:

1) Preventing financial abuse and exploitation by Powers of Attorney and Representative Payees,
2) Follow-up and Partnership on Reporting Banking Fraud and Exploitation.

Increase oversight of Power of Attorneys and Representative Payees

Power of Attorney and Representative Payee are important tools, but without regulations, they provide a mechanism for exploitation.

Power of Attorney

A Power of Attorney (POA) is a document authorized by Md. Code, Est. & Trusts § 17-101 etc., that gives someone legal authority to act on another person's behalf. Through the document, a

[17] "Representative Payees: A Call to Action" Social Security Advisory Board. March 3, 2016, available at https://www.ssab.gov/research/representative-payees-a-call-to-action/

person, an “Agent,” (also sometimes called “Attorney-in Fact”) is assigned to manage the person granting the authority, the “Principal’s” affairs, in the event the Principal is unable to do so.

The POA defines the limits of the power the Principal gives to the Agent. The Principal retains authority to act and make decisions and only gives the Agent the power to act for the Principal and only under defined circumstances. For the POA to be valid, the Principal must grant the power to the Agent of their own free will. Principal determines who is named as their Agent, and how much power is given to the Agent. If a Principal is subject to undue influence is pressured or coerced, or is not of sound mind, the POA will be found invalid in a court of law.

The following are the recommendations of this subcommittee to mitigate some occurrences of fraud, financial abuse and exploitation of Principals having a POA.

- <u>Maryland should require education of potential Agents about their fiduciary duties as POA prior to Agents being assigned and create a system of oversight for after a POA is signed.</u>

    - Specifically, Maryland does not require any education, acknowledgment of duties, etc. for individuals nominated to become a POA. This leaves open plausible deniability, ignorance of the law and fiduciary obligations, and more, and causes liability when bad actors commit fraud, scams, and financial exploitation.

    - Maryland should develop and include an informational packet for POA nominees explaining what their role and obligations are to the Principal. Incorporating an educational component into the process of granting POA, along with a clear acknowledgment of the duties and obligations by the appointed Agent, could significantly bolster the accountability of POA arrangements. This measure would provide a stronger foundation for claims regarding liability and criminal proceedings in cases where Agents engage in misconduct or abuse their authority. By ensuring that Agents fully understand their responsibilities and the potential consequences of their actions, it can serve as a deterrent to unethical behavior and provide recourse for those affected by abuse of power.

    - We recommend examining how other states have incorporated education and acknowledgment of duties into the POA nomination process. We believe that practices in other states may model best practices and more robust requirements for Agents, including mandatory educational components and explicit acknowledgment of duties and responsibilities. For example, California has specific forms that agents must sign, acknowledging their duties and obligations under the POA. Additionally, educational materials may be provided to both the Principal and the Agent to ensure they understand their respective roles and responsibilities. Maryland's current approach lags behind in this regard, potentially leaving individuals vulnerable to financial abuse and exploitation by agents who may not fully grasp their duties or the

potential consequences of their actions. To address this gap, advocacy efforts could be directed towards legislative changes that would enhance the requirements for POA nominations in Maryland. This could include proposals for standardized educational materials, mandatory training for agents, or specific acknowledgment forms outlining duties and obligations. By bringing attention to the importance of strengthening POA regulations, advocates can work towards ensuring better protection for individuals and reducing the risk of financial abuse and exploitation perpetrated by bad actors holding POA

- A comprehensive review of existing POA statutes is essential, with a focus on introducing amendments that strengthen protections against the financial exploitation of older adults. These amendments should aim to provide effective mechanisms for recourse and prevention. By bolstering the legal framework surrounding POA, avenues can be created for holding perpetrators of financial exploitation accountable and implementing measures to safeguard vulnerable and other older adults.

Representative Payee

In contrast to a POA, a Representative Payee (Rep Payee)[18] receives funds from a particular program that are intended for the beneficiary. The Rep Payee has a fiduciary duty to manage the funds, such as Social Security benefits, for the beneficiary's benefit and must be placed into a dedicated account for the beneficiary's benefit.[19] From that account, the facility may pay itself rent and other charges.[20] Although federal law prohibits a facility from conditioning admission upon a designation of facility-named Rep Payee,[21] many residents of assisted living facilities and skilled nursing facilities have been pressured into designating the facility as Representative Payee, despite it being illegal to do so.

When Rep Payees are designated by the Social Security Administration, they are required to provide Social Security with a short form (accounting), which shows expenditures for food and housing and separately, personal spending (recreational expenses, clothes, etc.). The Rep Payee must ensure that the beneficiary's bills are paid and that the beneficiary does not have a high level of excess income, which could disqualify them from their benefits eligibility.

However, even with this accounting, there is an apparent conflict of interest:

[18] In this letter, we are using the term "representative payee" to describe a person or entity appointed to receive and manage an individual's governmental benefits.

[19] Social Security Administration, Representative Payee Report of Benefits and Dedicated Account (available at https://secure.ssa.gov/apps10/public/pomsimages.nsf/gfx_num/G-SSA-6233-BK-1/$File/G-SSA-6233-BK-1.pdf) (commonly referred to as Form 623).

[20] *Id.*

[21] *See* 42 CFR §483.10(f)(10), which provides "The facility may not require residents to deposit their personal funds with the facility although a resident can if he or she so desires." Note: Facilities similarly use resident trust accounts. Maryland does not distinctly regulate resident trust funds in ALPs, of note, Texas requires assisted living facilities to keep funds received from or on behalf of a client a separate bank account from the facility's operating funds and outlines the types of accounts that may be used. 40 Tex. Admin. Code § 46.63(a), (b).

> "Appointment of a residential care facility [as rep payee], however, is disfavored because it creates a conflict of interest for the representative payee: on one hand, the care facility has a duty as payee to expend Social Security funds in a manner with the beneficiary's best interests; on the other hand, the care facility has a financial incentive to maximize its compensation for services provided to the beneficiary, and that compensation can be drawn directly from the beneficiary's monthly Social Security benefit check."[22]

Rep Payee programs can yield benefits for beneficiaries, enhancing their ability to maintain independence, meet basic needs, and mitigate risks such as hospitalization, homelessness, and victimization. These programs also contribute to an improved quality of life and can have positive economic implications for communities by reducing the need for costly institutional care.

However, the appointment of a Rep Payee carries inherent risks. Foremost among these is the loss of financial autonomy, which can have profound psychological effects, including diminished self-esteem, heightened anxiety, increased dependency, and compromised autonomy. Moreover, entrusting another individual with control over the disbursement of funds exposes beneficiaries to potential mismanagement, misuse, or outright financial exploitation. Thus, while representative payee programs offer crucial support, it's essential to address and mitigate these risks to safeguard the well-being and financial security of vulnerable individuals.

Importantly, facilities do not have to become representative payees in order to secure control of residents' funds. In lieu of becoming a Rep Payee, SSA permits a facility to create a "resident trust account" for a beneficiary, into which the resident's social security benefits are deposited.[23] The facility owns the account, and while the beneficiary is supposed to have access to the account, the facility deducts amounts it claims are owed to it.[24]

A focus on the following recommendations we believe will serve to help mitigate some occurrences of financial abuse and exploitation of persons who have a Rep Payee in place:

- <u>Maryland should work more closely with the Social Security Administration to address Rep Payee issues of financial abuse and exploitation.</u>

    - Collaborating with the Social Security Administration (SSA) to develop state regulations or establish legal avenues for recourse could bolster accountability measures and prevent bad actors from evading consequences by simply changing business names and reemerging as new Rep payees. This proactive approach is crucial to address instances of misconduct and abuse, such as those resulting from insufficient oversight. By implementing stronger

[22] Reid K. *Weisbord, Social Security Representative Payee Misuse*, 117 PENN ST. L. REV. 1257, 1257 (2013).
[23] While Maryland does not distinctly regulate resident trust funds in ALPs, of note, Texas requires assisted living facilities to keep funds received from or on behalf of a client a separate bank account from the facility's operating funds and outlines the types of accounts that may be used. 40 Tex. Admin. Code § 46.63(a), (b).
[24] POMS GN 00603.020 Collective Checking and Savings Accounts Managed by Representative Payees available at https://secure.ssa.gov/poms.nsf/lnx/0200603020; JUSTICE IN AGING, *Skilled Nursing Facilities and Other Creditors Acting as Rep payees* (January 2018), at 7, available at https://www.justiceinaging.org/wp-content/uploads/2018/01/Skilled-Nursing-Facilities-and-Other-Creditors-Acting-As-Representative-Payees.pdf.

mechanisms to hold accountable those individuals and businesses who exploit vulnerable older adults, we can enhance the integrity of representative payee programs to better protect beneficiaries from harm. Even specific requirements based in state law for skilled nursing facilities and assisted living facilities serving as Rep Payee would be a critical step in ensuring monetary benefits used in good faith for the intended beneficiary.

- Expand the "Representative Payee Investigations Program" to include more vendors, modeled after the program housed at Disability Rights Maryland (DRM).

    - DRM houses federally funded SSA-trained investigators that receive referrals from SSA to investigate potential bad actor Rep Payees through an outlined thorough process that includes screening, site visits, records requests, Rep Payee re-education, and reporting of findings and recommendations that may or may not yield restrictions of Rep Payees or potentially referral to the Office of Inspector General (OIG).

    - DRM can also receive community referrals about potential bad Rep Payees, refer them to SSA, and have SSA essentially approve it and send it back to DRM to proceed with the investigation.

Increase oversight in Reporting Banking Fraud and Exploitation

Fraud in banking is a type of financial crime that involves the use of deceptive or illegal practices to gain an unfair or unlawful financial advantage. It is a serious crime that can cost banks and customers significant amounts of money. Bank fraud can come in many forms, from small-scale scams to large-scale operations that involve millions of dollars. It can occur in many ways and can involve any type of banking activity, including deposits, withdrawals, transfers, loan applications and investments. One of the most common types of banking fraud is identity theft and another form of banking fraud is phishing.

The responsibility for banking fraud lies with both the bank and the customer. The responsibility of the banks is to ensure the security of customers' financial data and accounts. They should have strong protocols in place to protect customers' accounts from fraud and theft. Banks should also ensure that their staff is adequately trained in detecting and preventing banking fraud.

On the flip side, customers have a responsibility to protect their accounts from fraud. They should ensure that their passwords are secure and not easily guessed. Customers should also be alerted of any suspicious activity in their accounts and should immediately report it to the bank.

Both customers and banks have a responsibility to protect themselves from banking fraud. By taking the necessary precautions and staying vigilant, both customers and banks can reduce the likelihood of fraud.

The issue that arises when addressing bank fraud is the reporting agency not receiving any follow-up after the claim is submitted. Maryland law requires fiduciary institutions to submit reports of suspected abuse. Md. Code, Fin. Inst. § 1-306. However, they are left not knowing if their referrals were dismissed, investigated, and if so, what the investigation yielded as it relates to consequences and/or reimbursement to the victim in question.

A focus on the following recommendations we believe will serve to help bridge that gap between the follow-up and sharing of information as it relates to reported bank fraud and exploitation.

- Establish a sharing of information among the various agencies and banking institutions that closes the loop on reporting.
- Robust education and awareness regarding older adult exploitation.
- Create a process on how agencies learn the outcomes of referrals so that referral agencies continue to provide the appropriate support.
- Research HIPAA
    - Allow clients/patients at intake to have the ability to sign a release of information that allows feedback to be shared with referring agencies.

Conclusion

Maryland is home to nearly 1.4 million people over the age of 60, and according to the Governors recent State Plan on Aging, Maryland is expected to see considerable growth in the older adult population in the next two decades. In fact, this age group is expected to grow to 1.7 million by 2040. Additionally, the population of Marylanders over the age of 85 will more than double in the same time period. This means Maryland must be prepared now to support its senior population, by protecting them from identifiable and preventable forms of elder abuse.

This task force aims to publicize the issues of elderly abuse and neglect and promote the implementation of legal, administrative, service provision, and educational responses. As stated above Maryland's elderly population is expanding, with the oldest group growing most rapidly. These individuals are more likely to be ill, have diseases that affect seniors such as Alzheimer’s and Dementia, or be dependent on family or community caregivers, making them vulnerable to abuse and neglect. Maryland must mobilize its resources now to prevent a parallel increase in abuse and neglect with the projected growth in the oldest population members.

This Taskforce believes it has identified the most prevalent areas of preventable abuse to Maryland Senior population. As stated above these areas are being studied by separate committees include the on Collaborative Study of Maryland and Other States' Laws, the Committee on Guardianship, the Committee on Hospital Discharge and Long-Term Care Quality of Care, and the Committee on Fraud, Scams, and Financial Exploitation. This Task Force is committed to continuing its research and investigation into the study of these areas and issues. In its final report this Task Force will build upon the great research it has done to identify these areas and will provide comprehensive recommendations on how to prevent and prosecute these four areas of elder abuse.

The goal of this Task Force is to provide the Governor and his aids with a comprehensive approach to addressing the four areas of study and to create a path to provide sustained change through recommendations that can be adapted into legislation.

Appendix

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

January 24, 2024

The Honorable Bill Ferguson
President of the Senate
100 State Circle
Annapolis, MD 21401-1991

The Honorable Adrienne Jones
Speaker of the House
100 State Circle
Annapolis, MD 21401-1991

Re: Health General-Article §19–308 (b)(4) – Office of Health Care Quality FY 23 Annual Report, MSAR # 5624

Dear President Ferguson and Speaker Jones:

Pursuant to the requirements Health General-Article §19–308 (b)(4), the Maryland Department of Health (MDH) respectfully submits the Office of Health Care Quality FY 23 Annual Report.

If you have any questions or comments concerning the report, please contact Sarah Case-Herron, Office of Governmental Affairs, at sarah.case-herron@maryland.gov.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

cc: Marie Grant, JD, Assistant Secretary for Health Policy, Office of the Secretary
Nilesh Kalyanaraman, MD, Deputy Secretary of Public Health Services
Sarah Case-Herron, JD, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies), MSAR # 5624

MARYLAND DEPARTMENT OF HEALTH
Office of Health Care Quality

Maryland Department of Health
Office of Health Care Quality

Annual Report and Staffing Analysis
Fiscal Year 2023

Health-General Article § 19-308(b)(4)
Health-General Article § 19-1409(e)

Wes Moore, Governor
Aruna Miller, Lt. Governor
Laura Herrera Scott, MD, MPH, Secretary
Nilesh Kalyanaraman, MD, FACP, Deputy Secretary for Public Health Services
Patricia Tomsko Nay, MD, CHCQM, FAAFP, FABQAURP, FAAHPM, Executive Director

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Executive Summary

On behalf of the Office of Health Care Quality (OHCQ), it is my privilege to submit the FY 23 Annual Report and Staffing Analysis. This document is submitted pursuant to Health-General Article § 19-308(b)(4) and Health-General Article § 19-1409(e). OHCQ is the agency within the Maryland Department of Health (the "Department") that determines compliance and non-compliance with State licensure and/or federal certification requirements in health care facilities and community-based programs. As of July 1, 2023, OHCQ oversees 21,221 providers in 47 industries, an increase of 6.7 percent from the number of providers on July 1, 2022.

On behalf of the Maryland Secretary of Health, OHCQ issues State licenses that authorize the operation of certain health care facilities or programs in Maryland, such as nursing homes or assisted living programs. The State licensure requirements establish the minimum health and safety requirements to obtain and maintain a license to operate in Maryland.

On behalf of the Secretary of the U.S. Department of Health & Human Services, OHCQ conducts certification, recertification, and CLIA activities. The Social Security Act mandates the establishment of minimum federal health and safety and Clinical Laboratory Improvement Amendments ("CLIA") standards that must be met by providers and suppliers to participate in the Medicare and Medicaid programs. Based on outcomes from certification surveys, OHCQ makes recommendations regarding certification of a provider or supplier to the Centers of Medicare & Medicaid Services ("CMS"). Once certified, a provider or supplier may participate in and seek reimbursement from Medicare and Medicaid for services rendered to beneficiaries.

In FY 18, the Department developed and implemented a seven-year staffing plan for OHCQ. As anticipated, this controlled growth in the agency's workforce is progressively improving compliance with federal and State mandates. FY 24 marks the final year of this staffing plan. The Department is developing a staffing plan for OHCQ for FY 25 through FY 29.

Every day, OHCQ staff conduct or support licensure and certification activities that protect the health and safety of Marylanders across the health care continuum. It is an honor and a privilege to lead this group of dedicated staff. OHCQ appreciates the ongoing support of the Secretary, the Deputy Secretary, the Administration, members of the General Assembly, and all of our stakeholders.

Patricia Tomsko Nay, MD

Patricia Tomsko Nay, MD, CHCQM, FAAFP, FABQAURP, FAAHPM
Executive Director
Office of Health Care Quality

Roles of the Office of Health Care Quality

The Office of Health Care Quality ("OHCQ") is the agency within the Maryland Department of Health that determines compliance and non-compliance with State licensure and/or federal certification requirements in health care facilities and community-based programs in 47 industries.

On behalf of the Maryland Secretary of Health, OHCQ issues State licenses that authorize the operation of certain health care facilities or programs in Maryland, such as nursing homes or assisted living programs. The State licensure requirements establish the minimum health and safety requirements to obtain and maintain a license to operate in Maryland.

The Social Security Act mandates the establishment of minimum federal health and safety and Clinical Laboratory Improvement Amendments ("CLIA") standards that must be met by providers and suppliers to participate in the Medicare and Medicaid programs. In this context, providers are patient care institutions, such as hospitals, hospices, nursing homes, and home health agencies. Suppliers are agencies for diagnosis and therapy rather than sustained patient care, such as laboratories and ambulatory surgery centers.

The agreement between the U.S. Department of Health & Human Services ("HHS") and the Maryland Department of Health ("MDH") relates to the provisions of Sections 1864, 1874, and related provisions of the Social Security Act (the "1864 Agreement"). The 1864 Agreement specifies the functions to be performed by Maryland's state survey agency. MDH has designated OHCQ as the state survey agency. In accordance with the 1864 Agreement, OHCQ conducts certification, recertification, and CLIA activities for the purpose of certifying to the HHS Secretary the compliance or non-compliance of providers and suppliers. OHCQ makes recommendations regarding certification of a provider or supplier to CMS. A certified provider or supplier may participate in and seek reimbursement from Medicare and Medicaid for services rendered to beneficiaries.

It is through licensure and certification activities that OHCQ fulfills its mission to protect the health and safety of Marylanders and to ensure that there is public confidence in the health care and community delivery systems. OHCQ's vision is that all those receiving care in Maryland can trust that their health care facility or program is licensed and has met the regulatory standards for the services that they offer.

Licensed and/or Certified Providers

As of July 1, 2023, OHCQ oversees 21,221 providers in 47 industries, an increase of 6.7 percent in the total number of providers overseen by OHCQ since July 1, 2022. The increase in providers occurred primarily in residential service agencies, health care staff agencies, the number of sites serving individuals with developmental disabilities, and clinical laboratories.

Table 1 lists the number of licensees per provider types as of July 1st of 2021, 2022, and 2023.

Table 1: Number of Licensees per Provider Type as of July 1, 2021, 2022, and 2023

Provider Type	Number of Licensees		
	July 1, 2021	July 1, 2022	July 1, 2023
Adult Medical Day Care Centers	122	116	120
Assisted Living Programs	1,672	1,691	1,721
Assisted Living Referrers	41	73	100
Birthing Centers	2	1	0
Cholesterol Testing Sites	0	0	0
Community Mental Health Centers	3	3	3
Comprehensive Outpatient Rehabilitation Facilities	1	1	0
Cosmetic Surgery Facilities	5	5	9
Developmental Disabilities Sites (365 in 2023)	3,008	3,383	3,631
Employer Drug Testing Facilities	250	259	272
Federally Qualified Health Centers	77	77	84
Federally Waived Laboratories	3,894	3,982	4,011
Forensic Laboratories	45	45	46
Forensic Residential Centers	1	1	1
Freestanding Ambulatory Surgical Centers	340	338	360
Freestanding Medical Facilities	5	7	7
Freestanding Renal Dialysis Centers	175	175	170
Health Awareness Testing Sites	60	55	51
Health Care Staff Agencies	593	848	1,179
Health Maintenance Organizations	7	7	7
Home Health Agencies	56	56	56
Hospices	26	26	26
Hospice Houses	16	16	13
Hospitals	63	60	61
Hospital Laboratories	91	99	99
Hospitals within Correctional Facilities	10	10	10
Independent Reference Laboratories	148	165	145
Intermediate Care Facilities for Individuals with Intellectual Disabilities	2	2	2
Limited Hospice Care Programs	1	1	1
Limited Private Inpatient Facilities	7	7	7
Long Term Care Facilities	226	225	225
Major Medical Equipment Providers	201	205	209
Nursing Referral Service Agencies	158	168	243
Outpatient Physical Therapy Providers	67	66	66
Physician Office Laboratories	3,749	3,564	3,675
Point-of-Care Laboratories	1,804	1,766	1,861
Portable X-Ray Providers	10	11	10
Public Health Testing Sites	34	25	28
Rare Disease Testing Laboratories	1	1	1
Residential Service Agencies	1,605	1,874	2,209
Residential Treatment Centers	6	6	6
Rural Health Clinics	1	1	1
Surgical Abortion Facilities	11	11	12
Tissue Banks	438	451	481
Transplant Centers	2	2	2
Total Number of Providers	**19,034**	**19,885**	**21,221**
Percent of Growth of Total Number of Licensed Providers	**7.7%**	**4.5%**	**6.7%**

Surveyor Staffing Analysis

The surveyor staffing analysis in Appendix A calculates the number of surveyors needed in FY 24 to complete the projected number of mandated licensure and certification activities in FY 24. These projections consider historical information as well as anticipated upcoming changes in federal or State oversight of an industry. The activities include the duties performed by surveyors, but not those duties performed by managers and administrative staff.

The number of hours required for each activity is multiplied by the projected number of required activities in FY 24. The total is divided by 1,500, which is the industry standard for the number of hours that the average surveyor spends conducting surveys in a year. The 1,500 hours considers time taken for holidays, vacation, personal days, sick leave, training, meetings, and travel. The number of full-time equivalents of surveyors required for each activity is calculated and then totaled by unit based on its specific mandates. The surveyor staffing deficit (number needed – current positions) for each unit is calculated. The sum of all units' surveyor staffing deficit is OHCQ's surveyor staffing deficit.

Table 2 summarizes the projected surveyor staffing deficit by unit, with an overall deficit of 21 surveyor positions. Appendix A details this analysis by unit, provider type, and activity. Note that this year, certain activities that require less than 0.05 FTE surveyors were combined in other rows.

Table 2: Surveyor Staffing Deficit Projected for FY 24

Unit	Current Number of Surveyor Positions	Number of Surveyor Positions Needed	Surveyor Deficit
Long Term Care	64	75	11
Federal	20	20	0
Assisted Living	34	37	3
Developmental Disabilities	54	59	5
Laboratories	5	7	2
Totals	**177**	**198**	**21**

OHCQ Staffing Plan for FY 18 through FY 24

Through the seven-year staffing plan, the Department continues to make significant progress towards meeting OHCQ's overall staffing needs. The plan includes the need for surveyors, managers, and other positions. The plan considers historical data as well as anticipated changes in federal and State oversight and industry trends. A controlled growth of 5 to 6 percent increase in workforce annually can be accommodated. OHCQ's mandated activities include licensure, certification, and survey activities, including the investigation of complaints and facility-reported incidents. As predicted, compliance with federal and State mandates is progressively improving as additional surveyors are hired and trained. The FY 18 through FY 23 staffing plans were fully implemented.

In FY 24, OHCQ received 10 new merit positions, including 5 nurse surveyors in the long term care unit; 1 nurse surveyor in the assisted living unit; and 2 nurse surveyors, 1 administrative officer surveyor, and 1 coordinator (supervisor) in the developmental disabilities unit. Table 3 provides additional details about the allocation of positions from FY 18 through FY 24.

Table 3: OHCQ Staffing for FY 18 through FY 24

OHCQ Unit	Position	FY 18	FY 19	FY 20	FY 21	FY 22	FY 23	FY 24	Total
Long term care	Coordinator	2	1	1	0	0	0	0	**4**
Long term care	Nurse surveyor	1	4	3	5	1	3	5	**22**
Long term care	Physician surveyor	0	1	0	0	0	0	0	**1**
Long term care	Nurse trainer surveyor	1	0	0	0	0	0	0	**1**
Assisted living	Coordinator	1	0	0	1	0	0	0	**2**
Assisted living	Nurse surveyor	0	2	1	0	2	1	1	**7**
DD	Coordinator	1	1	1	0	1	1	1	**6**
DD	Nurse surveyor	1	2	2	2	0	2	2	**11**
DD	Coordinator special program surveyor	0	1	1	1	0	0	0	**3**
DD	Administrative officer III surveyor	0	0	0	0	4	2	1	**7**
DD	Office secretary II	1	0	0	0	0	0	0	**1**
Federal	Coordinator	1	0	1	0	0	0	0	**2**
Federal	Nurse surveyor	0	0	0	1	1	1	0	**3**
Federal	Triage specialist	0	0	0	0	1	0	0	**1**
Federal	Assistant deputy director	1	0	0	0	0	0	0	**1**
Federal	Health policy analyst	1	0	0	0	0	0	0	**1**
State	Health policy analyst	1	0	0	0	0	0	0	**1**
Positions per fiscal year		**12**	**12**	**10**	**10**	**10**	**10**	**10**	**74**

The Department is developing a long-term staffing plan for OHCQ that will be implemented in FY 25. In conjunction with staffing plans, OHCQ continues to develop and implement initiatives to enhance regulatory efficiency and effectiveness.

Long Term Care Unit

The long term care unit conducts surveys to determine if nursing homes are compliant with federal health and safety standards, certification requirements, State licensure requirements, and local requirements through unannounced on-site surveys, follow-up surveys, complaint investigations, and administrative reviews.

Table 4: Nursing Homes

Units of Measurement	FY21	FY22	FY23
Number of licensed nursing homes	226	225	225
Initial surveys	0	0	0
Annual full surveys	27	28	42
Follow-up surveys (onsite)	33	41	41
Follow-up surveys (offsite)	277	144	54
Complaints and facility reported incidents (FRI)	4,067	4,414	4,692
Complaints and FRI investigations	2,281	1,549	2,855
Life safety code surveys	79	82	132
Resident fund surveys	31	59	64

Assisted Living Unit

The assisted living unit is responsible for the oversight of all assisted living programs in Maryland, including those that participate in the Medicaid waiver program. The unit completes surveys for prelicensure, licensure, inspection of care, change of ownership, change of the level of care, follow-up, and to investigate complaints and facility-reported incidents. Allegations of unlicensed assisted living programs are investigated by this unit. The unit is also responsible for registering assisted living referrers.

The unit oversees adult medical day care centers, including surveys for prelicensure, licensure, biannual, change of ownership, follow-up, and investigates complaints and facility-reported incidents.

Table 5: Assisted Living Programs

Units of Measurement	FY21	FY22	FY23
Number of licensed assisted living programs	1,672	1,691	1,721
Initial surveys	164	102	146
Renewal surveys	817	543	298
Other surveys	100	33	114
Complaints and facility reported incidents (FRI)	1,079	1,010	1,349
Complaints and FRI investigated	1,192	474	661
Investigations of alleged unlicensed programs	116	138	80

Table 6: Assisted Living Referrers

Units of Measurement	FY21	FY22	FY23
Number of referrers	41	73	100
Complaints investigated	0	0	0

Table 7: Adult Medical Day Care Centers

Units of Measurement	FY21	FY22	FY23
Number of licensed adult medical day care centers	122	117	120
Initial surveys	7	13	9
Full surveys	3	55	46
Follow-up surveys	0	5	30
Complaints investigated	10	27	49

Developmental Disabilities Unit

The developmental disabilities unit is the licensing and monitoring agent for the Developmental Disabilities Administration ("DDA"). Through periodic surveys, the unit oversees community-based providers serving individuals with developmental disabilities. The unit completes on-site surveys and administrative reviews of complaints and facility reported incidents.

This unit also licenses health care staff agencies and nurse referral agencies and investigates complaints in these industries.

Table 8: Developmental Disabilities Unit

Units of Measurement	FY21	FY22	FY23
Licensed developmental disability agencies	304	333	365
Number of sites	3,008	3,383	3,631
New agencies	31	26*	58
Initial site surveys	164	349	379
Agencies surveyed	90	112	112
Complaints and FRI	4,253	3,695	4,864
Complaints and FRI, administrative reviews	2,363	3,494	2,919
Complaints and FRI, on-site investigations	1,434	1,353	1,585

*Corrected FY22 number of new agencies from 9 to 26

Table 9: Developmental Disabilities Mortality Unit

Units of Measurement	FY21	FY22	FY23
Developmental disabilities deaths	313	293	254
On-site investigations	102	93	99
Administrative reviews	133	306	197

Table 10: Health Care Staff Agencies

Units of Measurement	FY21	FY22	FY23
Health care staff agencies	593	848	1,179
Initial licensure administrative surveys	94	287	332
Complaint investigations	2	0	4

Table 11: Nursing Referral Service Agencies

Units of Measurement	FY21	FY22	FY23
Nursing referral service agencies	158	168	243
Initial licensure administrative surveys	12	27	55
Complaint investigations	0	0	1

Federal Unit

As applicable to the provider type, under State and/or federal authority the federal unit conducts various types of surveys, investigates complaints and facility-reported incidents, and reviews reports from accreditation organizations. It is responsible for the State licensure and/or federal certification of all non-long term care facilities as well as certain providers under State oversight only.

Table 12: Birthing Centers

Units of Measurement	FY21	FY22	FY23
Licensed birthing centers	2	1	0
Initial surveys	0	0	0
Full surveys	2	1	0
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 13: Community Mental Health Centers

Units of Measurement	FY21	FY22	FY23
Community mental health centers	3	3	3
Complaint investigations	0	0	0

Table 14: Comprehensive Outpatient Rehabilitation Facilities

Units of Measurement	FY21	FY22	FY23
Licensed comprehensive outpatient rehab facilities	1	1	0
Initial surveys	0	0	0
Full surveys	0	0	0
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 15: Cosmetic Surgical Facilities

Units of Measurement	FY21	FY22	FY23
Licensed cosmetic survey facilities	5	7	9
Initial surveys	0	2	2
Full surveys	0	0	0
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 16: Federally Qualified Health Centers

Units of Measurement	FY21	FY22	FY23
Federally qualified health centers	77	77	84
Complaint investigations	0	0	0

Table 17: Forensic Residential Centers

Units of Measurement	FY21	FY22	FY23
Number of licensed forensic residential centers	1	1	1
Renewal surveys	1	1	1
Complaints investigated	11	12	41

Table 18: Freestanding Ambulatory Surgery Centers

Units of Measurement	FY21	FY22	FY23
Licensed freestanding ambulatory surgical centers	340	355	360
Initial surveys	10	28	15
Full surveys	90	97	98
Follow-up surveys	9	12	4
Complaint investigations	9	3	3

Table 19: Freestanding Medical Facilities

Units of Measurement	FY21	FY22	FY23
Licensed freestanding medical facilities	5	7	7
Initial, full and follow-up surveys	0	1	1
Complaints investigated	0	0	1

Table 20: Freestanding Renal Dialysis Centers

Units of Measurement	FY21	FY22	FY23
Licensed freestanding renal dialysis centers	175	175	170
Initial surveys	1	2	0
Full surveys	45	58	28
Follow-up surveys	3	3	16
Complaint investigations	32	36	39

Table 21: Health Maintenance Organizations

Units of Measurement	FY21	FY22	FY23
Health maintenance organizations	7	7	7
Full surveys	0	0	0
Follow-up surveys	0	0	0
Complaint investigations	1	0	0

Table 22: Home Health Agencies

Units of Measurement	FY21	FY22	FY23
Licensed home health agencies	56	56	56
Initial surveys	0	0	0
Full surveys	14	6	8
Follow-up surveys	0	1	0
Complaint investigations	6	3	2

Table 23: Hospices and Hospice Houses

Units of Measurement	FY21	FY22	FY23
Licensed hospices	26	26	26
Initial surveys	0	1	0
Full surveys	2	3	1
Follow-up surveys	1	0	0
Complaint investigations	11	0	2
Licensed hospice houses	16	15	13
Initial surveys	0	0	0
Complaint investigations in hospice houses	0	0	0

Table 24: Hospitals

Units of Measurement	FY21	FY22	FY23
Licensed or certified hospitals	63	60	61
Validation surveys of accredited hospitals	0	0	0
Complaints investigated on-site	44	10	14
Administrative reviews	207	73	121
Follow-up surveys	9	3	5

Table 25: Hospitals within Correctional Facilities

Units of Measurement	FY21	FY22	FY23
Licensed hospitals within correctional facilities	10	10	10
Initial surveys	0	0	0
Full surveys	0	0	6
Complaint investigations	0	0	0

Table 26: Intermediate Care Facilities for Individuals with Intellectual Disabilities

Unit of Measurement	FY21	FY22	FY23
Number of licensed ICF IIDs	2	2	2
Renewal surveys	2	2	1
Follow-up surveys	0	0	0
Complaints and facility reported incidents, investigated	21	27	39

Table 27: Limited Private Inpatient Facilities

Units of Measurement	FY21	FY22	FY23
Licensed limited private inpatient facilities	7	7	7
Initial, full and follow up surveys	7	3	1
Complaint investigations	2	1	1

Table 28: Major Medical Equipment Providers

Units of Measurement	FY21	FY22	FY23
Licensed major medical equipment providers	201	204	209
Initial administrative licensure surveys	0	0	7
Full or follow-up surveys	0	0	0
Complaint investigations	3	0	1

Table 29: Outpatient Physical Therapy Providers

Units of Measurement	FY21	FY22	FY23
Licensed outpatient physical therapy providers	67	67	66
Initial surveys	2	1	0
Full surveys	9	1	0
Follow-up surveys	1	0	0
Complaint investigations	0	0	0

Table 30: Portable X-ray Providers

Units of Measurement	FY21	FY22	FY23
Licensed portable x-ray providers	10	12	10
Initial surveys	0	1	1
Full surveys	1	0	2
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 31: Residential Service Agencies

Units of Measurement	FY21	FY22	FY23
Licensed residential service agencies	1,605	1,874	2,209
Initial licensure administrative surveys	155	105	387
Full surveys	14	0	20
Follow-up surveys	18	17	10
Complaint investigations	99	47	73

Table 32: Residential Treatment Centers

Units of Measurement	FY21	FY22	FY23
Licensed residential treatment centers	6	6	6
Follow-up surveys	0	1	2
Validation surveys, seclusion or restraint investigation	0	0	0
Complaint investigations	7	13	22

Table 33: Rural Health Clinics

Units of Measurement	FY21	FY22	FY23
Licensed rural health clinics	1	1	1
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Table 34: Surgical Abortion Facilities

Units of Measurement	FY21	FY22	FY23
Licensed surgical abortion facilities	11	11	12
Initial surveys	0	0	1
Renewal surveys	1	4	0
Complaints investigated	2	1	1

Table 35: Transplant Centers

Units of Measurement	FY21	FY22	FY23
Licensed transplant centers	2	2	2
Follow-up surveys	0	0	0
Complaint investigations	0	0	0

Clinical and Forensic Laboratories Unit

The Clinical and Forensic Laboratories Unit is the agent for federal certification in the CLIA program, which is required for all clinical laboratory testing sites. The unit is also responsible for State licensure of all laboratories that perform tests on specimens obtained from Marylanders. The programs include tissue banks, blood banks, hospitals, independent reference, physician office and point-of-care laboratories, public health awareness screening, pre-employment related toxicology testing for controlled dangerous substances, and public health testing programs that offer rapid HIV-1 and rapid Hepatitis C antibody testing to the public. This unit conducts surveys to ensure compliance with applicable federal and State requirements.

This unit also provides oversight for accredited and non-accredited laboratories that perform forensic analyses.

Table 36: Cholesterol Testing Sites

Units of Measurement	FY21	FY22	FY23
Cholesterol testing sites	0	0	0
Initial surveys	0	0	0
Full surveys	0	0	0
Complaint surveys	0	0	0

Table 37: Employer Drug Testing Facilities

Units of Measurement	FY21	FY22	FY23
Employer drug testing facilities	250	259	272
Initial surveys	2	9	13
Full surveys	27	16	38
Follow-up surveys	0	0	0
Complaint surveys	0	0	0

Table 38: Forensic Laboratories

Units of Measurement	FY21	FY22	FY23
Forensic laboratories	45	45	46
Full surveys	15	23	36
Follow-up surveys	0	0	0
Surveillance surveys	0	0	0
Complaint investigations	0	0	0

Table 39: Health Awareness Testing Sites

Units of Measurement	FY21	FY22	FY23
Health awareness test sites	60	55	51
Initial surveys	6	3	9
Full surveys	11	16	31
Follow-up surveys	0	0	1
Site approvals	403	772	868
Complaints surveys	0	0	2

Table 40: Hospital Laboratories

Units of Measurement	FY21	FY22	FY23
Hospital laboratories	91	99	99
Initial surveys	0	0	0
Full surveys	0	0	0
Follow-up surveys	0	0	4
Validation surveys	0	0	4
Complaint surveys	1	0	2

Table 41: Independent Reference Laboratories

Units of Measurement	FY21	FY22	FY23
Independent reference laboratories	148	165	145
Initial surveys	2	5	21
Full surveys	12	50	78
Follow-up surveys	0	0	13
Validation surveys	0	0	5
Complaint surveys	4	0	0

Table 42: Physician Office and Point of Care Laboratories, State Only Surveys

Units of Measurement	FY21	FY22	FY23
Physician office and point of care labs, State only	475	566	597
Initial surveys	12	33	21
Full surveys	87	219	250
Follow-up surveys	0	33	90
Complaint surveys	8	2	4

Table 43: Physician Office and Point of Care Laboratories, Federal CLIA Surveys

Units of Measurement	FY21	FY22	FY23
Physician office, point of care labs, CLIA surveys	475	566	597
Initial surveys	12	33	21
Renewal surveys	72	186	229
Full surveys	84	219	250

Table 44: Public Health Testing Sites

Units of Measurement	FY21	FY22	FY23
Public health testing	34	25	28
Initial surveys	0	0	3
Full surveys	0	0	12
Follow-up surveys	0	0	0
Complaint surveys	0	0	0

Table 45: Rare Disease Testing Laboratories

Units of Measurement	FY21	FY22	FY23
Licensed rare disease testing laboratories	1	1	1
Initial surveys	0	0	0
Complaint surveys	0	0	0

Table 46: Tissue Banks

Units of Measurement	FY21	FY22	FY23
Tissue banks	438	451	481
Initial surveys	2	0	4
Full surveys	0	9	77
Follow-up surveys	0	0	1
Validation surveys	0	0	0
Complaint surveys	0	0	0

Appendix A: OHCQ Projected Surveyor Staffing Analysis for FY 24

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Long Term Care Unit						
Long Term Care Facilities (Nursing Homes)						
Initial surveys	0	240	0	0.00		
Annual surveys	225	232	52,200	34.80		
CHOW initial surveys	32	240	7,680	5.12		
CHOW follow-up surveys	32	45	1,440	0.96		
Complaint investigations	3,830	10	38,300	25.53		
Follow-up surveys onsite	50	32	1,600	1.07		
Follow-up surveys offsite	72	16	1,152	0.77		
State resident funds surveys, all activities	N/A	N/A	N/A	2.00		
Life safety code surveys, all activities	N/A	N/A	N/A	3.50		
Informal dispute resolutions	50	16	800	0.53		
Testifying in hearings	9	120	1,080	0.72		
Long Term Care Unit				**75.00**	**64**	**11.00**
Assisted Living Unit						
Adult Medical Day Care Centers						
Initial surveys	6	24	144	0.10		
Renewal surveys	74	16	1,184	0.79		
Complaints and facility reported incidents	70	8	560	0.37		
Assisted Living Programs						
Initial surveys	154	40	6,160	4.11		
Annual surveys	1,506	16	24,096	16.06		
Complaints and facility reported incidents	1,146	16	18,336	12.22		
Follow-up surveys	82	16	1,312	0.87		
Informal dispute resolutions	14	16	224	0.15		
Testifying in hearings for unit	5	80	400	0.27		
Investigations of alleged unlicensed programs	96	32	3,072	2.05		
Assisted Living Referrers						
All activities	N/A	N/A	N/A	0.01		
Assisted Living Unit				**37.00**	**34**	**3.00**

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Developmental Disabilities Unit						
Developmental Disabilities Programs						
Initial site openings	409	6	2,454	1.64		
Annual surveys of providers	365	120	43,800	29.20		
Complaint and FRI, on-site	1,428	16	22,848	15.23		
Complaint and FRI, administrative	2,968	4	11,872	7.91		
Death investigations, on-site	94	28	2,632	1.75		
Death investigations, administrative	173	4	692	0.46		
Children's providers, all activities	N/A	N/A	N/A	2.00		
Informal dispute resolutions	8	12	96	0..06		
Settlements and hearings	5	80	400	0.27		
Health Care Staff Agencies						
Initial licensure administrative surveys	130	4	520	0.35		
Complaint investigations	3	8	24	0.02		
Nurse Referral Agencies						
Initial licensure administrative surveys	40	4	160	0.11		
Complaint investigations	1	8	8	0.01		
Developmental Disabilities Unit				**59.00**	**54**	**5.00**
Federal Unit						
Birthing Centers						
All activities	N/A	N/A	N/A	0.1		
Community Mental Health Centers						
All activities	N/A	N/A	N/A	0.2		
Comprehensive Outpatient Rehabilitation Facilities						
All activities	N/A	N/A	N/A	0.1		
Correctional Health Care Facilities						
All activities	N/A	N/A	N/A	0.30		
Cosmetic Surgery Facilities						
All activities	N/A	N/A	N/A	0.1		
Federally Qualified Health Centers						
Complaint investigations	4	24	96	0.1		

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Federal Unit						
Forensic Residential Centers						
Annual surveys	1	160	160	0.11		
Complaints and facility reported incidents	32	8	256	0.17		
Freestanding Ambulatory Surgical Centers						
Initial surveys	16	48	768	0.51		
Renewal surveys	90	48	4,320	2.88		
Follow-up surveys	8	16	128	0.09		
Complaint investigations	12	16	192	0.13		
Freestanding Medical Facilities						
All activities	N/A	N/A	N/A	0.10		
Freestanding Renal Dialysis Centers						
Initial surveys	4	48	192	0.13		
Renewal surveys	55	48	2,640	1.76		
Follow-up surveys	10	16	160	0.11		
Complaint investigations	45	16	720	0.48		
Health Maintenance Organizations						
All activities	N/A	N/A	N/A	0.15		
Home Health Agencies						
Initial surveys	1	40	40	0.03		
Renewal surveys	14	40	560	0.37		
Complaint investigations	8	24	192	0.13		
Hospice Care Programs						
Initial surveys	1	40	40	0.03		
Renewal surveys	9	40	360	0.24		
Complaint investigations	10	16	160	0.11		
Hospitals						
Initial surveys	1	210	210	0.14		
Validation surveys	2	210	420	0.28		
Complaint investigations, on-site	70	48	3,360	2.24		
Complaint investigations, administrative	250	6	1,500	1.00		
Follow-up surveys	12	16	192	0.13		
Transplant surveys	2	210	420	0.28		
Mortality review, psychiatric hospitals	36	24	864	0.58		

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Federal Unit						
Intermediate Care Facilities for Individuals with Intellectual Disabilities						
Annual surveys	2	160	320	0.21		
Complaints and self-reports	60	8	480	0.32		
Limited Private Inpatient Facilities						
All activities	N/A	N/A	N/A	0.15		
Major Medical Equipment Providers						
All activities	N/A	N/A	N/A	0.10		
Outpatient Physical Therapy Providers						
All activities	N/A	N/A	N/A	0.25		
Portable X-ray Providers						
All activities	N/A	N/A	N/A	0.15		
Residential Service Agencies						
Initial on-site surveys	12	32	384	0.26		
Initial administrative surveys	288	4	1,152	0.77		
Follow-up surveys	14	16	224	0.16		
Complaint investigations	170	16	2,720	1.81		
Residential Treatment Centers						
Initial surveys	2	80	160	0.11		
Complaint investigations, on-site	36	32	1,152	0.77		
Complaint investigations, administrative	55	4	220	0.15		
Validation surveys	6	80	480	0.32		
Follow-up surveys	3	16	48	0.03		
Surgical Abortion Facilities						
All activities	N/A	N/A	N/A	0.40		
All provider types in the unit						
Life safety code activities	N/A	N/A	N/A	0.50		
Informal dispute resolutions and hearings	N/A	N/A	N/A	0.50		
Federal Unit				**20.00**	**20**	**0.00**

Mandates	A. Number of activities required in 2024	B. Hours required per activity	C. Hours required for activities (A x B)	D. # of surveyors required (C/1500)	E. Current # of surveyors	F. # of additional surveyors needed
Clinical and Forensic Laboratories Unit						
Cholesterol Testing Sites						
Cholesterol testing	0	4	0	0.00		
Employer Drug Testing Facilities						
Initial surveys	8	8	64	0.04		
Full surveys	125	8	1,000	0.67		
Forensic Laboratories						
Initial surveys	1	40	40	0.03		
Renewal surveys	23	40	920	0.61		
Complaints and self-reports	3	24	72	0.05		
Health Awareness Testing Sites						
Health awareness testing surveys	55	8	440	0.29		
Health awareness site approval	1,750	0.5	875	0.58		
Full surveys	50	8	400	0.27		
Hospital Laboratories						
Initial surveys	1	40	40	0.03		
Independent Reference Laboratories						
Initial surveys	6	8	48	0.03		
Full surveys	34	8	272	0.18		
Physician Offices and Point-of-Care Laboratories						
Initial surveys	20	6	120	0.08		
Full surveys	130	6	780	0.52		
Follow-up surveys	95	4	380	0.25		
Validation surveys	6	16	96	0.06		
Public Health Testing Sites						
Full surveys	25	6	150	0.10		
Tissue Banks						
Initial surveys	6	8	48	0.03		
Full surveys	178	8	1,424	0.95		
Forensic Genetic Genealogical Laboratories						
All activities	N/A	N/A	N/A	2		
Clinical and Forensic Laboratories				**7.00**	**5.00**	**2.00**
All units				**198.00**	**177**	**21.00**