A Snapshot of Texas Assisted Living Facility Care During Hurricane Harvey with Policy Recommendations

August 2018
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Hurricane Harvey ravaged the southeastern Texas coast from August 25 to 29, 2017.¹ During the flooding that accompanied Hurricane Harvey, a Texas assisted living facility became infamous when a photo of residents sitting in waist-deep water went viral.

Accounts like that, including stories from organizations assisting individuals impacted by Harvey, prompted AARP to examine complaints made to the Texas Health and Human Services Commission (HHSC) about the safety of residents in Texas’ assisted living facilities during and after the hurricane.

An Associated Press news story from October 29, 2017, also examined problems at long-term care facilities in Texas and Florida—both states saw problems in the wake of Hurricanes Harvey and Irma. In the story, a Texas HHSC spokesperson said that “90 Harvey-related complaints were filed against 53 nursing homes, assisted living facilities and other long-term care centers between Aug. 25 and Oct. 9” and that “the agency will investigate each of the Harvey-related claims, the vast majority of which involved allegations of patient neglect.” AARP Texas then requested “Harvey-related complaints” from that same time period made against assisted living facilities to focus on a facility type that has less stringent disaster preparedness regulations compared to nursing homes.²

Based on a review of these complaints, it is clear that emergency preparedness requirements and enforcement for assisted living facilities (ALFs) operating in Texas should be strengthened to protect the lives and well-being of residents. In just the complaints reviewed, several assisted living facility residents faced harm, neglect or abandonment during Hurricane Harvey and its aftermath. Yet the facilities responsible for the residents’ safety faced little, if any, consequence for their failure to protect vulnerable residents.
A Fast-Growing Industry

The growth of ALFs is rapidly outpacing the increase of other long-term care providers in Texas. From 2013 to 2017, the number of assisted living beds grew 17.8 percent, compared with 2.6 percent growth in nursing facility beds. Licensed ALFs in Texas have a total capacity of 70,570 residents. A licensed ALF can house as few as four residents, while the largest facility in Texas has capacity for 270 residents.

Consumers often confuse assisted living facilities with nursing homes. Typically, they are quite different. While nursing homes are able to provide skilled nursing care, assisted living facilities are generally limited to providing personal services, such as helping with medication or with daily tasks like bathing and dressing.

Assisted living facilities regularly admit residents who have Alzheimer’s or other dementias, and some Texas assisted living facilities are licensed to care for residents who have limited mobility and are not able to evacuate on their own. Unlike nursing homes, which face both state and federal scrutiny, ALFs are only overseen by the Texas HHSC, which is responsible for licensing and enforcement of regulations. To ensure compliance with licensing requirements, the Texas HHSC is required to conduct regular licensing inspections and to investigate complaints.

What Went Wrong?

State inspection reports obtained by AARP through an open records request indicate that some ALF residents were abandoned and neglected during Hurricane Harvey and its aftermath. It is impossible to know the full extent of the harm residents experienced because state inspection reports are redacted to protect the residents’ privacy. What follows are examples of instances when complaints were investigated and formally cited as violations by state surveyors. These examples should guide efforts to prevent similar harm during future natural disasters.
Texas HHSC inspectors visited this facility on November 2, 2017, in response to complaints received regarding the evacuation of residents during Hurricane Harvey. The state was unable to inspect the facility until November because the facility was closed.

According to the state inspection documents, the administrator of La Vita Bella made the decision to have residents shelter in place. When flood waters began filling the facility and it was necessary to evacuate, none of the vehicles identified in the emergency preparedness and response plan were on site. The plan depended on the vehicles of the manager, the administrator and her husband, none of whom were at the facility.

In addition, this facility sits approximately 500 yards from the Dickinson Bayou, which the state found was not monitored during the storm.

Texas HHSC investigators found that the facility also had a contract with an ambulance company that requires 72 hours’ notice for evacuation. The Texas HHSC inspection report states that failure to initiate evacuation in a timely manner resulted in residents sitting in waist-deep flood water for hours, awaiting rescue.

Nearly eight hours after the facility began to flood, help arrived in the form of a resident’s family member, who brought a boat and was able to use plastic-covered mattresses to transfer four residents from the facility to a local hospital. Meanwhile, the other 11 residents were evacuated by two Army trucks from Texas City. These residents were taken to temporary shelters before being moved to a nursing facility.

Two violations were substantiated, resulting in $550 in fines.

FINES:

- $200 for violations related to abuse, neglect and exploitation
- $350 for safety operations related to their emergency preparedness and response plan
In September 2017, Texas HHSC inspectors visited Lakewood 24 Hr Personal Care in response to a series of complaints related to the evacuation of residents during Hurricane Harvey and other quality of care issues. What follows are some of the violations found and substantiated when inspectors visited the facility.

While this facility is licensed for 14 residents, 21 individuals were found to be sleeping there when Texas HHSC inspectors visited. Inspectors reported mattresses stacked up in the back of the facility for use by the additional residents.

One resident had an 8-inch-long and 5-inch-wide wound that was “bloody, open and had pus,” according to the investigation report. His wound was healing until it “re-opened when he walked in the flood waters.” The resident said he had been asking to go to the hospital.

State inspectors reported that the facility’s inner walls did not appear to have been repaired after the flood, which inspectors said placed residents at risk of health issues due to potential mold and mildew. Water damage lines and dark circular areas were observed. In an interview with inspectors, a representative of the facility said that walls had been painted over rather than installing new drywall.

State documents identify several other violations, including a medication cart that was not secured. The door to the medication room was found to be “wide open,” directly adjacent to the residents' day area. In addition, the freezer was observed having a temperature of 73.2 degrees Fahrenheit and a package of chicken parts was “soft and in the process of thawing.”

Inspectors also determined that a medication aide had been convicted for “Abandoning/Endangering Child, Criminal Negligence,” which, according to state law, should have barred the aide from employment in the facility.

In all, eight violations were substantiated but no fines were assessed.

FINES: None
Texas HHSC inspectors visited Lakewood 24 HR PC 2 in September 2017, in response to a complaint regarding the evacuation of residents during Hurricane Harvey.

Texas HHSC investigators found that this facility did not have an emergency preparedness and response plan, and residents were left unattended during Hurricane Harvey. The owner of the facility told Texas HHSC investigators that water was already entering the facility when she called 911 for assistance with evacuating residents. The owner called from her home several blocks away.

According to inspection documents, residents were evacuated by boat. They were not told where they were going or for how long. Residents were transported to the George R. Brown Convention Center, where they stayed for three weeks.

Three violations were substantiated, resulting in fines totaling $1,000.

FINES:

- $250 for violation of “rights to be free from abuse, neglect and exploitation”
- $300 for “missing personnel records”
- $450 for lack of an emergency preparedness and response plan
State inspectors visited the building on August 29, 2017, in response to complaints.

Four days earlier, the City of Victoria had issued a mandatory evacuation order. Vitality Court evacuated all residents—except one. State investigators found that although the emergency preparedness and response plan called for the use of an official roster to account for residents, a handwritten list of names was created as residents boarded buses for a four-hour ride to Cedar Park.

According to state inspection documents, once in Cedar Park, facility administrators realized that someone had been forgotten. Administrators called the Victoria Police Department, who entered the facility and found the forgotten resident in her locked room. She was transported by EMS to a local hospital.

Inspection reports show the administrator failed to follow the facility’s own plan and did not report the incident to the state, as is required by law. Two violations were substantiated, but no fines were assessed.

FINES: None
Recommendations

Current statutory and regulatory requirements for assisted living facilities specify the need for a written emergency preparedness and response plan that includes eight core areas that must be addressed. These areas are: (1) direction and control, (2) warning, (3) communication, (4) sheltering arrangements, (5) evacuation, (6) transportation, (7) health and medical needs and (8) resource management.

Unlike the safety requirements for nursing facilities, assisted living facilities are given very few detailed expectations by the state and no requirements to review the plan for needed updates at regular intervals. In contrast, nursing homes are required to document reviews and drills, making it easier for facilities to stay current on their plans and for Texas HHSC inspectors to identify weaknesses or deficiencies in a facility’s plan prior to an emergency.

In March 2018, the Texas HHSC recommended implementing more specific regulations for ALFs related to the content of emergency plans and require mandatory compliance with emergency evacuation orders. AARP supports this recommendation and offers the following additional recommendations with the goal of protecting the health and well-being of older Texans in assisted living facilities.

1. **Ensure fines associated with emergency preparedness are sufficient to deter violations.** The Texas HHSC should review recent changes to state statutes and rules to ensure that the violations cited in these surveys—particularly in the instances where individuals were harmed—would no longer be subject to an automatic right-to-correct in lieu of paying a fine. If implementation of HB 2025 from the 2017 legislative session does not impact how these violations would be treated today, then changes should be made to further restrict the right to correct and increase penalties.

2. **Strengthen requirements for assisted living facility written emergency preparedness and response plans to include the following:**
   - ALFs must maintain the plan and procedures inside the facility at one or more locations easily accessible to all staff. ALFs must review the plan and procedures at least annually. ALFs must review and possibly modify the plan in the event of construction, a change in facility administrator or new emergency phone numbers. All reviews of the plan must be documented.
   - All employees must be familiar with the plan. ALFs must train all employees on emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff and carry out unannounced staff drills using those procedures.
   - ALFs must include procedures for prompt transfer of residents with injuries, relevant records and medications, and notification of appropriate persons in the plan.
» ALFs must have a contingency plan to ensure the residents’ comfort and safety, including the provision of potable water.

» ALFs must inform residents and their families of evacuation plans. Each facility’s plan must include how evacuation details will be communicated in accordance with privacy laws. These details must be reviewed with residents and their families when they move into the facility and followed in the event of an emergency.

3. Require ALFs to notify the Texas HHSC of damage or flooding. Facilities must notify the Texas HHSC by phone when any damage occurs to the facility—including any water in the facility—regardless of whether or not the facility is evacuated. This notification must happen as soon as practically possible but within 24 hours. Note: This requirement does not exist for nursing homes. However, given the emphasis placed on facilities sheltering residents in place whenever possible, such a requirement should also be considered for nursing homes.

4. Require the Texas HHSC inspection of facilities with damage or flooding. Texas HHSC inspectors must visit damaged assisted living facilities within a reasonable time after being notified to assess the safety of the facility for their residents. This includes facilities with water damage that choose to shelter in place during an emergency. Once repaired, a facility must be inspected by the Texas HHSC to ensure it meets licensing requirements. Note: This requirement does not exist for nursing homes. However, given the emphasis placed on facilities sheltering residents in place whenever possible, such a requirement should also be considered for nursing homes.

Conclusion

These cases illustrate severe shortcomings in the emergency preparedness and response plans of some Texas assisted living facilities. State leaders, assisted living facility operators and the public should learn from the lessons of Hurricane Harvey to avoid similar problems in the future. Given the rapid growth of the assisted living industry in Texas and the vulnerability of the residents it serves, increased oversight is imperative.
REFERENCES


2 As a result of that request, we received information on complaints for seven assisted living facilities, and among those there were five facilities with substantiated violations. In two of the five facilities the substantiated complaints were not specifically related to Hurricane Harvey. The complaint regarding La Vita Bella – the facility where the photo of residents sitting in water was taken – was not included in the information provided by the agency, but the information was provided upon request. AARP was informed that the information was not provided as part of the original request because the investigation had not been completed by October 9. It is possible there are other complaints not reflected here because they were considered by the agency to be outside the requested time frame.


7 HB2025, enacted during the 2017 Texas legislative session, restricts the application of the right to correct for some of the most serious violations related to emergency preparedness.

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