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Personal Care Home Program

Improvements needed to better ensure residents' safety and well-being

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Why we did this review

More than 2,800 Personal Care Home Program facilities in Georgia provide residential care to nearly 48,000 vulnerable residents. These facilities are licensed and monitored by the Department of Community Health's Healthcare Facility Regulation Division (HFRD).

This audit evaluated HFRD's efficiency and effectiveness related to conducting routine inspections, addressing complaints, and ensuring violations are corrected within state-licensed residential facilities, which include assisted living communities, personal care homes, and community living arrangements.

About HFRD

First established in 2009, HFRD assumed responsibilities from the Office of Regulatory Services within the Department of Human Resources. In addition to overseeing state-licensed facilities, HFRD is the state surveying agency that conducts inspections and investigations of federally certified facilities (such as hospitals and nursing homes) on behalf of the Centers for Medicare & Medicaid Services.

In fiscal year 2024, HFRD received approximately $40 million in state and federal appropriations to oversee state-licensed and federally certified facilities, of which at least $3.1 million was used for oversight of the Personal Care Home Program's facilities.

Personal Care Home Program

Improvements needed to better ensure residents' safety and well-being

What we found

The Healthcare Facility Regulation Division (HFRD) within the Department of Community Health (DCH) could improve oversight over the residential facilities that serve elderly and disabled adults. Over the past six years, HFRD has not routinely inspected many facilities or fully utilized its authority to assess penalties for identified violations. Most routine inspections and some complaint investigations were also initiated after internally established deadlines. Finally, HFRD lacks written guidance for certain core operations but has been in the process of writing some.

HFRD has conducted few routine inspections, leading to limited oversight.

Between 2019 and 2024, HFRD did not ensure all facilities received a routine inspection, and those that did were often less frequent than HFRD's established 18-month goal. While many facilities have received site visits related to complaint investigations, routine inspections are intended to be more comprehensive to identify all types of noncompliance.

- Of the 2,540 active facilities due for a routine inspection, 43% (1,100) had no routine inspection between January 2019 and November 2024.
- Of the 1,440 that received an inspection, 63% (900) were not inspected within HFRD's established 18-month goal.

During the period reviewed, HFRD prioritized complaint investigations, which have increased by 38%, over routine inspections. Staff also incorrectly assumed many facilities were accredited by bodies that performed routine inspections, which would have exempted facilities from HFRD's requirement. HFRD stated that the recent reduction in the complaint backlog should result in more routine inspections.

HFRD has not consistently followed its standards related to complaint investigations or penalties.

HFRD has not monitored its complaint process to ensure all

serious complaints are consistently categorized and investigated according to established standards. Our review of 190 complaints found approximately 30% (54) could have been categorized at a higher priority than what HFRD assigned during intake—potentially delaying investigations. According to HFRD, complaint triage is heavily reliant on staff experience and discretion; however, it was not possible to verify that categorizations were appropriate because determinations are not sufficiently documented. Additionally, even when categorizations were appropriate, HFRD did not always initiate investigations within their required timeframes. For example, the most serious complaints indicate harm may be occurring or resident health and safety is in immediate jeopardy; however, 15% (14) of these complaints were not investigated within the required two days. Similarly, 13% (1,492) of investigations into other complaints occurred outside the 45-day requirement.

HFRD also did not fully use its authority to penalize facilities with violations. Total fine amounts have decreased in recent years, with approximately $68,000 assessed in fiscal year 2024—a 77% decrease from the nearly $300,000 assessed in calendar year 2021. Additionally, it does not appear HFRD imposed fine amounts on all serious violations (defined as Category I or II violations), which HFRD procedures state incur a mandatory fine. Finally, HFRD has not established timeframes for when facilities should be contacted regarding their payment obligation, and approximately 30% of fines assessed since 2022 ($93,200) remain outstanding. HFRD staff stated they prefer facilities return to compliance using Plans of Correction (rather than suspending or revoking licenses, which they are also statutorily authorized to do). However, HFRD has not systematically ensured the Plans of Correction were completed. Staff indicated HFRD's new data system should assist in tracking violations, fines, and Plans of Correction.

HFRD lacks written, formalized policies for certain core operations.

We found that certain HFRD core operations lacked written policies and procedures, but staff have been in the process of creating some. For example, there are no written procedures for determining which facilities should be routinely inspected or which requirements to sample when inspecting facilities; HFRD instead relies on individual surveyor judgment to make such decisions. Additionally, while HFRD has written procedures on complaint triage and penalty assessment, they are not comprehensive or exclude some processes HFRD mentioned in interviews. HFRD staff indicated they have primarily relied on hands-on training and institutional knowledge of tenured staff to conduct operations, resulting in less urgency to create written guidance. However, best practices state that written procedures help ensure program obligations are met, communicate clear expectations to staff, and maintain sufficient knowledge even as experienced staff leave.

What we recommend

We recommend that HFRD perform routine inspections within its established timeframe and that the General Assembly consider codifying a required frequency, similar to other states. HFRD should also establish additional guidance related to prioritizing complaints (which determines complaint investigation timelines) and ensure facilities deemed noncompliant with state requirements are appropriately penalized. Finally, HFRD should continue its efforts to formalize policies and procedures specific to state operations, such as inspections, complaint prioritization, and penalties.
See Appendix A for a detailed listing of recommendations.

DCH's Response: *DCH agreed or partially agreed with most of the findings and recommendations in the report. However, DCH expressed concerns about codifying a required frequency for conducting routine inspections, citing the need for additional staff to meet any requirement. DCH also disagreed with recommendations related to developing additional guidance for categorizing complaints and formalizing policies and procedures for certain operations. Finally, DCH provided technical corrections and general clarifications in addition to its detailed response, which were incorporated.*

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Purpose of the Audit

This report examines the Personal Care Home Program within the Department of Community Health's Healthcare Facility Regulation Division (HFRD). Specifically, our audit set out to determine the following:

- Are HFRD's processes for conducting initial and routine inspections efficient and effective?
- Are HFRD's processes for receiving and addressing complaints efficient and effective?
- Do HFRD's procedures ensure violations are corrected when they are identified?

A description of the objectives, scope, and methodology used in this review is included in **Appendix B**. A draft of the report was provided to HFRD for its review, and pertinent responses were incorporated into the report.

Background

Georgia regulates and oversees facilities that care for those who require assistance with daily living and other essential needs. This includes those aged 65 or older, as well as individuals with disabilities and chronic illnesses.

Between 2000 and 2030, Georgia's population of people aged 65 or older is projected to increase by more than 140%.

Personal Care Home Program

The Healthcare Facility Regulation Division (HFRD[1]) within the Department of Community Health (DCH) licenses and regulates healthcare facilities to protect residents' health, safety, and quality of life. The Personal Care Home Program (the Program) within HFRD has primary responsibility for licensing and overseeing Program facilities. This audit focuses on HFRD's oversight of residential facilities under the Program (see **Exhibit 1**), which excludes adult day centers.[2]

Exhibit 1

HFRD's Personal Care Home Program oversees three residential facility types

Facility Type	Statutory Description	Number of Facilities[1]	Licensed Bed Capacity
Personal Care Homes	A dwelling that provides housing, food service, and personal care for two or more unrelated adults. (Created in 1981)	1,339	1-25+ Beds
Assisted Living Communities	A licensed personal care home serving 25 or more residents with assisted living care. (Created in 2011)	303	25+ Beds
Community Living Arrangements	A residence providing daily personal services, support, care, or treatment for two or more unrelated adults, financially supported by DBHDD funds from Medicaid waivers. (Created in 2002)	1,202	2-4 Beds

[1] Actively operating as of November 15, 2024. We identified two community living arrangement facilities listed as "Active" that were closed at some point during our data period. Because we could not confirm their closure dates, they were included in our analyses.
Source: OCGA and DCH Rules and Regulations

[1] HFRD was established in 2009 with the passage of HB 228 and SB 433, which transferred responsibilities previously handled by the Office of Regulatory Services under the Department of Human Resources to DCH.
[2] Adult day centers are non-residential facilities also under the purview of the Personal Care Home Program.

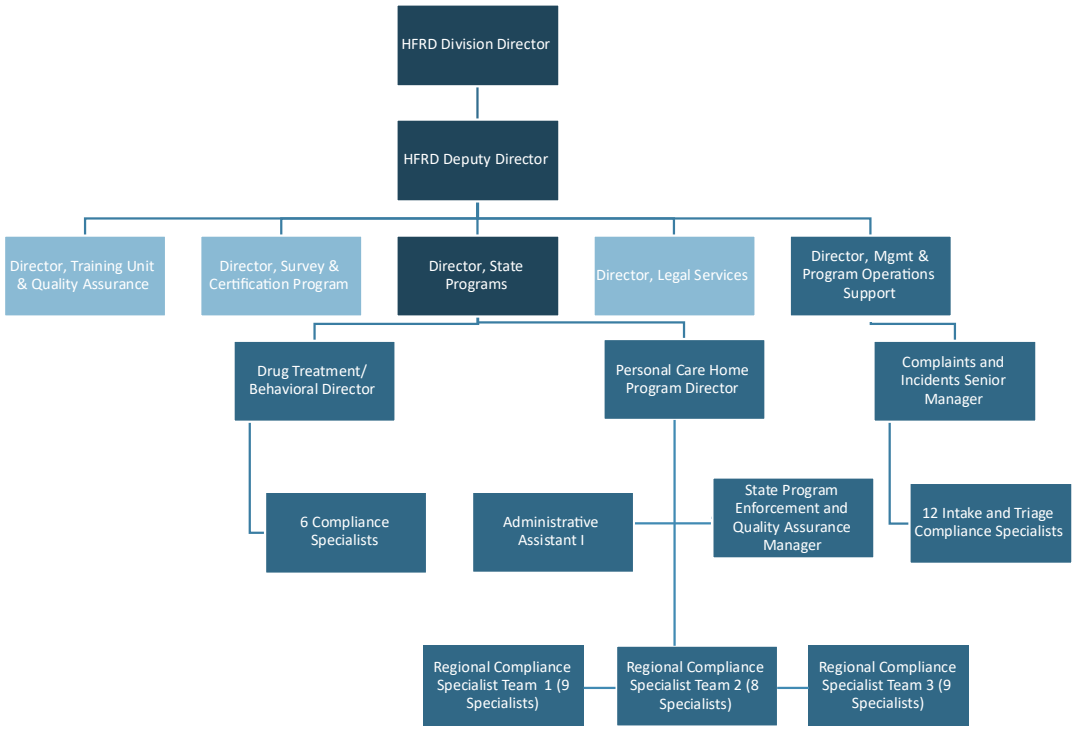
As of November 2024, there were approximately 2,800 residential facilities licensed by the Program to operate in the state. Residents of personal care homes (PCHs) and assisted living communities (ALCs) are primarily elderly individuals who must be ambulatory (able to walk) upon admission, and facility staff cannot provide skilled nursing care (which nursing homes provide instead). However, PCHs and ALCs may be certified to offer specialized services, such as memory care units caring for individuals with dementia. Residents in PCHs and ALCs typically pay for services out of pocket, but Medicaid may cover some expenses.

Community living arrangements (CLAs) serve individuals with intellectual or developmental disabilities who require medical care and treatment services. Unlike PCHs and ALCs, CLA services—known as community residential alternative (CRA) services—are funded by Medicaid waivers managed by the Department of Behavioral Health and Developmental Disabilities (DBHDD). DBHDD oversees CRA services provided, while HFRD oversees the licensure of CLA facilities providing the services. Both agencies are required to investigate complaints and incidents occurring in CLAs.

A survey is considered any routine inspection, complaint investigation, or other site visit.

As shown in **Exhibit 2**, the Program has 32 full-time surveyors who typically work within a specific geographic region. According to HFRD staff, there are typically few vacancies among the Program's surveyors (as of 2025, there were two vacancies). HFRD also has 12 Intake and Triage Unit (ITU) specialists who review, intake, and triage all complaints and incidents, as well as 11 support staff who help with general HFRD operations.

Exhibit 2
The Program employs 32 full-time surveyors and 12 intake staff



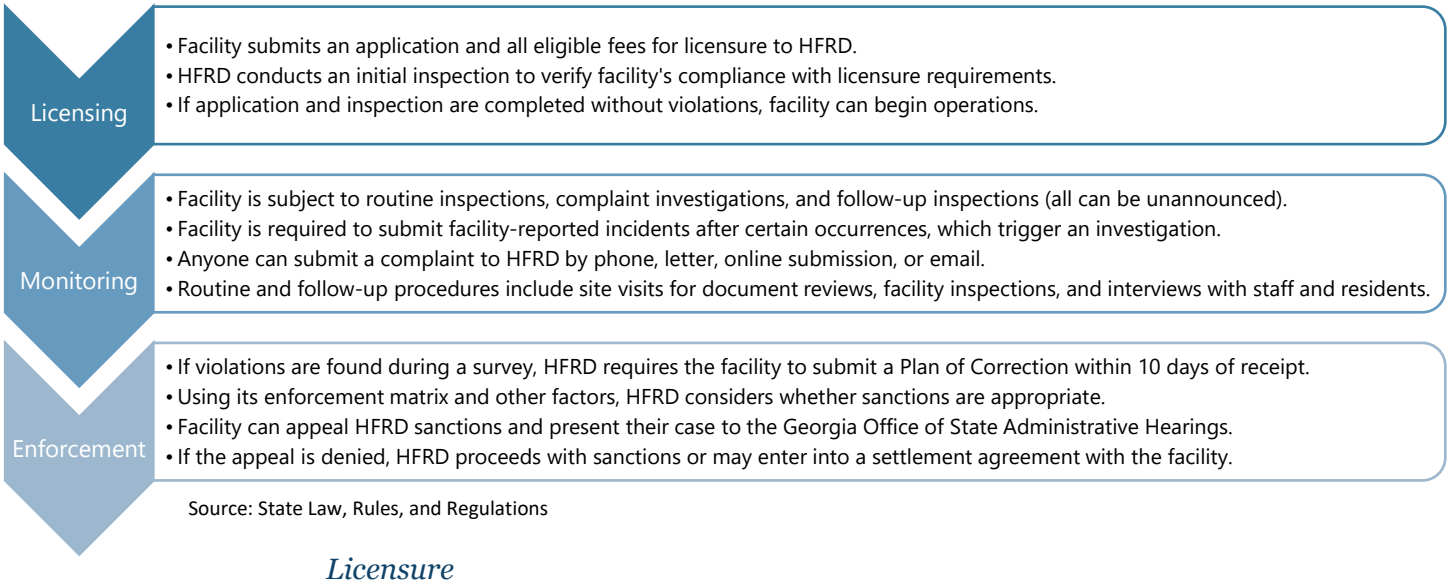
Source: HFRD Documents

Licensure and Regulatory Process

As shown in **Exhibit 3**, HFRD's oversight responsibilities—which are the same for all Program facilities—consist of three distinct functions: licensing, monitoring, and enforcement. Each is described in more detail below.

Exhibit 3

HFRD's regulatory process consists of three main functions



Source: State Law, Rules, and Regulations

Licensure

For initial licensure, an administrator seeking to open a facility must submit to HFRD an application that attests to meeting their respective facility's requirements, as outlined in DCH rules and regulations. While most licensure requirements are consistent across Program facilities (such as proof of ownership, facility floor plans, and water, fire, and electrical safety reports), there are some differences. For example, PCH and ALC fees vary based on bed space, and an approved Certificate of Need must be obtained before HFRD will consider licensure applications for PCHs with 25 or more beds (ALCs and CLAs are not required to have a Certificate of Need).

Once the application is received, a surveyor visits the facility for an initial inspection to verify that the application is complete and includes all supporting documentation. After the surveyor confirms all requirements are met, the facility is granted its license to operate and house residents. Historically, HFRD does not revoke a facility's license once it is established, except in rare circumstances.

HFRD's data system for state licensed facilities changed in November 2024

Until November 2024, HFRD used the federal Centers for Medicare and Medicaid Services' ASPEN system to house Program data, with connections to a separate Laserfiche system for document management. To assess fines for noncompliant facilities, it used a separate in-house system called GRAILS. Since November, HFRD has transitioned Program data to an in-house data system, GAHLES. Unlike ASPEN, GAHLES has a portal that allows facilities to upload their own documentation directly to HFRD and connects with the GRAILS system to help assess fines.

Monitoring

Each licensed facility is subject to unannounced visits in the form of routine inspections and investigations concerning specific complaints (HFRD refers to both as "surveys"). These surveys are performed by a team of typically one or two surveyors and include inspecting the facility, interviewing facility staff and residents, and reviewing administrative documents. HFRD's goal is to conduct routine inspections approximately every 18 months, while investigation timelines are based on complaint severity.

DCH rules allow for residential facilities under the Program to be exempt from HFRD's routine inspections if they hold accreditation with recognized bodies that have similar or more stringent standards (though the rules allow HFRD to still perform routine inspections of accredited facilities if its standards are more rigorous or comprehensive). In addition, HFRD still investigates complaints involving accredited facilities.

A **routine inspection** determines whether a facility complies with licensing requirements.

An **investigation** is conducted in response to allegations of non-compliance.

Anyone, including residents themselves, can file a complaint with HFRD on behalf of a resident through various methods such as an online form, email, phone, or letter/fax. Facility staff are also required to report facility-reported incidents (FRIs) if they observe any incidents that may violate state law, rules, and regulations (such as resident elopement) or if a resident is seriously injured in an accident (this includes death not associated with medically documented conditions). When complaints or FRIs are submitted, HFRD intake specialists review the information and assess its level of risk. Most complaints and FRIs fall within three categories of prioritization (as described in **Exhibit 4**), which dictates the investigation timeline.

Exhibit 4

Triage levels and timelines for investigations vary based on severity[1]

	Priority Description	Investigation Timeline
Immediate Jeopardy (IJ)	Alleged noncompliance in which a resident has suffered serious injury, harm, impairment or death or remains at potential ongoing risk and requires immediate corrective action	Inspection must be initiated within 2 business days of agency receipt.
Non-IJ High	Alleged noncompliance that may have harmed a resident's well-being and requires a prompt agency response	Inspection must be initiated within 45 calendar days of agency receipt.
Administrative Review/Offsite Investigation	Complaints and FRIs that do not allege noncompliance with state law, rules, or regulations	No on-site investigation required.

[1] There are two additional categories (non-IJ medium and non-IJ low). However, non-IJ low is not applicable to facilities overseen by the Program, and very few of the facilities' complaints were categorized as non-IJ medium.
Source: HFRD Documents and ASPEN Data

If a complaint or FRI is triaged as immediate jeopardy (IJ) or non-IJ high, an on-site investigation is triggered for either 2 business days or 45 calendar days, respectively. Investigative procedures are largely similar to those performed in

routine inspections (document reviews, interviews with staff and residents, physical observations) but they are specifically targeted to determine whether an allegation of noncompliance is substantiated. While complaint investigations are not designed to review a facility's general compliance with requirements (unlike routine inspections), they can be expanded if additional issues are identified.

Enforcement

In accordance with policy, HFRD assigns violations a specific letter tag with an associated fine amount. The actual fine amount assessed is based on a facility's compliance history.

If violations are identified during routine inspections or complaint investigations, surveyors document them in a report containing a statement of violations, which HFRD sends to the facility. In accordance with policy, violations are categorized based on their scope and severity, with each assigned a specific designation and associated with a fine amount (see **Exhibit 5**). For example, a J-tag indicates the violation caused immediate jeopardy to a resident's health or safety in an isolated manner, while a K- or L-tag would indicate a pattern or widespread threat, respectively (e.g., one resident being administered the wrong medication was considered isolated, while multiple residents routinely not receiving medications in a timely manner were considered to be widespread incidents).

Exhibit 5

HFRD categorizes violations based on scope and severity[1]

Severity	Violation	Scope and Fine		
		Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	Category I	J ($1,201)	K ($1,600)	L ($2,000)
Actual harm that is not immediate	Category II	G ($601)	H ($900)	I ($1,200)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	Category III	D ($100)	E ($300)	F ($600)
No actual harm with potential for minimal harm	N/A	A (No Fine)	B (No fine)	C (No fine)

[1] Fines listed are in accordance with their letter tag. However, actual fine amounts fall within each category's range and depend on compliance history over the prior 24 months (as discussed below). Additionally, Plans of Correction are required for all violations except A-tag violations.
Source: DCH Rules and Regulations and HFRD Documents

Between 2019 and 2024, HFRD identified approximately 16,400 violations in 1,912 facilities.[3] Most (82% or 13,500) were isolated Category III violations (D-tags), while the most severe—widespread Category I (L-tags)—represented only 0.2% (35) of all violations.

To help ensure violations are corrected, HFRD requires facilities to submit a Plan of Correction (POC) within 10 days of receiving their inspection report for any violations classified as "B" or higher on severity/scope matrix (see **Exhibit 5**). Previously, surveyors would review a facility's POC for compliance during HFRD's next site visit to that facility. Since November 2024, HFRD has required facilities to upload POCs to the portal of its new data system, GAHLES, and staff then review to ensure the facility's noncompliance was sufficiently addressed.

[3] *Out of 4,054 facilities open and actively housing residents at some point between January 2019 and November 2024.*

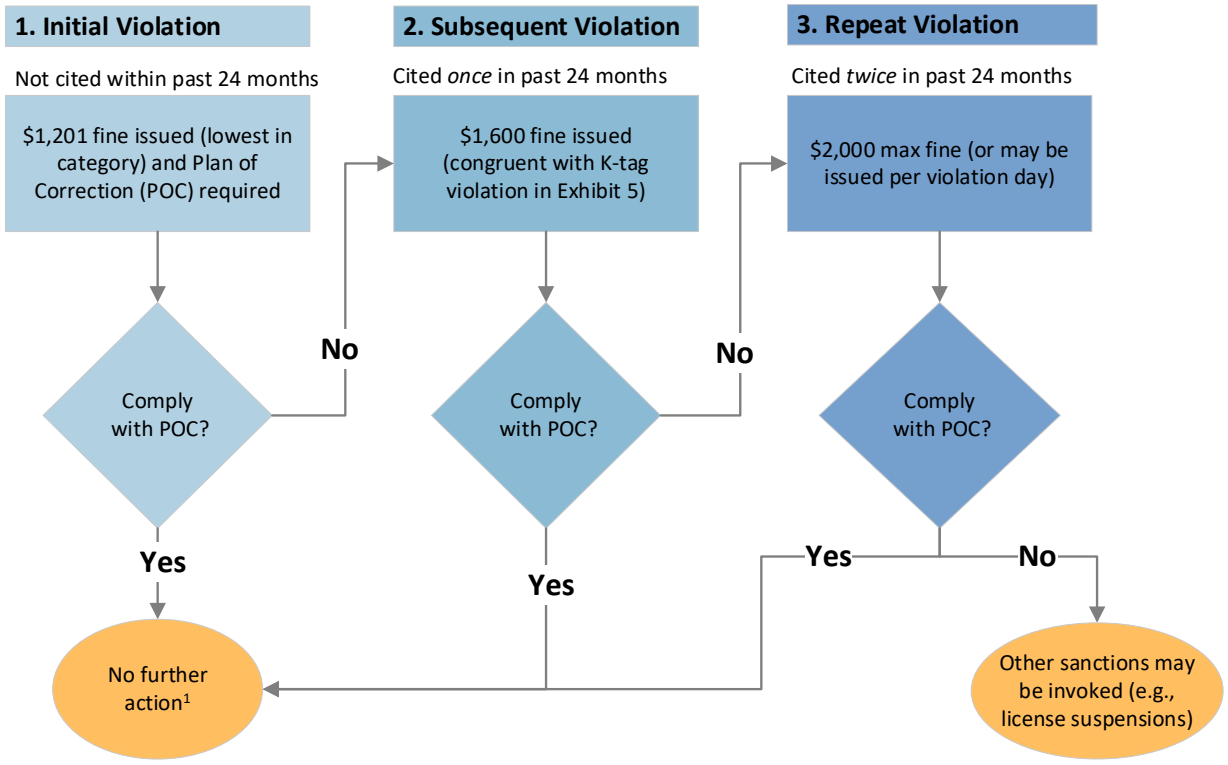
In addition to POCs, state law, rules, and regulations permit HFRD to sanction noncompliant facilities. Sanctions may include suspending or revoking a facility's license and prohibiting certain individuals from managing a facility, but HFRD typically only imposes fines. State law permits HFRD to apply fines of up to $2,000 per day for each violation, up to a maximum of $40,000 for violations from one inspection or investigation. In addition, state law requires HFRD to impose a fine of at least $5,000 for noncompliance that causes death or serious physical harm to residents.

As discussed above, DCH rules and regulations establish fine amounts based on the severity of violations.[4] However, actual fine amounts assessed are based on previous noncompliance and whether the facility completed its POC and returned to compliance, as shown in **Exhibit 6**. For example, if a facility committed a Category I, K-tag violation and the violation was the first offense within the prior 24 months, HFRD would require a POC and assess a fine at the lowest level of its respective category (or $1,201). However, if HFRD determines continued noncompliance during the 24-month period, fines up to $1,600 or $2,000 could ultimately be assessed (see **Exhibit 6**).

Exhibit 6

Fine amount could change based on compliance history and completion of POCs

Example Violation: Category I, K-tag



[1] If HFRD finds an additional violation similar to one already cited in the prior 24 months, it is considered a subsequent violation. If HFRD finds a violation similar to two already cited in the prior 24 months, it is considered a repeat violation.

Source: DCH Rules and Regulations and HFRD Documents

[4] After the passage of HB 987 (which increased maximum fines for violations), DCH revised fine amounts in its rules and regulations. These changes took effect in May 2021.

When HFRD identifies violations and notifies facilities of sanctions, facilities are permitted to appeal HFRD sanctions and dispute their violations in court. In addition, HFRD may enter into settlement agreements with noncompliant facilities, which may result in lower fines in exchange for a guarantee that facilities comply with HFRD's methods to return to compliance and pay fines on an established schedule.

Financial Information

As shown in **Exhibit 7**, Program expenditures ranged from $2.7 million to $3.1 million between fiscal years 2022 and 2024. This represents approximately 9% of HFRD's total expenditures ($33.6 million in 2024). However, the Program accounts for most expenditures (65% of $4.8 million in fiscal year 2024) associated with HFRD's oversight of state-licensed facilities.[5]

Exhibit 7
Program oversight costs ranged from $2.7 to $3.1 million[1] (FY 2022-2024)

Year	Personal Care Home Program Costs
FY 2022	$2,732,631
FY 2023	$2,796,622
FY 2024	$3,072,205

[1] Additional costs are included in HFRD's indirect support costs. These costs (ranging from $2.2 million to $10 million between fiscal years 2022 and 2024) are shared across all HFRD oversight programs for federal- and state-licensed facilities. Therefore, costs specific to the Program could not be determined.
Source: DCH Financials

HFRD's Personal Care Home Program is largely supported by state funds.[6] HFRD also collects civil penalty fines from noncompliant facilities. However, according to staff, fees collected from facilities during the licensure and annual routine inspection process, as well as fines collected from sanctioned facilities, are not applied to HFRD operations. These fees and fines are instead remitted to a separate DCH fund that is then remitted to the State Treasury. For more information about Program fines collected by HFRD, see Finding 3.

[5] Other state-licensed facilities outside the Program include X-ray centers and private home care.
[6] The Program also receives a portion of Operational Indirect Support funds, a mixture of federal and state funds used to support all HFRD operations. In fiscal year 2024, these expenditures totaled $5.2 million.

Findings and Recommendations

Finding 1: HFRD has conducted few routine inspections, leading to limited oversight.

Nearly half of facilities reviewed have had no routine inspections in nearly six years, limiting HFRD's oversight of these facilities. Of those that did receive an inspection, approximately 60% were performed outside HFRD's goal of 18 months. While most facilities have been visited for complaint or incident investigations in the past 18 months, these are not as comprehensive as routine inspections.

Unlike other southeastern states, Georgia has no statutorily required frequency for its routine inspections.

As discussed on page 4, DCH rules require HFRD to inspect licensed facilities, including those in the Program, periodically. During these "routine inspections," HFRD reviews a facility's general compliance with state law, rules, and regulations. HFRD's goal is to inspect each facility at least every 18 months, which is similar to other states and federal requirements for nursing homes (though most other states we reviewed—unlike Georgia—have codified the requirement).[7]

As shown in **Exhibit 8**, 43% (1,100) of the 2,540 active facilities[8] had no routine inspection between January 2019 and November 2024 (these facilities have a licensed bed capacity of approximately 11,000 residents). Of the 1,440 that had received an inspection, 63% (900) had not been routinely inspected in more than 18 months.[9] It should be noted that HFRD performed a site visit within the 18-month period reviewed for approximately one-third of these facilities (622 of 2,000); however, these were typically complaint investigations, which are more targeted (therefore, a routine inspection would still be necessary to ensure broad compliance). Nearly 10% (251) of the 2,540 active facilities—with a total licensed bed capacity of more than 1,000 residents—had no site visit at all between January 2019 and November 2024.

When comparing by facility type, a larger percentage of CLAs had no routine inspections—73% (793) compared to 19% (229) and 28% (78) of PCHs and ALCs, respectively. Additionally, nearly 20% of CLAs (221) had no site visit. It should be noted that, as discussed in Finding 5, DBHDD has oversight responsibility over services provided by CLAs, which includes site visits from DBHDD and contracted staff. However, DBHDD's review of CLA services is not a substitute for HFRD's routine inspections.

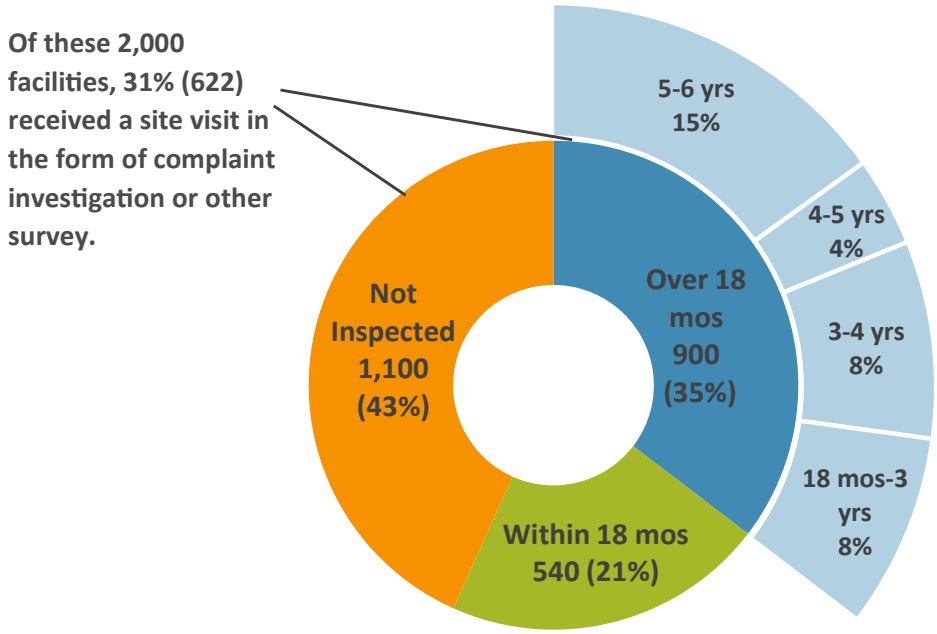
[7] Arkansas, Florida, Kentucky, North Carolina, Tennessee, and Virginia agencies are required to routinely inspect facilities every 12 to 24 months. Alabama, Mississippi, and South Carolina agencies can routinely survey facilities at intervals deemed appropriate by the agencies. The Centers for Medicare and Medicaid Services requires state surveys of nursing homes every 15 months.

[8] Currently operating as of November 15, 2024. Excludes facilities that were closed, as well as those with pending licenses that have not yet admitted residents.

[9] Inspected within 18 months as of November 2024.

Exhibit 8

Most facilities did not receive an inspection but were visited within 18 months (CY 2019-2024)[1]



[1] Percentages will not add to 100%. Results based on review of inspections as of November 2024. Those with no inspections within 18 months are based on a review of activity from May 2023 to November 2024; those not inspected at all are based on a review of activity from January 2019 to November 2024. We excluded 302 facilities from the population because they opened after May 2023. Of these, 236 (78%) received an initial inspection, and 8 (3%) had received a routine inspection by November 2024.
Source: DCH ASPEN Data

We identified several reasons for HFRD's delays in performing routine inspections. These include:

- **Complaint and Incident Prioritization –** According to HFRD staff, investigations related to complaints and facility-reported incidents are prioritized because they relate to specific allegations that may indicate facility noncompliance. As discussed in Finding 2, HFRD experienced a nearly 40% increase in the volume of complaints and facility-reported incidents in 2023 compared to 2019, which has required more staff resources to investigate. According to HFRD, staff have also been managing a backlog of complaints received in 2023 or earlier, which was not fully addressed until 2024.

  It should be noted that HFRD can conduct a routine inspection when surveyors are investigating a complaint. We found this occurred in 22% (1,609) of the 7,268 complaint investigations between January 2019 and November 2024. Additionally, staff indicated surveyors may check some general compliance requirements during complaint investigations, but this would not be documented as completing a routine inspection.

- **Assumption of Facility Accreditation** – In 2023 and 2024, few ALCs or CLAs received a routine inspection. HFRD staff stated this was because

they believed most were accredited and per state law (see page 4), would be exempt from HFRD's routine inspections. However, HFRD could not provide a list of accredited facilities that would justify the exemption. We found all 303 ALCs and 25% (296) of CLAs lacked accreditation; most did not have a routine inspection within the last 18 months.

Prior to our review, HFRD had a practice of verifying a facility's accreditation status during on-site visits rather than requesting accreditation documentation from facilities. HFRD has since resumed routine inspections of ALCs and has stated that it will request accreditation status and inspection reports from facilities as it begins implementing its new data system (GAHLES). However, it has not performed any routine inspections of CLAs since 2023.

- **COVID-19 Pandemic Investigations** – In much of 2020 and 2021, HFRD staff were ordered to cease regular operations and respond to the COVID-19 pandemic in licensed facilitates. As such, HFRD prioritized infection control surveys primarily related to COVID-19 in state-licensed facilities (similar to those federally required in nursing homes), as well as investigating complaints and facility-reported incidents. As a result, according to HFRD, many routine inspections were deprioritized or delayed.
- **Staffing** – HFRD management indicated staffing resources are often limited and prevent the division from meeting its 18-month inspection goal. State appropriations and funded positions for the Program remained static during our period of review. However, according to HFRD, Program facilities now house more medically complex residents, which means routine inspections and investigations take longer to complete and thus fewer site visits are performed. We found the average number of days to complete a site visit did increase since the COVID-19 pandemic (from 3 days in 2019 to 15 days in 2021), but it has since decreased (to 6 and 5 days in 2023 and 2024, respectively).

The upcoming move of all CLA oversight to DBHDD (see Finding 5) will transfer routine inspection responsibilities from HFRD to DBHDD.

HFRD indicated it has worked to use staff resources by selecting facilities most in need of inspection based on volume of complaints and history of noncompliance. This appears to be occurring; for example, among PCHs with at least 10 complaints, nearly 75% (228 of 309) had their last routine inspection within 18 months prior to November 2024 (compared to 56% of all PCHs). Additionally, as discussed above, routine inspections can be added to complaint investigations. However, neither process has been formally documented to ensure these options are maximized or deployed when necessary.

RECOMMENDATIONS

1. The General Assembly should consider codifying a required frequency for HFRD to perform routine inspections of residential facilities within the Program. Consideration could be given to additional staffing needs, but further analysis would be necessary.

2. HFRD should perform routine inspections in accordance with its internal frequency goal. When this is not feasible, HFRD should strategically identify facilities most in need of routine inspections and perform them jointly with complaint and incident investigations whenever possible.

3. In its new online portal, HFRD should incorporate a place for facilities to document their accreditation status and provide copies of inspection reports performed by accrediting bodies. HFRD should review these documents to determine whether routine inspections are needed. HFRD should resume its routine inspections for all facilities that lack accreditation.

DCH's Response: *DCH stated that the report "does not convey the impact of the COVID-19 pandemic on the PCH program survey process." According to DCH, the governor's March 14, 2020 executive order (signed March 20, 2020) "prohibited survey activity in long-term care facilities" with the exception of surveys involving "complaints that alleged immediate jeopardy" and "limited survey activity for a period of greater than 9 months." In addition, DCH stated that "the backlog of complaints resulting from this period created the need to prioritize and address suspected non-compliance over conducting routine inspections."*

According to DCH, there are no statutory timeframes for conducting surveys or investigating complaints and they have not been funded to meet any minimum requirements. "Any timelines provided during the audit are internal goals that were created to support best practice with consideration for operational conditions."

DCH estimates HFRD "would require 5 additional full-time employees (FTEs) at an additional cost of $513,569.30 [in state general funds] to meet the internal frequency goal for routine inspections and meet complaint timelines." According to DCH, other costs (such as those associated with rules changes) would also need to be considered. DCH also noted that two other states with codified frequencies referenced in the report can use Medicaid funding to support some survey costs.

> ***Auditor's Response:*** *We agree that the executive order stopped HFRD's normal operations due to the pandemic. We observed it in the data and acknowledged it in the report. However, as noted in the finding, other factors limited the frequency of routine inspections (which DCH acknowledged), such as the prioritization of complaint investigations and assumption of ALC accreditation.*
>
> *As noted in the recommendation, further analysis is necessary to determine any additional costs associated with a codified frequency for routine inspections. Based on this assessment, the General Assembly could choose to appropriate state funds for additional resources as needed.*

Recommendation 1.2: *DCH agreed with the recommendation, stating that HFRD "already works to combine routine inspections with complaint inspections when feasible," though "there are times that staffing may be a limiting factor as a complaint survey in addition to a compliance survey may take multiple days and this may conflict with timelines and volume of complaints based on triage levels."*

Recommendation 1.3: *DCH agreed with the recommendation, stating that "GAHLES has this capacity for facilities to document their accreditation status, which is reflected on the program dashboard. In addition, the name of the accrediting body is then logged in the facility details page." DCH also noted that "routine inspections may be limited at times due to the need to prioritize complaints that show an increased risk to resident safety at risk over a facility with no complaints."*

Finding 2: HFRD has not consistently followed its standards for how severe allegations are categorized and when they are investigated.

Our review of 190 complaints and facility-reported incidents found that approximately 30% could have been categorized at a higher priority than what was assigned during intake, which potentially delayed investigations. We also found 15% of the highest priority investigations were initiated after HFRD's two-day deadline. As a result, it is possible residents experienced continued harm.

From 2019 to November 2024, HFRD received almost 38,000 complaints and FRIs, or an average of nearly 6,300 per year.

As discussed in the background, HFRD may receive complaints from family members, residents, or the facilities themselves (known as facility-reported incidents, or FRIs). These complaints are reviewed by HFRD's Intake and Triage Unit (ITU), which assigns each complaint a priority that dictates whether and when an investigation should occur. Since 2019, the number of complaints received has increased annually, peaking in 2023 with approximately 7,000 complaints. Complaints received in 2024 were on track to meet or exceed 2023 totals (approximately 6,300 as of November 2024).

HFRD procedures require the Program's regional directors to review all complaints within their regions and ensure they are prioritized and scheduled according to internal standards. However, senior management (i.e., the Personal Care Home Program director and HFRD's executive director) does not conduct regular reviews to verify at an aggregate level that complaints are prioritized consistently across all regions or that investigation timelines are met. We reviewed HFRD's actions related to complaints received between 2019 and November 2024 and found potential gaps in the prioritization, as well as delays in investigation. These areas are described below.

Complaint Prioritization

When receiving a complaint, ITU staff assign a priority based on the severity of the allegations, as outlined in HFRD's standard operating procedures for intake and triage (categories are not codified in statute but are modeled after federal

Centers for Medicare and Medicaid Services (CMS) categories for nursing home complaints). As shown in **Exhibit 9**, nearly all complaints are categorized into four priority levels: immediate jeopardy (IJ), non-IJ high, non-IJ administrative review/offsite investigation, and no action necessary. Of the approximately 38,000 complaints triaged from 2019 to November 2024, the majority required an administrative review or no action.

Exhibit 9
Most complaints were categorized into four priority levels (CY 2019 to November 2024)

Intake Priority	Investigation Requirement	% of Complaints Triaged[1]
Immediate Jeopardy (IJ)	Within 2 business days	0.3% (98)
Non-IJ High	Within 45 calendar days	32% (12,032)
Admin Review/Offsite Investigation	None	59% (22,084)
No Action Necessary	None	9% (3,472)

[1] Percentages will not add to 100%. There are two additional categories (non-IJ medium and non-IJ low). However, non-IJ low is not applicable to facilities overseen by the Program, and very few of the facilities' complaints (76) were categorized as non-IJ medium (which must be investigated during the next on-site survey).

Source: ASPEN Data

HFRD categorized most complaints based on the four categories described in **Exhibit 9**. At the time of our review, it did not separately track the type of incident (such as sexual assaults, abuse, or an incident resulting in death).

According to HFRD's ITU procedures, most complaints related to violations that could continue to seriously harm residents should be coded as IJ; violations are coded as non-IJ high when they may have caused harm but the threat was removed. For example, if a complainant alleges that a resident was abused by a facility staffer who has been terminated from their position, it should be triaged as non-IJ high. However, if the alleged perpetrator is still working at the facility with access to the resident, it should be triaged as IJ.

We reviewed the intake records of 190 complaints[10] submitted between 2019 and November 2024 and found that approximately 30% (54) could have been assigned a higher priority based on the documented information. Most were assigned a non-IJ high priority despite allegations that indicated there was serious injury or harm to a resident but did not mention the threat had been removed (the remaining were complaints triaged as no action necessary or non-IJ administrative review that could have been triaged as non-IJ high). When we requested further explanation for a subset of these complaints, HFRD was unable to provide documentation to sufficiently support their categorization. Examples are described below (see **Exhibit 10** for examples of similar allegations categorized as IJ from the keyword search described in Footnote 10).

- **Sexual Abuse** – HFRD's ITU procedures state that any sexual abuse should be coded as IJ unless the alleged abuser has been removed from the facility. We found nine complaints involving

[10] We chose 150 complaints at random from 28 facilities selected based on factors such as complaint volume, licensed bed capacity, and geographic location. To find similar complaints that were categorized differently, we selected an additional 15 IJ and 25 non-IJ high complaints from the entire complaint dataset using keyword searches.

nonconsensual sexual activity that were coded as non-IJ high, even though there was no indication that the perpetrator had been removed, while five similar complaints were coded as IJ.

- **Improper Use of Restraints –** HFRD's ITU procedures state that any use of restraints that results in injury or death, or could result in serious injury if not addressed, should be coded as IJ. We found seven complaints of facility staff using physical or chemical restraints inappropriately (e.g., over-administering medication or tying to a chair) that were coded as non-IJ high. Seven similar complaints were coded as IJ.
- **Unsafe Living Conditions** – HFRD's ITU procedures state that excessive temperatures (either hot or cold) should be coded as IJ if the conditions are present and ongoing. We found 10 complaints mentioning excessive temperatures (e.g., facilities with no air conditioning in the summer) that were coded as non-IJ high even though there was no indication that the situation had been resolved. Three similar complaints were coded as IJ.

Exhibit 10

Cases with similar allegations were prioritized differently

Allegation Type[1]	Example Case Categorized as Non-IJ High	Example Case Categorized as IJ
	Example 1	
Sexual Misconduct & Abuse	• Victim reported ongoing sexual assault over multiple weeks • Possible physical evidence of assault • No attempts made to protect the victim or other residents from perpetrator	• Victim reported ongoing sexual assaults over multiple weeks • Alleged perpetrators pulled victim from room, despite efforts to fight off perpetrators • Victim afraid to stay at facility and no mention of individuals removed from facility
	Example 2	
Improper Use of Restraints	• Facility owners accused by former resident of restraining residents by physically holding them down and preventing them from moving • Residents left with bruises on their backs and arms due to being shoved and restrained • Facility owners alleged to be taking away residents' phones	• Resident in memory care unit placed between two chairs by two aides and is unable to move • Incident not reported by staff or director, despite meeting criteria for a reportable incident • Resident director made aware, but no action taken to resolve the situation
	Example 3	
Unsafe Living Conditions (Excessive Temperatures)	• Air conditioning in facility's memory care unit not working for several months • Resident passed out due to heat and other residents visibly sweating through their clothes • DHS staff member filed complaint	• Air conditioning in facility not working for two months • Complaint filed when temperature outside was 90 degrees

[1] Allegation types were assigned by the audit team based on a review of complaint allegations described in intake notes.
Source: HFRD complaint data

When complaints are coded at a lower priority level than warranted, investigations can be delayed, which potentially endangers residents for longer than necessary. For example, the complaint related to excess temperatures prioritized as non-IJ high in **Exhibit 10** was not investigated for nine days compared to the IJ complaint that was investigated within two business days. Similarly, the non-IJ high complaint regarding restraints was not investigated for five weeks (39 days), compared to the IJ complaint that was investigated the same day of receipt.

HFRD staff stated that because there are no state requirements on complaint and FRI prioritization, ITU's written procedures serve as guidance and intake staff can use their own discretion when triaging complaints. However, such discretion may present risks for inconsistency, particularly when procedures provide limited guidance on complaints that do not clearly fit into one category. Additionally, according to HFRD staff, complaints triaged as IJ may require surveyor schedules to be rearranged to accommodate the two-day investigation window. This may incentivize prioritizing complaints into a lower category.

When cases do not clearly fit into one category, HFRD management indicated ITU staff rely on discussions with Program managers, follow-up calls to the complainant, details within the complaint, and/or the facility's complaint history when determining whether to triage a complaint as non-IJ high or IJ. However, it is not HFRD's practice to document these discussions or any additional context obtained. As a result, any information that ITU staff used subsequently (such as a threat being removed) would not always be documented in the intake notes, which would help justify the final prioritization. Without such documentation, it was not possible to verify whether the complaints we identified as potentially miscategorized were actually appropriate, nor was it possible for HFRD management to confirm.

Complaint Investigation Timeframes

ITU's procedures require surveyors to begin an investigation within 2 business days of intake for IJ complaints and within 45 calendar days for non-IJ high complaints, similar to those required by CMS. As shown in **Exhibit 11**, HFRD met these requirements for most investigations that occurred between 2019 and 2024. However:

While investigations were delayed for these complaints, other surveys (such as routine inspections) were still taking place.

- 15% (14 of 95) of IJ complaints had investigations initiated after HFRD's required window of two business days. While the majority (12) were initiated within two weeks, two were initiated between 20 and 39 days and one did not have an investigation initiated until nine months after receipt (273 calendar days).[11]
- 13% (1,492 of 11,881) non-IJ high complaints were initiated after 45 calendar days or did not have a record of an investigation start date.[12]

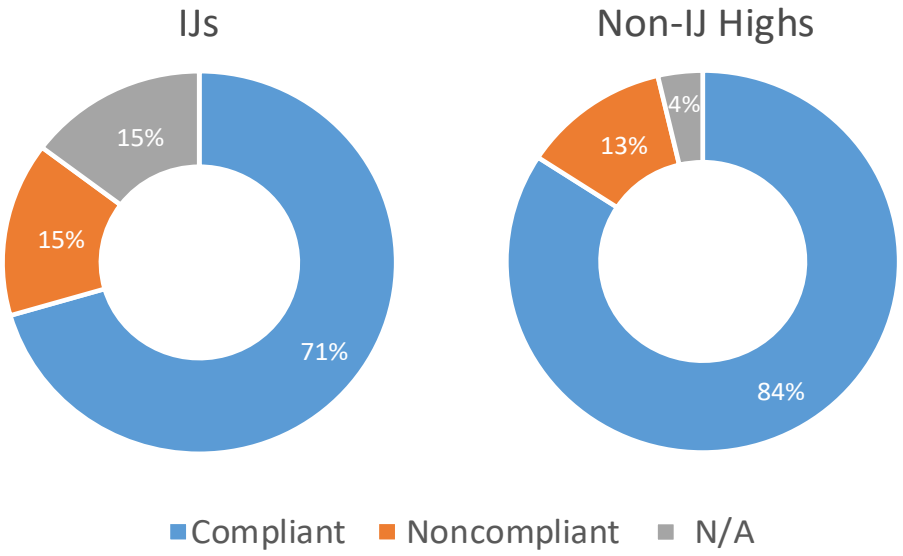
[11] The policy of two business days can extend the time to investigate when complaints are triaged before a weekend or holiday. When assessing timeframes based on the number of calendar days between receipt and investigation initiation, we found 22 IJs took more than two days.

[12] 38 non-IJ high complaints (0.3%) lacked investigation start dates and were considered noncompliant. Most had a status of "pending review/assignment," but some had a status of "under investigation."

Among those, 27% (402) were not investigated for at least three months, and 35 were delayed for six months to a year. Finally, 20 took between one and five years to initiate—while HFRD did conduct other site visits to most of these facilities within 65 days of receiving the complaints, there is no evidence that these particular complaints were resolved during those visits. It should be noted that 2% (284) of all non-IJ high complaints had investigations initiated within two days, indicating that HFRD does expedite the investigations of certain non-IJ high complaints.

Exhibit 11

Most investigations began within required start dates[1]



[1] Percentages will not add up to 100%. 15% of IJ (14) and 4% of non-IJ high (433) allegations had receive dates recorded as occurring after their investigation dates. As a result, we could not determine whether these investigations began within the required timeframes.
Source: ASPEN Data

It should be noted that 15% of IJ (14) and 4% of non-IJ high (433) allegations had receive dates that were recorded as occurring after their investigation dates. As such, we could not determine whether these investigations began within the required timeframes. Had HFRD management reviewed compliance with its own internal standards, it could have discovered and addressed these anomalies as necessary.

The upcoming move of all CLA oversight to DBHDD will transfer responsibility for investigating complaints to DBHDD (see Finding 5).

According to HFRD, the increase in complaint volume has caused significant strain on intake staff, as well as on survey staff's ability to initiate investigations in accordance with procedures. As previously discussed, the approximately 6,300 complaints received in calendar year 2024 represents a nearly 23% increase (or almost 1,200 more complaints compared to the 5,000 in 2019, and on track to meet or exceed 2023 totals) compared to the approximately 5,000 in 2019. However, the number of staff has remained the same since 2019 or prior.

RECOMMENDATIONS

1. HFRD should establish guidelines within written procedures that

identify allegations that may border between priority categories, set clearer criteria, and clarify more examples on which allegations fall in each category.

2. HFRD should require Intake and Triage staff to document all factors that contributed to determining how an allegation was ultimately prioritized.

3. HFRD should take steps to ensure that IJ and non-IJ high allegations are investigated within their required timeframes.

4. HFRD senior management should perform regular reviews of overall complaint categorization and investigation timeframes to ensure consistent adherence to internal standards.

DCH's Response:

Recommendation 2.1: *DCH disagreed with the recommendation, stating that it "currently has written guidance that provides a general framework for how allegations may be prioritized," but that healthcare requires multiple factors to be considered when reviewing complaints. DCH discussed the use of an experienced, multidisciplinary team to "review, discuss, and designate the priority level for complaints." According to DCH, "written guidance cannot address all issues that may create 'border' allegations and cannot replace experience and professional decision making."*

> ***Auditor's Response:*** *Our recommendation is intended to enhance the current written guidance by clarifying additional examples of allegations in each category using the informed experience of HFRD's intake and survey staff. We do not intend written guidance to replace the use of staff experience in decision making; rather, we view it as a complementary resource.*

Recommendation 2.2: *DCH partially agreed with the recommendation, acknowledging that while "staff has always documented who was involved in decisions on prioritization, there were not sufficient details to understand why a decision was made." DCH indicated that staff have been asked to sufficiently document the details of complaints to ensure "other team members…understand the rationale for the priority level."*

Recommendation 2.3: *DCH partially agreed with the recommendation, stating it "recognizes that it would be beneficial to investigate allegations in accordance with our timeframe goals, but these timeframe goals are not written in statute nor written program rules." DCH indicated that every effort is made to meet timeframe goals but prioritizes complaints based on risk and staff capacity, particularly given the increase in complaint volume over the course of the review period. DCH reiterated that despite the increase in complaints, "there has not been an increase in budgeted staff positions."*

> ***Auditor's Response:*** *In order for an agency to be accountable to residents and the public, it is necessary to establish and follow*

consistent internal goals even when not required to do so for compliance purposes.

Recommendation 2.4: *DCH partially agreed with the recommendation, stating that HFRD program managers are subject matter experts and "are best positioned to evaluate if complaint prioritization is correct based on all relevant factors." DCH stated that HFRD's "timeframe goals have been integrated into the strategic planning process that was started in 2024" and that the new GAHLES system generates reports that allow HFRD senior managers and leadership to monitor compliance with these goals.*

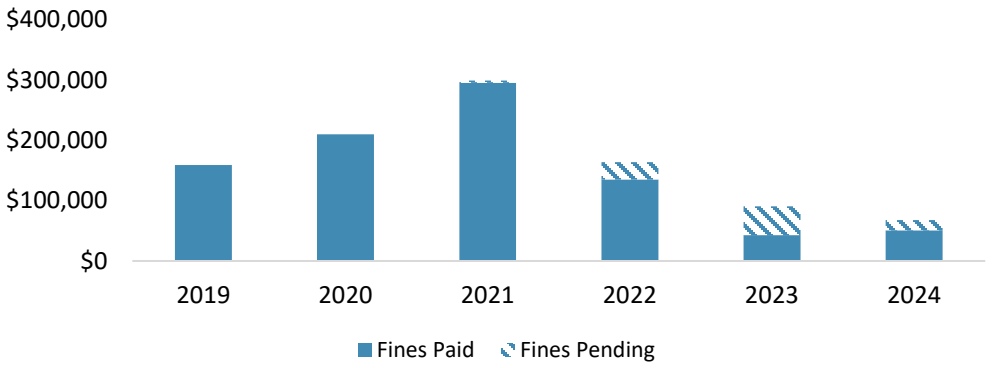
Finding 3: HFRD has not consistently sanctioned noncompliant facilities or verified they return to compliance.

HFRD has not fully used its authority to fine noncompliant facilities, and the amount of fines assessed and collected has decreased in recent years. HFRD prefers facilities come into compliance via a Plan of Correction (POC) process (rather than suspend or revoke licenses, which they are also statutorily authorized to do). However, HFRD has not verified that the vast majority of POCs have been completed. Staff believe HFRD's recently updated data system will allow for tracking of violations, fines, and POCs.

State law and DCH rules give HFRD the authority to impose sanctions on facilities that violate state requirements. These include monetary fines based on the severity of violations, as well as facility license suspension or revocation. In 2020, state law was revised to increase HFRD's maximum fine to a potential $40,000 per on-site inspection or investigation. It should be noted that one inspection or investigation visit can result in many violations identified. Violations are categorized based on the scope and severity of harm (see **Exhibit 6** on page 6). According to HFRD, fines are optional for Category III violations but mandatory for Category I and II violations (though amounts can vary based on noncompliance history).

As shown in **Exhibit 12**, HFRD's total fine assessment has decreased significantly since 2021. In calendar year 2024, approximately $68,000 was assessed on 27 facilities—a 77% decrease from approximately $300,000 on 124 facilities in 2021 (the peak after gradual increases since 2019). The most significant decrease (45%) occurred in 2022, with additional decreases in the subsequent years. Further, HFRD has not collected a large percentage (29%, or $93,000) of the approximately $322,000 in fines assessed over the past three years—in particular, only 47% of the nearly $91,000 in fines in 2023 has been collected, leaving nearly $48,000 outstanding. The average fine amount per facility has increased over time—from approximately $800 in 2019 to $1,700 in 2023 and 2024.

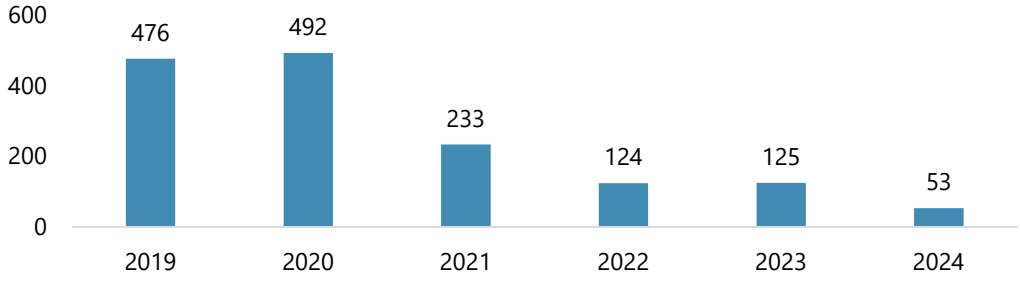
Exhibit 12
Fines assessed and paid have decreased since 2021 (CY 2019-2024)



Source: DCH GRAILS Data

One reason for the decrease in fines is HFRD has identified fewer violations in recent years, including those eligible for mandatory fines (Category I and II violations). As shown in **Exhibit 13**, nearly 500 of these violations were identified in 2019 and 2020, compared to 125 in 2023 and 53 in 2024 (as of November 2024). During the period reviewed, HFRD's data did not track which violations received penalties; as such, it was not possible to determine how the number and type of violations correlated with penalty amounts within a given year. It should also be noted that some fines may have been assessed for violations that occurred in previous years, resulting in potential time lags.

Exhibit 13
HFRD has identified fewer violations eligible for mandatory fines since 2019



Source: DCH ASPEN Data

Additionally, it appears HFRD has not imposed fine amounts for all violations identified. We estimated[13] that nearly $500,000 in additional fines could have been assessed based on the number of violations that occurred between 2019 and November 2024. Due to data limitations, this amount likely underestimates the full extent of fines that could have been assessed. For example, HFRD does not

[13] *See **Appendix B** for more information regarding the calculation of this estimate.*

track[14] information that would indicate fine amounts should increase, such as whether a facility's noncompliance resulted in a resident's death (which incurs a mandatory $5,000 fine, compared to a maximum of $2,000 for a subsequent widespread Category 1 violation). Additionally, our estimate was calculated based on each violation receiving one fine, while statute allows fines to be assessed per violation per day (up to a maximum of $40,000).

During our period of review, HFRD had not established a complete process to follow violations from their penalty assessment to payment. This has likely contributed to fewer fines being assessed and collected. Specific areas are discussed below.

It should be noted that HFRD also uses settlement agreements to further ensure compliance with correcting violations.

- **Lack of Documented Guidance** – At the start of our review, HFRD did not have documented guidance for how penalties should be assessed or what criteria should be implemented when determining fine amounts. HFRD enacted written guidance in May 2024, which clarifies how HFRD assesses fines for initial, repeat, and subsequent violations found in a facility over the prior 24 months (see **Exhibit 6** on page 6).
- **Inconsistent Correspondence** – HFRD has not established when facilities should be initially or subsequently contacted regarding their payment obligations. For example, initial letters demanding payment were sent to facilities over a wide range of timeframes, with some sent more than a month and one sent seven months after assessment.[15] According to staff, HFRD is developing a process within its new data system (GAHLES) to establish consistent timelines of initial and subsequent demand letters.
- **Inability to Track Fines** – Management's ability to monitor fine assessment and collections has been limited due to functionality issues in its prior data system (used until November 2024). During the period of our review, violations and associated fines were not linked and payments were tracked separately, limiting management's ability to ensure fines were consistently assessed and the full amount was paid. For example, there is no way to know whether the 178 Category I and II violations in 2023 and 2024 were assessed a fine, the specific fine amount, or facilities' progress on payment. According to HFRD staff, GAHLES has allowed for more consistent tracking by linking specific fines and payments to their respective surveys (where individual violations would be documented).

*[14] While HFRD does not track whether a facility's noncompliance caused a resident's death, HFRD does categorize violations based on categories identified in **Exhibit 5**.*

[15] It should be noted that if a facility does not pay fines issued by initial and legal demand letters, DCH must defer to the Department of Law to initiate collections. According to HFRD staff, this is often not a priority for the Department of Law because fine amounts are typically considered low.

HFRD staff indicated they prefer to bring facilities into compliance using Plans of Correction (POC) rather than more punitive actions such as license suspensions or revocations (see text box below). However, we found HFRD only verified completion of 17% (2,725) of the approximately 16,400 violations with POCs; this includes only 15% (217) of the approximately 1,400 severe violations. According to HFRD, surveyors would verify POCs were completed on their next site visit, but this process was not consistently followed or updated in its data system. Since the launch of GAHLES, HFRD has required facilities to submit POCs within 10 days of receiving their report of violations, consistent with DCH rules. Additionally, DCH's new data system will flag any Category I or II violation and require a follow-up inspection to verify that the POC corrected violations.

HFRD has suspended few licenses

While state law, rules, and regulations give HFRD the authority to suspend or revoke licenses of noncompliant facilities, this sanction is rarely used. According to HFRD, the division prefers that facilities come into compliance voluntarily because closing a facility requires residents to relocate to another facility, which can impact well-being. Additionally, suspending licenses creates an administrative burden, particularly because facilities can appeal any sanction, which can cause delays in the process.

Between 2019 and 2024, we identified 451 facilities with at least one Category I violation, which has been noted as the basis for a potential suspension or revocation. However, HFRD has only attempted to revoke the license of one facility under this criteria. Ultimately, the facility appealed and the revocation was denied because the judge found that HFRD did not produce the evidence used to determine the revocation was necessary.

RECOMMENDATIONS

1. HFRD should ensure that facilities found to have violated state requirements are appropriately fined in accordance with state law, rules, regulations, and established internal procedures.
2. HFRD should document penalizing actions taken against specific violations.
3. HFRD should establish timeframes for notifying facilities of payment obligations when fines are assessed and facilities fail to pay.
4. With its new data system, HFRD should ensure that facilities submit required Plans of Correction within 10 days and consider subsequent sanctioning actions (such as fines) for facilities that do not comply.
5. HFRD should establish clear criteria and relevant documentation requirements related to suspending or revoking facilities' licenses.

DCH's Response:

Recommendation 3.1: *DCH agreed with the recommendation and has already taken action to ensure facilities are appropriately fined. In 2024, DCH developed standard operating procedures and implemented weekly meetings to review citations "that would result in any enforcement action*

other than Plans of Correction." According to DCH, these weekly meetings continue to run successfully and are attended weekly by senior leadership." The standard operating procedure also "outlines timelines for issuing notification letters" of assessed fines to facilities.

Recommendation 3.2: *DCH agreed with the recommendation, stating that the new "GAHLES system has a dashboard that allows tracking of all fines." DCH discussed the role of program staff and the legal team in ensuring all fines are entered into the system. In addition, DCH noted that HFRD's "Special Enforcement Counsel also reviews appropriate enforcement actions other than fines, including suspension, public reprimand, or revocation."*

Recommendation 3.3: *DCH agreed with the recommendation but indicated a plan to issue fine notification letters and use GAHLES to track unpaid fines that includes a "three-tiered process to collect fines." Finally, "if a fine is not paid, a flag system is being created that would notify the team of outstanding fines when it is time for annual renewal."*

Recommendation 3.4: *DCH partially agreed with the recommendation, stating that while its rules require PCH and ALC facilities to file Plans of Correction "within 10 days of receipt of the inspection report," the rules do not require HFRD to review and approve the plans. Rather, the rules require facilities to implement Plans of Correction, which HFRD staff will review during subsequent compliance reviews. DCH described the "progressive enforcement matrix" and other actions (e.g. revocation) used by HFRD to address non-compliance.*

> ***Auditor's Response:*** *Given that DCH rules already require facilities to submit Plans of Correction (when facilities were previously required to keep a record of plans for surveyors to review on the next visit), we do not believe it is necessary to create a rule to ensure HFRD staff review them. We believe this is implicitly part of the rule.*

Recommendation 3.5: *DCH partially agreed with the recommendation and acknowledged the importance of consistency when considering revoking or suspending a facility's license. However, "enforcement actions that have such a significant impact on the life of a resident must consider and balance many factors that can vary case to case." According to DCH, a primary consideration is the adverse impact on residents who would have to be relocated.*

In addition, "all enforcement cases are presented and reviewed by the HFRD Special Enforcement Council during the weekly meetings which include Executive Leadership, Legal Counsel and Program." According to DCH, the discussions' content is not documented because it includes legal counsel.

> ***Auditor's Response:*** *We agree that forcing the closure of noncompliant facilities could negatively impact residents; however, that does not negate the need to establish clear and consistent criteria for when facilities should have their licenses revoked.*

Finding 4: Websites maintained by HFRD and facilities do not enable the public to easily identify violations and compare them across facilities.

DCH rules require facilities to post their inspection reports and Plans of Correction online; however, this requirement is not enforced and few facility websites contain the information. In addition, HFRD's website allows consumers to research facilities (including their inspection reports and violations), but consumers are not able to easily compare performance across multiple facilities.

When selecting a care facility, it is reasonable to expect consumers would consider facility quality in addition to location and services provided. While online reviews are one method of determining facility quality, the extent to which the facility complies with rules and regulations is also an important decision-making tool. Without complete, clear, and accessible information, consumers may unknowingly place their family members in facilities they might otherwise avoid if they had better insight into the facility's history of violations and corrective actions. These items are required to be on facilities' websites and are included on HFRD's website; however, we identified gaps in both.

Facility Websites

DCH rules[16] require facilities with websites to post in a prominent location on their main page a web link that provides access to copies of all inspection reports and Plans of Correction from the previous 18 months. The rule is included in HFRD's section, though it does not explicitly state who is responsible for enforcement. It should be noted that HFRD maintains its own website where it uploads publicly available inspection reports (see section below).

We reviewed a random selection of 150 facilities from the more than 300 that had violations from May 2023 to November 2024; more than half (80) maintained an active website. Of these, only two posted intake and compliance monitoring reports from the past 18 months and none posted violations. Violations not posted included medication administration errors, inadequate staffing, and insufficient activities to promote resident well-being (e.g., enriching activities).

According to HFRD staff, routine inspections and complaint investigations have taken precedence over the rule's enforcement. However, it could be incorporated into the oversight process. For example, HFRD could require facilities to post screenshots or website links in its new data system. Alternatively, HFRD could incorporate website review into its routine inspections or complaint investigations process. HFRD could penalize facilities that fail to post their links under Category III violations, which include facility noncompliance with reporting requirements (see page 17).

[16] DCH Rule 111-8-63.-10(4) & DCH Rule 111-8-62.-11(4) only apply to ALCs and PCHs. Rules for CLAs have not been updated since before 2007; as a result, they are excluded from this requirement.

HFRD Website

Most other southeastern states do not maintain websites consumers can use to compare facilities.

In addition to facility websites, consumers have access to HFRD's GaMap2Care website (https://forms.dch.georgia.gov/HFRD/GaMap2Care.html), which has housed certain information about all active facilities since 2018. Website capabilities permit customers to do the following:

- **Find Licensed Facilities –** Consumers can search for licensed facilities through geolocation with filtering options for facility type, bed capacity, and location. Upon selecting options, a table populates with various fields that allow consumers to compare facilities based on the filtering options. These fields include facility type, licensed bed capacity, city, county, and zip code.
- **Search Inspection and Investigation Reports** – GaMap2Care redirects users to a Laserfiche site, where they can utilize the "Quick Search" option to locate inspection reports by facility type, name, survey date, location, and whether violations were identified. Users can browse all inspection reports since 2017 and export individual reports in PDF format. HFRD's website also houses reports of complaint investigations with de-identified information to protect resident confidentiality.

  It should be noted that facilities that have not received site visits for long periods of time have no inspection or investigation reports posted. As discussed in Finding 1, approximately 10% of facilities had no site visits between 2019 and November 2024. As a result, consumers could erroneously assume these facilities are all high-quality with few problems.
- **Verify Licenses** – Consumers can verify facility licenses by searching for facilities by name. The site displays the facility's information, effective license date, and the date the license was last verified.

Despite the functionality described above, the number and type of violations that a facility has incurred are not easily accessible on HFRD's website. Currently, consumers must download lengthy inspection reports and read through several pages of surveyor records to understand the nature of the violation (if any). For example, an inspection report with more than three violations is usually about 10 pages long. If a facility has had multiple inspections resulting in violations, consumers must continually search separate reports to determine the extent of the noncompliance. Moreover, the inspection reports do not provide details regarding the severity of the violation, any penalties that may have been assessed, or whether violations have been corrected.

In contrast, we identified two southeastern states that offer more robust tools for comparing facilities based on their violation history. For example, North Carolina's website aggregates facilities' violations and quality-of-care metrics and applies a rating that consumers can view online. Florida's website (see **Exhibit**

14) is an interactive platform that enables users to sort facilities by the number and severity of violations, fine amounts, and the number of substantiated complaints. The database provides inspection reports spanning a five-year period and allows users to view detailed inspection information for each facility. This includes a comprehensive list of regulatory violations identified during surveys along with the survey date, inspection type, and correction date.

Exhibit 14
Florida's facility finder provides detailed information on violations

Displays the total number of complaints that were substantiated

Shows the total number of deficiencies along with the severity classification of the violations

Number of Substantiated Complaints	Sanctions/ Final Orders	Fine Amount	Number of Deficiencies						Number of Activities	Number Nurse Avail
			Total Deficiencies	Class 1	Class 2	Class 3	Class 4	Unclassified		
▸ 0	1	$400.00	2	0	0	2	0	0	1	6
▸ 2	0	$0.00	1	0	0	1	0	0	2	3
▸ 3	7	$7,500.00	18	0	0	16	0	2	1	10
▸ 1	0	$0.00	0	0	0	0	0	0	1	9
▸ 4	2	$7,000.00	19	0	1	17	0	1	2	9
▸ 10	1	$0.00	14	0	0	13	0	1	NR	10
▸ 12	7	$12,500.00	30	0	3	24	0	3	1	8
▸ 3	0	$0.00	0	0	0	0	0	0	2	10
▸ 1	0	$0.00	0	0	0	0	0	0	1	8
▸ 1	1	$0.00	0	0	0	0	0	0	1	7
▸ 5	2	$10,000.00	3	1	0	2	0	0	2	7
▸ 1	0	$0.00	1	0	0	1	0	0	1	9
▸ 1	0	$0.00	2	0	0	1	0	1	1	6

S

- File Number
- Facility
- City
- County
- Bed Size
- Number of Substantiated Complaints ✓
- Sanctions/ Final Orders ✓
- Fine Amount ✓
- Total Deficiencies ✓
- Class 1 ✓
- Class 2 ✓
- Class 3 ✓
- Class 4 ✓
- Unclassified ✓
- Activities ✓
- Nurse Availability
- Special Programs and Services

Source: Florida Health Care Transparency HealthFinder (https://quality.healthfinder.fl.gov/Facility-Provider/ALF?&type=0)

HFRD staff indicated they would face challenges in updating the website due to limited staff and resources. Staff indicated the website does not have the functionality to display aggregated data on violations and that such changes would require additional funding. HFRD was able to use Medicaid Information Technology Architecture (MITA) funding to develop its new data system (GAHLES) but indicated that it would not be able to use such funding to improve the GaMap2Care website.

RECOMMENDATIONS

1. HFRD should ensure facilities comply with the requirement to post violations on their websites.
2. HFRD should consider penalizing facilities that fail to post inspection reports and Plans of Correction on their websites.
3. The General Assembly could consider requiring HFRD to publish on its website aggregated data on facilities' noncompliance so consumers can more easily compare facilities by the number and severity of their violations. Additional funding may be needed to implement any legislative mandate.

DCH's Response: *"The website was designed to be a simple solution with automation to post survey results in real-time, allowing the general population to find a facility in their area as well as view the results of the surveys at those facilities, empowering them to make choices about care for their loved ones. Individuals can find a facility using various filters, pull a report for an individual facility, and compare reports against another facility using the same filter criteria. Any additional enhancements would require a budget for design, implementation, and maintenance."*

Recommendation 4.1: *DCH agreed with the recommendation, stating that it "will review facility websites as a part of the survey process to ensure that results are posted as required by rules."*

Recommendation 4.2: *DCH partially agreed with the recommendation. In the response, DCH staff noted they would "cite" facilities for noncompliance "with rules requiring the posting of inspections and Plans of Correction, and any enforcement will follow HFRD's enforcement matrix."*

Auditor's Response: *In these cases, assuming the violation is isolated and corrective action is taken, a "citation" for noncompliance would likely not result in a fine based on HFRD's current enforcement matrix.*

Finding 5: HFRD and DBHDD's shared oversight of community living arrangements could be improved with increased coordination.

During the 2025 legislative session, a bill was passed to transfer all CLA oversight duties to DBHDD. The bill was signed by the governor on May 1, 2025.

State law requires that HFRD and DBHDD each oversee certain aspects of community living arrangement (CLA) facilities. State law also requires both agencies to investigate complaints and incidents reported by CLAs. Coordination and data sharing has decreased since the COVID-19 pandemic; this may increase the likelihood of duplication, which facilities indicate—and both agencies acknowledge—frequently occurs.

DCH and DBHDD each have statutory responsibilities related to CLA facilities, with HFRD overseeing licensure and DHBDD overseeing services.[17] Additionally, O.C.G.A. § 31-8-83(a) requires DCH to "immediately initiate an investigation after receipt" of any complaint or facility-related incident (FRI), while O.C.G.A. § 37-1-20(21) requires DBHDD to "receive and consider complaints from individuals receiving services." DBHDD policy also mandates investigations into complaints and FRIs involving the services residents receive. DCH rules require HFRD to investigate issues related to CLA facility licensure, as well as allegations of abuse, neglect, and exploitation. HFRD has six surveyors dedicated to CLA oversight, which includes routine inspections and complaint investigations.

[17] *As discussed in the background (page 2), HFRD regulates licensure and facility-related aspects (such as ensuring safe living conditions and running water) of CLAs, while DBHDD regulates the community residential alternative services provided to residents and paid for by the Medicaid NOW/COMP Waivers. HFRD regulates all aspects of personal care homes and assisted living facilities (including services provided).*

Since each entity has oversight authority, CLAs must comply with both HFRD's and DHBDD's reporting requirements. Reportable incidents are similar across both entities, so CLAs must typically submit an FRI to both agencies for many of the same issues. In addition, HFRD and DBHDD may refer CLA FRIs and complaints to each other if they discover an allegation falls within the other agency's purview. However, there is no formal process to ensure such notification and coordination occur.

HFRD and DBHDD staff acknowledged they frequently investigate the same incidents.[18] In a survey sent to CLA owners and administrators, 71% of respondents agreed. According to HFRD, duplication of effort is unavoidable because both agencies must investigate any complaint or FRI that includes allegations of abuse, neglect, or exploitation (even if one agency has already resolved the complaint). DBHDD also agreed that both agencies are required to investigate any complaint or incident received concerning a CLA.

While HFRD and DBHDD staff stated their investigations are substantially different because they are governed by their respective policies, procedures are inherently similar. Both agencies' investigative procedures include interviewing staff and residents, reviewing files, and observing quality of care provided in CLA facilities. When investigating an allegation of neglect, for example, both agencies would go on site (typically at separate dates) to observe residents, review relevant documents, and interview staff who submitted the FRI, other staff, and residents.

The investigation overlap can create an administrative burden on facilities, as noted by 34% (50) of CLA survey respondents who perceived the investigations as excessively redundant. Redundancies can also unnecessarily impact how HFRD allocates its resources. As previously mentioned, HFRD has six staff dedicated to CLAs, and—as noted in Finding 1– will prioritize complaint investigations over routine inspections, for which HFRD is solely responsible.

Despite the shared oversight, communication between HFRD and DBHDD is generally on an ad-hoc basis, with no regularly scheduled meetings between the two agencies. DBHDD stated it held quarterly coordination meetings prior to the COVID-19 pandemic, but regular meetings no longer occur. The lack of coordination is likely exacerbated by the separation of the agencies (both were divisions of the Department of Human Resources until fiscal year 2010).

Additionally, data sharing between the entities is limited—both agencies maintain separate databases and do not have access to the other's data. HFRD staff stated its new system will assist in tracking DBHDD complaint referrals. However, our review of complaints that DBHDD referred to HFRD found the referrals typically lacked a detailed list of procedures that DBHDD had already performed in its own investigation. To help reduce overlap in investigative procedures, HFRD could incorporate this information into its new system.

[18] *We were unable to assess the magnitude of the overlap due to limited available data.*

During the 2025 legislative session, the General Assembly passed House Bill 584, which transfers full CLA oversight duties to DBHDD, effective January 1, 2026. The bill was signed into law by the governor on May 1, 2025. However, while HFRD and DBHDD continue to share oversight responsibilities, more formal policies and procedures are needed to reduce duplication of effort. This includes procedures on how complaints should be forwarded and tracked, as well as how investigation data and results should be shared.

RECOMMENDATIONS

1. While DCH and DBHDD responsibilities for CLAs remain shared:
    a. HFRD should coordinate with DBHDD to establish criteria to determine when a complaint or incident should be investigated by HFRD or DBHDD.
    b. HFRD should coordinate with DBHDD to investigate opportunities for sharing data and detailed information about CLA investigations.

DCH's Response:

Recommendation 5.1: *DCH agreed with the recommendation.*

Finding 6: HFRD lacks written, formalized policies for certain core operations.

HFRD does not have formal policies and procedures for certain core operations, though it has begun creating some. HFRD indicated it primarily relies on hands-on training and institutional knowledge of long-tenured staff to conduct operations. However, this approach increases the risk of inconsistent practices in intaking and triaging complaints, conducting routine inspections, and applying penalties to noncompliant facilities.

According to best practices, written policies and procedures help ensure an agency can fulfill its obligations consistently by communicating clear expectations and standards to staff. Documented policies and procedures also help maintain sufficient knowledge and skills among staff to carry out their responsibilities.

HFRD has created some written procedures for evaluating a facility's staffing ratio, scheduling investigation surveys, supervisory review of reports, and fine enforcement. However, we found other core operations lacked written guidance, and HFRD's written procedures lacked detailed instruction or were potentially contradictory to other division standards. These areas are described below.

- **Routine Inspection Selection** – As described in Finding 1, HFRD is unable to routinely survey all facilities within 18 months and therefore must select those that will be visited. HFRD staff stated they informally

use complaint and incident data to determine which facilities will undergo a routine inspection; however, they could not provide documentation of this methodology. As discussed in Finding 1, it appears HFRD takes complaint volume into account when determining which facilities should receive a routine inspection.

- **Routine Inspection Procedures** – HFRD provides its surveyors with each facility's complaint, site visit, and citation history to prepare them for surveys, as well as checklist survey forms to verify compliance with rules and regulations. However, due to the large number[19] of rules and regulations, HFRD relies on surveyor discretion regarding which are actually checked during the inspection. While sampling is practiced by other states, HFRD has not outlined how surveyors should determine which requirements should be checked in their review. The lack of written guidance on conducting surveys poses a risk that surveys may be inconsistent, with some facilities potentially facing more stringent inspections and investigations than others.
- **Intake & Triage** – As discussed in Finding 2, while ITU procedures contain guidance regarding the appropriate categorization of complaints, they do not contain formal procedures for documenting follow-up conversations to obtain more information. If complaints are not appropriately triaged, investigations may be delayed.
- **Penalties** – As discussed in Finding 3, HFRD has developed a written procedure for adverse actions when violations are identified, but it is not sufficiently comprehensive. For example, HFRD may move to revoke the license of facilities that receive a Category I violation (meaning that actual harm to a resident was confirmed). In addition, certain pattern and widespread Category III violations will incur a fine. However, neither practice is in HFRD's written procedures, and violations may not be consistently categorized or receive similar sanctions without clear criteria or examples.

HFRD staff have stated that staff experience has reduced the need for formal, documented policies and procedures. Additionally, management indicated DCH rules and regulations have been sufficient to perform operations without additional written guidance. Finally, HFRD is required to follow the federal Centers for Medicare and Medicaid (CMS) State Operations Manual when surveying nursing homes and has modeled the guidance they have after this manual, but the division is not required to follow these standards for surveying facilities overseen by the Program.

However, as discussed above, even with broad rules and regulations and staff experience, the absence of written guidance increases the risk of inconsistency in key operations within HFRD. Additionally, given the longevity of Program staff, HFRD also risks losing institutional knowledge as experienced staff retire,

[19] *For example, Personal Care Home facility rules have 34 sections, each with multiple subsections of requirements. For instance, Rule 111-8-62.20 on Medications contains 11 subsections that each contain multiple components.*

transfer, or are promoted. Future staff must rely on informal knowledge transfer and would benefit from more written guidance.

RECOMMENDATIONS

1. HFRD should develop and implement formal policies and procedures specific to state operations, including survey processes and staff training.
2. HFRD should assess the sufficiency of existing procedures and consider what procedures may be missing from them, particularly regarding how the division ensures consistency across operations.

DCH's Response:

Recommendation 6.1: *DCH disagreed with the recommendation, stating that HFRD's "operations are governed by statutes and rules" as well as decision tree tools and standard operating procedures. DCH also noted that the "survey process is guided by the standard forms that are used by all surveyors, and the GAHLES survey management system creates a framework for standardizing the surveyor process." According to DCH, "developing procedures would create an opportunity for conflict" with existing guidance.*

Finally, DCH noted that "staff training is standardized as each program has a team member that is responsible for on-boarding, which includes shadow experience with a surveyor…The actual steps of how to assess compliance cannot be written into a policy or procedure due to the nature of each facility."

> ***Auditor's Response:*** *We agree that written procedures were created in one area. However, as noted in the finding, there is no written guidance for surveyors when performing routine inspections. This may increase the risk of inconsistent inspections, particularly after long-tenured staff depart. If written procedures are modeled after what staff are already largely doing, there should be minimal opportunity for conflict with existing guidance.*

Recommendation 6.2: *DCH partially agreed with the recommendation, stating that it follows "philosophy and procedures for Continuous Quality Improvement," which involves "continuously looking for opportunities for improvement" including "gaps in standardized processes." When a gap is identified, DCH indicated "a team is brought together to define the gap, create a plan for resolving the gap, and memorialize the solution in a standard operating procedure." DCH stated it "will continue this process as it currently exists to ensure continued consistency across the organization."*

Appendix A: Table of Findings and Recommendations

	Agree, Partial Agree, Disagree	Implementation Date
Finding 1: HFRD has conducted few routine inspections, leading to limited oversight (p. 8)	**Partially Agree**	**7/1/2025**
1.1 The General Assembly should consider codifying a required frequency for HFRD to perform routine inspections of residential facilities within the Program. Consideration could be given to additional staffing needs, but additional analysis would be necessary.	N/A	N/A
1.2 HFRD should perform routine inspections in accordance with its internal frequency goal. When this is not feasible, HFRD should strategically identify facilities most in need of routine inspections and perform them jointly with complaint and incident investigations whenever possible.	Agree	7/1/2025
1.3 In its new online portal, HFRD should incorporate a place for facilities to document their accreditation status and provide copies of inspection reports performed by accrediting bodies. HFRD should review these documents to determine whether routine inspections are needed. HFRD should resume its routine inspections for all facilities that lack accreditation.	Agree	7/1/2025
Finding 2: HFRD has not consistently followed its standards for how severe allegations are categorized and when they are investigated. (p. 12)	**Partially Agree**	**7/1/2025**
2.1 HFRD should establish guidelines within written procedures that identify allegations that may be border between priority categories, set clearer criteria, and clarify more examples on which allegations fall in each category.	Disagree	N/A
2.2 HFRD should require Intake and Triage staff to document all factors that contributed to determining how an allegation was ultimately prioritized.	Partially Agree	5/1/2025
2.3 HFRD should take steps to ensure that IJ and non-IJ High allegations are investigated within their required timeframes.	Partially Agree	7/1/2025
2.4 HFRD senior management should perform regular reviews of overall complaint categorization and investigation timeframes to ensure consistent adherence to internal standards.	Partially Agree	7/1/2025
Finding 3: HFRD has not consistently sanctioned noncompliant facilities or verified they return to compliance. (p. 18)	**Partially Agree**	**7/1/2025**

3.1 HFRD should ensure that facilities found to have violated state requirements are appropriately fined in accordance with state law, rules, regulations, and established internal procedures.	Agree	7/1/2025
3.2 HFRD should document penalizing actions taken against specific violations.	Agree	4/1/2025
3.3 HFRD should establish timeframes for notifying facilities of payment obligations when fines are assessed and if facilities fail to pay.	Agree	5/1/2025
3.4 With its new data system, HFRD should ensure that facilities submit required Plans of Correction within 10 days and consider subsequent sanctioning actions (such as fines) for facilities that do not comply.	Partially Agree	7/1/2025
3.5 HFRD should establish clear criteria and relevant documentation related to suspending or revoking facilities' licenses.	Partially Agree	7/1/2025
Finding 4: Websites maintained by HFRD and facilities do not enable the public to easily identify violations and compare them across facilities. (p. 23)	**Partially Agree**	**7/1/2025**
4.1 HFRD should ensure facilities comply with the requirement to post violations on their websites.	Agree	7/1/2025
4.2 HFRD should consider penalizing facilities that fail to post inspection reports and Plans of Correction on their websites.	Partially Agree	7/1/2025
4.3 The General Assembly could consider requiring HFRD to publish on its website aggregated data on facilities' noncompliance so consumers can more easily compare facilities by the number and severity of their violations. Additional funding may be needed to implement any legislative mandate.	N/A	N/A
Finding 5: HFRD and DBHDD's shared oversight of community living arrangements could be improved with increased coordination. (p. 26)	**Agree**	**7/1/2025**
5.1 While DCH and DBHDD responsibilities remain shared: a. HFRD should coordinate with DBHDD to establish criteria to determine when a complaint or incident should be investigated by HFRD or DBHDD. b. HFRD should coordinate with DBHDD to investigate opportunities for sharing data and detailed information about CLA investigations.	Agree	7/1/2025
Finding 6: HFRD lacks written, formalized policies for certain core operations. (p. 28)	**Partially Agree**	**7/1/2025**
6.1 HFRD should develop and implement formal policies and procedures specific to state operations, including survey processes and staff training.	Disagree	N/A
6.2 HFRD should assess the sufficiency of existing procedures and consider what procedures may be missing from them, particularly regarding how the division ensures consistency across operations.	Partially Agree	7/1/2025

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the Department of Community Health's Healthcare Facility Regulation Division (HFRD). Specifically, our review set out to determine the following:

1. Are HFRD's processes for conducting initial and routine inspections efficient and effective?
2. Are HFRD's processes for receiving and addressing complaints efficient and effective?
3. Do HFRD's procedures ensure violations are corrected when they are identified?

Scope

This audit generally covered activity related to the Personal Care Home Program's (the Program) residential facilities, which included personal care homes, assisted living communities, and community living arrangements (we excluded adult day centers, which are also within the Program's purview but are not residential). We reviewed activity that occurred from 2019 to 2024, with consideration of earlier or later periods when relevant. Information used in this report was obtained by reviewing relevant laws, rules, and regulations, as well as agency documents. We interviewed agency officials and staff from the Department of Community Health (DCH), the Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia Long-Term Care Ombudsman; analyzed DCH data and reports; and conducted three site visits to observe surveys performed by HFRD staff. We received data from January 2019 to November 15, 2024 (calendar year 2024's request was limited because DCH transferred Program data from the federal ASPEN system to a new internally created system, GAHLES, effective November 16, 2024). We also sent a survey regarding the state's oversight to 1,936 facilities, of which 23% (441) responded. Finally, we interviewed agency officials from other southeastern states and reviewed other states' documents.[20] We found DCH's data to generally be reliable for the purposes of this project; however, we were unable to determine the completeness or accuracy of data showing fines assessed.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. All objectives address aspects of the internal control structure for the Program. Specific information related to the scope of our internal control work is described by objective in the methodology section below.

Methodology

To determine the extent to which HFRD's processes for conducting initial and routine inspections are efficient and effective, we reviewed state laws, rules, and regulations governing residential facilities and analyzed survey data from calendar year 2019 to November 2024. We examined survey records from a sample of 21 facilities to determine whether surveyors consistently performed similar procedures when conducting site visits. We also reviewed survey completion times to assess the frequency of initial and routine inspections, including instances in which facilities did not receive routine inspections during the period. Since state law does not establish a required frequency of routine inspections, we interviewed HFRD staff to obtain the division's internal goals for survey scheduling and decision-making process for initiating surveys and identifying violations. We compared Georgia's approach to other southeastern states and federal requirements through interviews and document reviews to determine the ways in which the survey processes align in terms of frequency and

[20] *We reviewed documents from Alabama, Arkansas, Florida, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. We interviewed staff with Alabama, Florida, Mississippi, Tennessee, and Virginia.*

oversight. We also examined whether HFRD senior management evaluates its oversight performance using available data and actions taken to address identified deficiencies. We assessed the controls over data used for this examination and determined that the data used were sufficiently reliable for our analyses.

To determine the extent to which HFRD's processes for receiving and addressing complaints are efficient and effective, we reviewed HFRD's website and agency documents. We also analyzed complaint data to determine the number of complaints received from calendar year 2019 to November 2024. Because state law and DCH rules do not establish a mandatory time frame for investigating complaints, we used HFRD's internal guidelines to determine how often they met their own goals for all complaints received. We also interviewed other southeastern states and reviewed these states' documents to determine the extent to which HFRD's practices aligned with its peers.

We reviewed a sample of 150 complaints to determine whether they were triaged in accordance with HFRD guidelines. The complaints reviewed were selected at random from 28 facilities, which were selected based on a risk assessment of each facility's total number of complaints, number of immediate jeopardy (IJ) and non-IJ high complaints, number of surveys from 2019 to 2024, bed count, number of complaints per bed, and geographic location. We also used keywords to identify an additional 15 IJ and 25 non-IJ high complaints with allegations similar to those identified as examples in HFRD's internal procedures. Based on our review of their allegations, we created three categories in **Exhibit 10** to group similar IJ and non-IJ high complaints. We assessed the controls over data used for this examination and determined that the data used were sufficiently reliable for our analyses.

Given the shared oversight of HFRD and DBHDD over community living arrangements and requirements for both agencies to investigate complaints in those facilities, we interviewed staff from both agencies and reviewed policies and procedures to determine how responsibilities are shared and whether there was overlap or duplication.

To determine the extent to which HFRD's procedures ensure violations are corrected when they are identified, we reviewed state law, rules, and regulations governing DCH's authority to sanction noncompliant facilities. We interviewed HFRD staff and DCH's general counsel and reviewed agency documents to determine policies and procedures used in penalizing noncompliant facilities. We also analyzed violations data in the ASPEN system to determine how frequently facilities were cited violations and the scope and severity of the violations identified from 2019 to November 2024. Our estimate of fines that could have been assessed included a calculation of potential mandatory and optional fines. To estimate potential mandatory fines, we determined the total number of violations identified in the same time period, assigned the penalty associated with the violation's category in accordance with penalty amounts in effect at the time, and applied a fine for each Category I and II violation as if each were an initial violation. To estimate potential optional fines, we also included pattern and widespread Category III violations and applied a fine as if each Category I, II, and III violation were a subsequent violation.

To determine the total amount of fines HFRD assessed, we analyzed an export from DCH's GRAILS system of fines paid by noncompliant facilities from calendar year 2019 to December 2024, as well as fines imposed but not yet paid. We assessed the controls over ASPEN data used for this examination and determined that the data used were sufficiently reliable for our analyses; however, due to data limitations we were unable to determine the completeness or accuracy of GRAILS data regarding fines assessed.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

If an auditee offers comments that are inconsistent or in conflict with the findings, conclusions, or recommendations in the draft report, auditing standards require us to evaluate the validity of those comments. In cases when agency comments are deemed valid and are supported by sufficient, appropriate evidence, we edit the report accordingly. In cases when such evidence is not provided or comments are not deemed valid, we do not edit the report and consider on a case-by-case basis whether to offer a response to agency comments.

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