Homemaker Companion Task Force

Special Act 22-12: A Study of Issues Concerning Homemaker-Companion Agencies

Distinguished Co-Chairs and Members of the Task Force, my name is Leah Cantor and it is with great respect that I thank you for the opportunity to share some powerful testimony.

My story is only one of many. I am here to represent the many CT daughters, sons and family members of loved ones who are or were clients of home companion agencies (HCA) who may have been mistreated, neglected, cared for by caregivers lacking the knowledge to safely care for them, those cared for by caregivers who were not fully vetted, or by HCAs who provided little to no supervision of their loved ones.

I'm also here to speak for those who don't know they have a voice, those not informed of this public hearing, those working 2-3 jobs who can't afford the time to share their stories, and those who were intimidated to tell their stories or entered into agreements to keep silent.

From my 3+ years of research including over 5000 pages of documentation shared with me by the Dept. of Consumer Protection (DCP), I have observed that CT is in crisis with regard to the regulation and oversight of care provided by CT's 900+ HCAs. This crisis is largely due in part to a serious lack of accountability on the part of not only HCAs oversight of caregivers but also the DCP's lack of enforcement of regulations and failure to exercise their authority.

My Dad developed advanced dementia and because of a serious fall, he could not learn to walk again without an aide and required 24/7 home care. My family engaged a CT home companion agency (a franchise of one the largest national home care agencies) to provide a 24/7 live-in caregiver for him in my parents' home. During the caregiver's assignment, my Mom passed away suddenly. Nine months later, I made my first unannounced visit to my Dad and found him home alone. When his caregiver returned, she was surprised to find there me and apologized for leaving him alone. We suspect she may have left him home alone dozens of times. My dad could and would rise from a sitting position by himself but would fall without aid. He was minimally verbal and a fall risk. Additionally, because of his advanced dementia, he did not have the wherewithal to know how to get help in case of an emergency. He was as vulnerable and helpless as a young child.

I filed a report with the local police who conducted an investigation. In interviewing the agency owner, the police report included the following notes regarding the owner's claims. To be clear, it was not acceptable to my family to have my father left home alone by his caregiver.

"[The Agency Owner] stated [my dad] was able to stay by himself briefly and because [the caregiver] had worked with [him] for 3 years she was very much aware of his condition and capabilities. There was no indication of abuse or neglect so [the agency] did not report this as neglect/abuse."

Both the agency as well as the police are designated Mandatory Reporters by CT law and BOTH failed to report the incident to DSS. To date, not one state agency including DSS has held the agency accountable for their failure to report for which there are legal consequences.

In response to the legal discovery process, the agency did not produce documentation supporting our family's consent to the caregiver's leaving my father home alone nor any request by the caregiver to the agency to request relief that day or any day. In fact, the agency's incident report included a statement from the caregiver apologizing for leaving my dad home alone.

I filed a lengthy complaint with the DCP detailing dozens of allegations many of which were substantiated through their investigation. A DCP investigator conducted an audit of the agency and cited 17 regulation/statute violations including multiple background check violations and a pattern of misconduct of repeat violations including a documented nearly 10 year history of misleading advertising. He discovered that multiple personnel files were not properly vetted. This included a lack of homeland security checks, reference checks, missing notarization signatures, etc. The DCP then issued a Letter of Correction requesting the agency's compliance. The DCP took no further action. It is my understanding that no policies exist to monitor compliance following a post-audit Letter of Correction.

Meanwhile, the agency continued its pattern of misleading advertising and it wasn't until two years later that complaints were filed against the same agency (including one from DPH). Consequently, the DCP issued an AVC, Assurance of Voluntary Compliance, to the agency which is a voluntary settlement allowing the DCP to bypass a disciplinary hearing. Without clear criteria regarding consequences of violations, Letters of Correction and AVCs are nothing more than a "pinky swear". It is important to note that an AVC is not a conclusion of law or admission of guilt, liability or violation. This AVC was specific to misleading advertising with no mention of any other allegations from my complaint. Since the AVC, the DCP received two complaints claiming that the agency violated the AVC four times within four months after its issuance. Nearly one year has passed since the alleged violations and to date the DCP still has not completed their investigation. Meanwhile, the agency continues to conduct business. At what point will the DCP start fulfilling its mission to protect consumers?

The DCP took 2-1/2 years to complete the investigation of my complaint. It was an additional 6 months until the DCP provided me with a comprehensive summary of my investigation. During this 3 year period, I submitted 11 inquiries about the status of my case and was assured the DCP would notify me when the case was closed. They did not. When the DCP failed to provide much of the information I requested, I retained counsel for assistance. Almost 3 years after filing my complaint, I was stunned to learn from a journalist that the DCP had sent him a 367 page investigative report of my case. It was not until months later that the DCP released the full set of investigation reports and documentation regarding my case to me – less than 24 hours before I would lose some of my legal rights and only after my threat to file an FOI complaint. **This is unacceptable.**

One of the most stunning revelations that I learned at least 2 years after my complaint was filed was that the agency did not terminate the caregiver and instead placed her on another assignment. Her identity was in question by homeland security, could not be verified and though this information was shared with the agency, the DCP stated that the agency did not "*seem concerned*".

Since 2015, two different DCP investigators submitted recommendations to revoke and suspend this agency's certification in two different years:

A DCP Investigator's Report in 2022 stated:

"A review of the agency's practices, documents, record keeping and compliance with CT statutes and Regulations has found numerous and ongoing incidents in which the agency has violated the law and negatively impacted the clients they have serviced. ***The Agency should either have their credential revoked or suspended*** *for a period of time in which sweeping changes and reforms are to be undertaken. The agency should be sufficiently fined for each violation they have been repeatedly cited for."*

A second DCP Investigator's Report in 2015 stated:

"This is a request for permission to refer this matter to the legal division of DCP for the ***revocation of the respondent's HCA registration****. There is a preponderance of evidence that this agency owner is in violation of the following statutes" and goes on to 10 regulation violations."*

To date, despite these recommendations, the DCP has not revoked, suspended or refused to renew this or any HCA's certification. Furthermore, despite the agency's repeat violations, to my knowledge, the DCP has never elevated their findings of this agency's actions to an administrative hearing. This precludes the DCP from making a determination as to a violation of law therefore avoiding issuing disciplinary action. The DCP's response to this failure of action is as follows: "*The Legal Division conducted a review and chose not to conduct hearings*" noting that audit reports are simply an investigators "opinion". The DCP was recently asked at a task force presentation why they have failed to act on disciplining HCAs. The response was that shutting down an agency would create turmoil in the lives of not only the caregivers but of their families. As we know, HCAs are tremendously understaffed and given CT's 900+ HCAs, the competitive nature of this industry would likely provide numerous opportunities for alternative employment for caregivers.

Evidence of the DCP's failure to exercise their authority to enforce regulations is evidenced in numerous excerpts of both internal and external correspondence (see below). The DCP is enabling agencies in violation to continue to jeopardize the health and safety of CT's elderly population.

DCP to an HCAs Counsel:

- *"Some of the actions of your client up to this point…indicate a lack of transparency with the way he conducts business." "We have serious concerns with the conduct of your client. His misleading and deceiving statements to not only the agency have led to unnecessary actions on the part of the clients as well as the DCP." "Both the agency and its employees have embarked in a pattern of behavior designed to mislead, deceive and defraud the public…as well as the Commissioner."*

- *"Your client is operating an illegal "homemaker-Home health Aide Agency"*

Internal DCP Memo:

"The HCA further engaged in an illegal scheme to obtain customers by implying that registered nurses would provide supervision giving this agency an advantage over other agencies that were not working outside the scope of their credential."

DCP to HCA:

"You have been and continue to be in violation of both the laws and regulations of the Department of Consumer Protection regarding your HCA registration."

DCP Investigatory Report:

- *"The HCA was deficient in its approach to maintaining compliance with the background procedures as outlined in chapter 400o. The evidence…indicates that the HCA neither was concerned nor cared about 'details' …and appeared to be going through the motions to fulfill the statutory requirements."*

- *"There was no evidence that [the HCA] was concerned with or attempted to corroborate the legitimacy of two different identities that the caregiver [in question] provided even after the DCP brought up these concerns."*

- *"The HCA's negligence allowed the caregiver to maintain her employment and continued to put her into homes of clients although her identity was questionable.*

- *"The HCA has a history of misleading and deceiving the public through its advertisements and promises to deliver services that are not delivered such as supervision."*

DCP Investigator to HCA:
"We have also seen your outright refusal to modify and correct your webpage as you are clearly advertising outside the scope of what our credential allows you to do. "

DCP Investigator's Final Report
"Since 2013 and during this investigation, the HCA demonstrated resistance for months to following instructions from the DCP for adhering to the requirements of Chapter 400o as well as from the DPH who articulated the violations of the laws they regulate. The HCA not only circumvented the law as applied to homemaker-companion agencies but also encroached upon laws overseen by DPH. The HCA routinely failed to follow the laws pertaining to Homemaker-Companion agencies despite the HCA being notified by the DCP ***years earlier*** *that they were operating outside of the DCP credential, and continued to do as evidenced by the HCA's 'previous complaint history' as well as the information found in their current advertisements."*

March 2015 Correspondence from HCA to DCP Investigator:
"We do not provide Nursing Care to our clients in anyway shape or form and the [HCA] website does not claim to provide nursing care services via Medicaid – Medicare or Private Duty."

April 2015 Screenshot of the above HCA's website - 3 weeks later than excerpt above:
"We provide Nursing Supervision and unannounced RN "spot checks" for all of our clients. This added level of Nursing Supervision separates [our agency] from all other homecare companies. There is not another homecare agency in CT that provides this level of homecare service." "You can be assured that you are getting a trained and certified caregiver that is managed by our Registered Nurses RN."

DCP Investigator's Report:
"The HCA has been utilizing the nurse supervision advertising campaign for almost 10 years."

DCP Investigator to HCA's counsel during an investigation of a complaint from DPH:
"Your client has failed to follow very straight forward instructions and in fact has blatantly violated the law on numerous occasions and is continuing to do so. We were about to seek a cease and desist order and implement civil penalties for these continuing violations"

Correspondence from DCP Administrators
"Our role is addressing violations in the homemaker companion act and bringing the company into compliance."

Question by Counsel, Answer by DCP Administrator
"What specific actions are entailed in 'enforce the law'? All HCAs are required to comply with CT General Statutes."

The following excerpts spotlight the failure of the DCP to exercise their authority:

Internal Correspondence between 2 Supervisory Investigators
"How do you want to go about enforcement of the LLC of an HCA using medical terminology in its names? Historically we have given them 10 business days to change with the SOS and send confirmation to us to verify the change. We give an extension when needed. We put a warning on the credential. Then they have 30 days to update the advertising materials including the website. Again we have given extensions. With the HCAs we worked with, they have been compliant. This could be an AVC if they do not comply"

The DCP claimed in a recent presentation that they "*focus on public health & safety"* of CT's elderly population. Per the DCP Commissioner's current testimony, *"If a complaint involves potential threat to the health and safety of a client, the complaint is moved to the top of the list so that we can ensure the health and safety of the client as well as other clients served by the respondent."* It is confusing that the DCP specifically states that the HCAs under its jurisdiction are non-medical and prohibited from providing advertising, or using the word "health" in its business name yet the DCP claims to focus on health and safety. The DCP specifically states "*There are no statutes or regulations per se that define …'parameters regarding how services are delivered'".* Additionally the DCP states that its jurisdiction is as follows: *"We look at contract disclosures, the performance of background checks, advertising and other limited administrative functions*". Furthermore, the DCP states that it specifically does not oversee quality of care. Given these statements, it is questionable how the DCP can justify making a statement that they focus on health and safety of the elderly.

I have spent the past 3-1/2 years seeking answers and accountability and have gotten a stifling education. Some of what I learned is detailed below:

- The DCP works under CT statutes and regulations. HCAs are encouraged but not required by the DCP to maintain compliance to these statutes and regulations.

- Complaints about HCAs filed with the DCP are made available to the public by request per FOI (Freedom of Information Act). This includes audits, reports and relevant case files though they are subject to redaction.

- The DCP does not provide oversight for quality of care for the HCAs under its jurisdiction.

- The DCP has no obligation to monitor agencies under its jurisdiction to ensure regulation compliance.

- It is my understanding that HCAs are not obligated to require live-in caregivers to take time off other than the required daily break/sleep times. My dad's caregiver took fewer than 4 days off in 2-1/2 years. That is unhealthy and unsafe for everyone involved.

- Years after my dad's caregiver left him home alone, the DCP informed me that HCA we hired did not terminate the caregiver's employment and placed her on another assignment.
- To my knowledge, the HCA we hired did not provide one unannounced visit in a 9 month period to check in on my dad. Though not required by law, it is reasonable to expect at least one visit in 9 months. In fact, a DCP investigator reported that the HCA neglected to properly and sufficiently supervise its staff.

- In a 9 month period after my mom's passing, the caregiver did not present one time sheet for an approval signature despite my presence on site. Yet the HCA invoiced my family for those hours.

- The DCP Investigator as well as the police suspect that my dad's caregiver had multiple fraudulent identifications. The investigator reported finding no evidence that the HCA was concerned with or attempted to corroborate the legitimacy of two different identities that the caregiver provided even after the DCP investigator brought up these concerns.

A majority of the information I have learned these past 3 years is not readily available or easily accessible to those seeking safe home care for their loved ones. Clear cut criteria needs to be established, implemented, and monitored to address HCAs with utter disregard for the law and agency that governs them. To date, there is nothing of the sort.

Another important aspect to be explored is DCP transparency. Please see below excerpts from memos that consider what documentation to share with the public.

Internal DCP Correspondence from DCP Investigator to Superior

"Should legal decide to not bring forth the background violation then that is what they will have to justify. Our unit will not be scrutinized for lying or withholding the obvious facts. What we learned and did will be documented."

Internal Correspondences Between Two DCP Supervisors

- *"Have you seen the final draft of the changes? We should include the employee id change because that is a part of [the complainant's] allegation. [DCP Administrator] has moved from don't include it to - I recommend not including it."*

- *"[Investigator] and I are concerned that the issue at hand, enforcement of the regulation of the background check for employees and potential employees and that it is comprehensive with a review of the records, is not being addressed. Is it possible that you, [Investigator] and I can have a brief meeting to discuss this in greater detail? Our concern is of course for this case but also for future cases as we do not wish to set a precedent on this matter because Andy and I agree that is problematic and not isolated to this case. We feel the regulation is enforceable and applicable to the case.*

In summary, my story is not an isolated one. I have spoken with others who have struggled with similar issues – look no further than the other testimonies submitted to this task force. Many have no idea where turn after spending years making phone calls with no resolve, some simply gave up, while others may have agreed to remain silent due to quiet settlements. Sadly, their stories will never be heard.

As the need for home care clearly increases steadily in CT, there is a huge gap in the availability of "real" information, advocacy support, and resources for those seeking and managing safe home care for their loved ones. CT is encouraging its citizens to age in place yet is not willing to provide effective safeguards for those who do so. It is my strong conviction that those who age in place whether by choice or not, deserve to be afforded the same rights, opportunities, and accessibility to resources as those who age in facilities. In fact, there is likely even more need as the supervision of HCA caregivers is virtually non-existent as demonstrated by CT laws.
The resources and time it takes to go through the complaint process to its completion is far beyond what most consumers are capable of. I spent three years and significant resources attempting to get answers and a fair process. The system failed my family and is continuing to fail CT's elderly population.

CT's elderly population deserves better than this. CT is a highly educated state with the means to protect this growing population. While we consider reforms within the industry, in the very minimum, state agencies should enforce the regulations already in place.

My testimony has been submitted to the Task Force in three parts. They are to be considered together.

1) My Personal Testimony
2) Proposals - regarding accountability, enforcement of regulations and oversight
3) Essential Tools for Selecting a CT Home Companion Agency

1) My Personal Testimony

An accounting of the situation my family experienced as a result of a currently broken system

2) Proposals

Goal: Improving the oversight and accountability regarding CT's home companion agencies. Currently in review by the CT Legislature. Developed to as a road map for the Task Force's recommendations to be presented to the CT Legislature in January 2023.

3) Essential Tools for Selecting a CT Home Companion Agency

Goal: Providing essential information for those seeking home companion agencies. It details vital questions for vetting a home companion agency, resources for verifying credentials and legal history, as well as experience based safeguards to keep loved ones safe. Sadly, when I needed it, this information was (not and still is not) accessible to the public. All of the online resources found in my years of research were highly lacking. This crucial information needs to be disseminated through state agencies such as AARP (with a wide and frequent reach), CT's agencies on aging, care managers, senior centers, hospital discharge planners, geriatric social workers, etc. to share it with those seeking home care. CT is encouraging its elderly population to age in place yet it is not providing the vital information to do so safely. It is our right and responsibility to ensure that our loved ones are safe and in responsible hands. It is my hope that the task force will consider during its formulations of recommendations a way to disseminate some of this vital information through various online channels to educate the public.

We can do better. Thank you for your time.

Respectfully,
Leah Cantor

11/15/22