

August 8, 2011

I would like to thank the Agency for Health Care Administration and the Governor's appointed Work Group for allowing me the opportunity to speak with you this afternoon. My name is Joan M. Andrade and I am a Mental Health Professional who currently works as a liaison at a county crisis stabilization unit for my employer in Pinellas County, Florida. I also serve on two local Boards. Since the beginning of my career, I have advocated on behalf of persons' with disabilities, not just psychiatric disabilities, but the entire disability community earning two awards and several recognitions for my work. I have spent my career in direct contact with residents of Licensed Mental Health Assisted Living Facilities as well as staff, Administrators and Owners. Regardless, of my community ties and affiliations, I am here to represent the residents of ALF's since there is no resident advocate appointed to this body to my knowledge.

After I read the first of the series of articles titled "Neglected to Death" written by three Miami Herald journalists in early May 2011, I have enmeshed myself in the topic of ALF system reform to the point of organizing and establishing a "Task Force" whose first meeting was held on June 30th. In fact, some of the people in this room were participants that day. It is stated that this work group's mission is "to comprehensively examine the regulation and oversight of assisted living facilities in Florida. The workgroup's purpose is to develop recommendations for improvement in the State's ability to monitor quality and safety in assisted living facilities and ensure the well-being of their residents." However, in my opinion the work group is not striving high enough to ensure the well-being and safety of ALF residents in the present and future.

I have spent the past two months becoming more educated regarding ALF practices as well as educating others. In fact many good ideas were born before the June 30th meeting and afterwards such as:

- Contacting former State Advisory Council members to become volunteer Ombudsmen to increase their numbers and ability to investigate complaints in a timelier manner. Also, to perform more ALF community outreach so that residents feel more comfortable contacting their Ombudsman if they have complaints or issues. Also, reach out to community groups such as NAMI who can provide training regarding mental health topics to help Ombudsmen become better informed regarding the SPMI (severe and persistent mental illness) population.
- Increase training requirements for ALF staff/Administrators especially those with a Licensed Mental Health (LMH) specialty license of which according to AHCA almost 1/3 of the ALF's (1100, 15,000+ beds) in Florida have this license. However, there is an exception since these are facilities that have at least three or more persons that have a psychiatric diagnosis. It does not mean that there are no persons with a mental health diagnosis in the other facilities. In my opinion, six hours is not sufficient to make someone knowledgeable to deal effectively with persons who have psychiatric disorders. Just to be a Certified Case Manager in this state requires at least a Bachelors' in a related field, one year of experience with the population, the passing of the Level II background check and continuing education credits. I propose that NAPPI training (non invasive de-escalation techniques proven to be quite effective with agitated individuals) and "Hearing Disturbing Voices" training utilized during CIT (Crisis Intervention Training for Law Enforcement Officers) be reviewed and considered for addition to the current 6 hour module for at least, all ALF LMH Administrators and staff.
- Interview the identified 7660 Optional State Supplement (OSS) recipients to determine if there are other instances of abuse, neglect, retaliation, etc. that they either witnessed, or experienced themselves. In my opinion, this group is the most vulnerable category of residents since they only receive a \$54 per month stipend from the state for personal needs. They are the "poorest" and the most financially restricted group of residents that we have. These residents tend to be all SSI beneficiaries and some may have minimal SSDI benefits totaling less than \$753 per month. In most cases, these residents will have to pay co-pays for transportation, some medications and doctor appointments; but most will need to pay for personal hygiene supplies including incontinence pads, clothing, shoes, etc. The stipend amount has been stagnant for several years.

Also, in many cases the ALF Administrators act as the residents' "representative payee" and have complete control of their financial benefits which could easily be viewed as a creditor/debtor relationship and a conflict of interest. Residents who desire to move to other facilities sometimes have a difficult time making the transition because of this financial arrangement. This can lead to some residents feeling trapped in their current living situation, even if they desire to move. The sentiment has been expressed to me several times over my career. In

my opinion, it is easier to have an independent entity such as a FFS Representative Payee, or even family member be the resident's representative payee. There are no current Social Security Administration guidelines regarding the topic of ALF representative payees. However, based on the efforts and collaboration of five people, this information is now with the SSA in Atlanta for review and may need national legislation to correct the deficiencies.

I have heard direct comments from ALF industry executives that the "abuse, neglect and other reported horrific incidents are isolated and not widespread". In my opinion, we do not know that to be fact as I have heard over and over again from residents and within the past week that they are "afraid" to call the Ombudsman and/or AHCA and complain about their ALF's. *Why is that?* I have also been informed by another Executive Director that presented today that members of her group attempted to outreach with residents and encourage them to fill out the comment form for today's event. They were also told by several residents' that they were "afraid". If someone is being abused and threatened that if they told "a, b and/or c will happen to you", most likely the person will not report his/her abuser. Who knows what residents are being told, threatened with whether verbal, physical and/or situational? Could some be threatened with more abuse, or with becoming homeless? We do not know the extent of the abuse and/or neglect unless we take proactive steps to uncover it. I firmly believe that this identified group of 7660 residents are the most likely to become victims of crimes whether committed by ALF staff or fellow residents, some with criminal histories to include violent crimes (i.e. registered sexual offenders/predators, battery, etc.).

- I have heard this many times during my career and just recently that some residents are hungry. Why is that when there are set dietary requirements? I have seen way too many bologna sandwiches with one slice of bologna (no cheese), servings of soups with little vegetables, peanut butter and jelly sandwiches and the like. Why don't the smaller ALF's form a purchasing group (per county) and buy in discounted bulk at Sam's Club, Costco, or the other wholesale stores so that they can purchase adequate food supplies for their residents and save dollars? Two of the resident comments that I have submitted speak of being hungry. Why are some ALF's purposely not adhering to the dietary requirements? In fact, I could have reported several facilities multiple times in the past for this observation, but I wasn't aware of the guidelines.
- Ensuring that all field staff of community non-profits who contract with the state to perform Case Management and other duties are fully aware of the dietary, staffing, medication and resident care standards to become better and more aware mandatory reporters.

58A-5.0182 Resident Care Standards.

(3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to needed health care, the facility shall, as needed by each resident:

(a) Assist residents in making appointments and remind residents about scheduled appointments for medical, dental, nursing, or mental health services.

(b) ***Provide transportation*** to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation for persons with disabilities.

(c) The facility may not require residents to see a particular health care provider.

58A-5.019 Staffing Standards.

(1) ADMINISTRATORS

(b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate "manager" for each facility who must:

1. Be at least 21 years old; and
2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C.

4) STAFFING STANDARDS.

(a) Minimum staffing:

1. Facilities shall maintain the following minimum staff hours per week:

Number of Residents	Staff Hours/Week
0-5	168
6-15	212
16- 25	253
26-35	294
36-45	335
46-55	375
56- 65	416
66-75	457
76-85	498
86-95	539

For every 20 residents over 95 add 42 staff hours per week.

6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.

7. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.

8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.

(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C.

(c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident's care.

58A-5.020 Food Service Standards.

(b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows:

1. Protein: 6 ounces or 2 or more servings;
2. Vegetables: 3-5 servings;
3. Fruit: 2-4 or more servings;
4. Bread and starches: 6-11 or more servings;
5. Milk or milk equivalent: 2 servings;
6. Fats, oils, and sweets: use sparingly; and
7. Water.

(c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three

or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.

(d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months.

(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.

(h) *A 3-day supply of non-perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity.* The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

Why did ALF industry representatives have such an issue with a prior Ombudsman who in the course of his job emphasized that facilities must have the 3 – day supply of non-perishable food and access to water in the event of an emergency, as required in 58A-5.020 section h?

The Resident Rights' document is not complicated, but unfortunately as I have listened to some ALF residents over the past two weeks, what I have witnessed in the past, continue to read articles and determined from experience; some residents have endured civil rights and human rights violations. A colleague of mine who visited four area ALF's within the past week looking for a home for a family member described her experience as "going into a third world country". She proceeded to describe the conditions of the homes and what appeared to be despondent residents. I am sure that there are some very good, in fact excellent ALF's in this state that not only follow the rules, employ competent and well-trained staff and are compassionate; however, all of them need to be that way. These ALF's take in a minimum of around \$1000 per bed per month and most are for profit businesses. However, if they can't operate within the parameter of the laws and don't feel that they are making enough profit then they have a choice. They either follow the rules, or participate in a different business venture.

As far as colleagues within the regulatory and mandatory reporting agencies concerned that if ALF's are closed for violations as to where will the residents go; my response would be that we cannot ignore, nor allow continued violations whether they be of resident rights', standards, or regulations. This only breeds contempt for law and allows these ALF's to maintain conditions that are ripe for abuse, neglect, exploitation, violence, etc. upon vulnerable elderly and/or young disabled residents. I really wonder how many of the 2900+ ALF owners, administrators and staff if they were to become ill and lose the ability to perform three or more of their activities of daily living (ADL's), with no one to help them; how many of them would agree to become residents of their own ALF's that they operate? If the answer is no, then why wouldn't they?

Thank you for your time, consideration of my concerns and attention to these vital matters.

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