

Recommendations received from Assisted Living Workgroup Members and state agency resources (as noted).

**Consumer Information**

1. Require the state to contract with an objective outside party to provide improved consumer information including ALF ratings.
2. Develop a consumer ALF guide similar to the AHCA nursing home guide in an electronic format to help people learn important facts such as deficiencies found at inspection, number of beds, languages spoken, inspection results, rates charged for a standard set of services, whether the facility accepts Medicaid waivers, and other information.
3. Require ALFs to enter capacity, capability, and cost of care into a statewide database allowing consumers, families, advocates, and hospitals to determine which facilities have the ability to best meet the individual needs and choices of each person.
4. Amend S.400.0078 to require long-term care facilities to notify residents that the complainant identification and the substance of their complaints are confidential and exempt from Florida's public record laws.
5. Consolidate and expand existing consumer resources. Currently Florida ALF information is available through the AHCA FloridaHealthFinder.gov website as well as the DOEA Affordable Assisted Living website (<http://elderaffairs.state.fl.us/faal/consumer/facilityselect.html>). Both sites contain information regarding how to evaluate an ALF, questions to ask and a resource to search for facilities (DOEA links to <http://www.floridahousingsearch.org/>). Each facility search contains unique information; AHCA [www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov) provides more regulatory information such as inspection reports, sanctions, owner and administrator names, while DOEA allows the ALF to update information about funding sources, available services, and other accommodations. (AHCA recommendation)

**ALF Administrator Qualifications**

1. Create a workgroup of providers and stakeholders to evaluate the current educational requirements and curriculum for certification as an administrator of an ALF, education and training requirements for staff, continuing education requirements, and training and education requirements for administrators and staff of specialty licensed ALFs.
2. Raise standards to become an ALF administrator including:
  - o Be at least 21 years of age,
  - o Have an associate degree or higher from an accredited college (in a health care related field) or,

- A bachelor's degree in a field other than in health care from an accredited college and (one year experience) working in a health care related field having direct contact with one or more of the client groups or,
  - A bachelor's degree in a field other than in health care from an accredited college and have successfully completed an assisted living administrator's training course approved by the department or the department's designee or,
  - At least two years experience working in a health care related field having direct contact with one or more of the client groups and have successfully completed an assisted living administrator's training course approved by the department of the department's designee or,
  - A valid nursing home administrator's license.
  - A valid registered nurse license.
  - Grandfather existing Administrators with certain training and experience, and no serious deficiencies in their past.
3. Require administrators to have a two year mentorship under an ALF administrator with no Class I or II violations.
  4. Increase administrator requirements for an ECC facility. Allow a registered nurse license to satisfy.
  5. Create ALF Administrator licensure with a Department of Health board to track and monitor discipline and core training. No exceptions for small facilities.
  6. If there are increased requirements for ALF Administrators, consider accepting licensure as a nursing home administrator or a registered nurse to satisfy requirements. (AHCA recommendation)
  7. Prohibit facility administrators from owning or serving as administrator of any facility if an action to revoke or deny a license is upheld at a facility they were previously employed.

## **Training/Staffing**

### Core Training

1. Create ALF Core Trainer Oversight. Consider a dedicated source of income and more explicit authority to enhance DOEA's ability to provide more oversight of core training providers.
2. Return core training responsibility to the Department of Elder Affairs (DOEA) and use training fees to fund the initiative.
3. Raise the qualifications of trainers and have AHCA strengthen review of their certification and training methods.
4. Require trainers to have experience in the industry.

5. Adopt a de-certification process for trainers.
6. Authorize DOEA to develop a partnership to conduct one standardized core curriculum course in English and Spanish that is updated as needed. This will increase the credibility and professionalism of the training process and will align the training of ALF administrators with other paraprofessionals. Options include existing accredited educational institutions or existing professional healthcare associations that currently provide continuing education. Allow existing registered trainers to provide training until July 1, 2013, when training will be turned over to either the educational institutions or professional associations. This will allow current trainers an opportunity to develop affiliations with training entities. (DOEA recommendation)
7. Develop a standardized, CORE curriculum, either through the Department or in partnership with educational institutions, and allow the Department to monitor and sanction training providers that do not follow the standardized curriculum.
8. Expand the number of minimum CORE training curriculum hours from 26 to 40 to include specific minimum training hours in each area and to include additional topics such as:
  - Use of physical and chemical restraints.
  - Elopement prevention.
  - Aggression, de-escalation, behavior management, and proper use of the Baker Act.
  - Do Not Resuscitate Orders.
  - Infection Control.
  - Admission, continuing residency and best practices.
  - Phases of care giving and interacting with residents.
  - Human resource management, finance and business operation, and supervision topics.
  - Require additional 8 training hours for administrators employed or to be employed in an Extended Congregate Care and Limited Mental Health licensed facility.
9. Raise the passing score for the Core exam from 70 to 80 or 85.
10. Require the competency exam be taken within 90 days of completing the initial core training. If an applicant fails the core exam, the applicant must wait 30 days to retake the exam and must reapply and pay the exam fee. If an applicant fails the exam three times, the applicant must retake the initial core training including payment of any course fees. (DOEA recommendation)
11. Develop supplemental core competency exams for ECC and LMH licensure. (DOEA recommendation)

#### Continuing Education

1. Increase and improve initial and on-going training for all ALF staff. Consider core training standards as the minimum and create additional orientation and in-service training for administrators and direct care staff based upon the types of residents served.

2. Revise continuing education requirements for administration and care. Include de-escalation techniques.
3. Expand the number of continuing education hours from 12 to 18 in topics similar to the initial core curriculum. (DOEA recommendation)
4. Establish in statute a procedure and fees similar to that used by the Department of Health in Section 456.025(7), F.S., to approve continuing education trainers and courses. This establishes an online education tracking system for approving training providers, initial core training, and continuing education credits for each biennial renewal cycle. Training entities shall provide information on course attendance to the department necessary to implement the electronic tracking system. The department shall specify the form and procedures by which the information is to be submitted and monitored. (DOEA recommendation)
5. Prepare and provide a well designed curriculum in a wide array of subjects by highly skilled trainers using readily accessible technology. Training should demonstrate methods and techniques for staff. Administer tests by an independent party on-line or at a testing center after the training is completed.
6. Allow flexible training to meet individual needs of direct care, frontline staff. Allow alternatives to instructor-led training. Create flexibility to accommodate staff who work nights and weekends. Offer training in staff native languages. Consider varying skill levels of staff.
7. Require the state to contract for the development of on- line courses similar to the DCF funded online series of Baker Act related courses (through USF/FMHI) that can be found at [www.BakerActTraining.org](http://www.BakerActTraining.org). Courses are available to anyone at no cost. Consider “subscription-based” online service to meet the needs of direct care workers, but recognize that a fee for classes may create a disincentive for participation.
8. Require staff to pass a short exam after initial and in-service training to document receipt and comprehension of the training.
9. Require one hour of elopement training for all staff.
10. Update the competency tests annually to ensure that the tests are informed by the best research and best practices knowledge.
11. Enable costs associated with training changes be borne solely by the trainers, administrators, and assisted living facilities and remain revenue neutral to the state. Reasonable fees should be imposed in a manner that will not be a barrier to job creation. (DOEA recommendation)

#### Limited Mental Health Training

1. Increase training for LMH facility staff, provided by mental health professionals and including an emphasis on aggression management, de-escalation techniques and proper use of restraints.

2. Require all staff members who have contact with residents with mental health issues, even incidental contact, to complete the mental health training.
3. Establish a panel of mental health experts to develop a comprehensive, standardized training curriculum for mental health training for assisted living facility staff members.
4. Require the 6 hour mental health training as a pre-service requirement. Currently, ALF staff can work directly with individuals for up to 6 months before getting trained. (DCF SAMH recommendation)
5. Increase the training hours for staff members working in facilities with an LMH license from 6 hours of limited mental health training to 12.
6. Require staff members to complete a test following their training in mental health and score a minimum of 80%.
7. Allow the Department of Elder Affairs to monitor and sanction trainers providing the mental health training course.
8. Collaborate with NAMI (National Alliance on Mental Illness) in each community with an active chapter to provide free training of residents (Peer-to-Peer), caregivers (Family-to-Family), and Provider Education, as well increased oversight when NAMI members are present in the facilities.

### **Surveys and Inspections**

1. Modify survey frequency. Inspect facilities with a problematic regulatory history more frequently than once every two years. Require more frequent and extensive inspections of those facilities that have recurring or observed deficiencies.
2. Require the Agency for Health Care Administration to survey ALFs annually.
3. Require additional inspections for certain facility types.
4. Establish a quarterly inspection cycle for facilities with a limited mental health license.
5. Conduct inspections of LMH facilities on an annual basis and include a mental health professional on the inspection team.
6. Authorize more abbreviated inspections for facilities in compliance. Create a streamlined regulatory process for facilities with a favorable regulatory history.
7. Conduct unannounced visits to facilities during evenings and on weekends as well as during weekday hours by the Agency and by LTCOC volunteers.

8. Deemed status is authorized in the statute for facilities that have undergone accreditation or certification by a nationally recognized body such as CARF might be helpful to reduce the number and frequency of on-site surveys. Any deemed status must be based on a nationally recognized accreditation body or upon a documented history of high performance without serious or repeated citations.
9. Acknowledge CARF accreditation – allow lighter inspection.
10. Require AHCA surveyors to rely more on site-based observations than paper review. While it is more difficult to measure quality care than technical compliance, rules must be created to provide objectively reasonable basis for surveyor judgment to be applied and the surveyors must be adequately trained to use the probes.
11. Require a specific number of lead surveyors in each area office to specialize on ALF inspections and be dedicated to ALF inspections only.
12. Require dedicated AHCA staff to monitor surveyors and the field work to ensure consistency in inspections, citing deficiencies, and enforcement throughout the state.
13. Require AHCA surveyors complete core training and continuing education hours equivalent to ALF Administrators.
14. Assess AHCA Inspection Forms. Create a workgroup that includes Ombudsman members to assess AHCA inspection forms to assure they adequately assess ALF compliance with the law, resident protection, and meeting resident needs. (Add Note: Senate Health Regulation report recommendation 5)
15. Require dedicated AHCA staff to focus on assisted living facilities including one position to monitor state-wide issues and lead surveyors in each field office.
16. Exercise caution when making changes to any business or industry to avoid having unintended consequences

## **Licensure**

1. Seek legislative changes to Chapter 429, FS, that are resident-care focused (Alzheimer's secured units, safekeeping of residents funds) and ensure that regulations are appropriately and consistently enforced (keep violations in Chapter 429, FS) yet streamlined where appropriate (advertising – use of “ALF”, combined adverse incidents reporting)
2. Create rigorous initial ALF license requirements to prevent persons who are unprepared or uncommitted to providing quality care from becoming licensed. Consider education and training of the administrator, background checks on the owner and proposed administrator regarding previous facility ownership and operations, and appropriateness of the facility.

3. Establish a more in-depth licensure application and background screening process for ALF licensure applicants.
4. Utilize the provisional license permitted in Ch 429, F.S., for initial licensure, then followed up within a specified period after the facility has opened, to conduct the more complete survey.
5. Revise regulations to be appropriate for specific persons served in an ALF including persons with serious mental illness and those serving a geriatric or medical needs.
6. The ALF licensure and regulatory provisions be placed back into Part I of Chapter 429, F.S.
7. Examine the current array of ALF specialty licenses and determine if they are still needed or should be modified.
8. Evaluate expectations for quality of life and care in an ALF. Focus can not be limited to physical health and safety – it must extend to other quality of life factors, including staff who are kind and focused on the individual wants / needs of each resident. Consider questions raised during public testimony “Would I want to live in this facility?” or “Would I place my mother in this facility?” No lower expectation should exist for other individuals.
9. Prohibit an administrator or property owner associated with an ALF with a regulatory record that would qualify for license revocation or denial, from future affiliation with an ALF. This provision would require disclosure of property ownership. (AHCA recommendation)

### **Resident Admission**

1. Hold state and local hospitals accountable for discharge planning that matches individual needs and desires to an appropriate and available setting that best integrates individuals into the community. Modify Chapter 395, F.S., to require hospital document consideration of an individual’s choices in discharge placements. Address hospitals that do not consider the individual’s preferences and community integration in discharge planning.
2. Adopt an ALF pre-admission screening process implemented by an independent body (a simplified and expedited version of PASRR). This “single point of contact” would permit choice counseling and referral to an ALF most appropriate to align with the individual resident needs.

### **Resident Discharge**

1. Enact legislation that provides ALF residents a formal appeal process for disputed discharge.
2. Afford ALF residents the same appeal rights as residents of nursing homes. Discharge protection that mandates specific reasons for relocation, provides ample notice to residents, and provides residents with an administrative appeal hearing process similar to that of nursing home residents.

3. Reduce the resident discharge notice from 45 to 30 days and provide an option for the resident to appeal with a decision within 15 days.
4. Clarify in statute that a written notice, with the reason for the relocation or termination listed, along with an explanation of the reason, be given to the resident 45 days before the relocation or termination of residency. The resident or legal representative should sign indicating receipt. Require the facility to send a copy of the written notice to the local long-term care ombudsman office within 5 days of providing the notice to the resident.
5. Establish in statute that relocation or termination of residency from an assisted living facility may only occur if one of the statutorily specified reasons has been documented. These reasons should include a change in the resident's health, nonpayment, or the health and safety of other residents is in danger.
6. Permit the resident to appeal the relocation or termination to a neutral third party.
7. Permit the ombudsman to represent the resident at an appeal hearing.
8. Require assisted living facilities provide prospective residents with a statement acknowledging the continued residency requirements to allow owners to initiate transfer of a resident to a more appropriate setting when they no longer meet the requirements of an assisted living facility. Require residents sign this acknowledgement.
9. Clarify that a temporary transfer such as a Baker Act is not a discharge and the resident may return to the facility once released. Require ALFs to hold the resident bed / room during the absence.

### **Resident Safety and Rights**

1. Increase amount and quality of activities made available to ALF residents. Require ALFs to seek out individualized activities and services independent of the facility that are chosen by each resident and expedite participation in these activities and services. Activities must be meaningful activities and allow residents the opportunity for productive learning, life skills, and job experience. This may include meaningful part-time work or volunteer activities, depending on the preferences of the resident. Some structured and meaningful activities can be provided in the ALF, but those integrated in the community with non-disabled persons should be encouraged.
2. Prohibit practices that lock residents out of the facilities during certain hours to cut costs or give staff a break. Positive activities of each resident's choice during these hours should be substituted.
3. Examine ALF staffing ratios.

4. Prohibit ALF related staff from serving as Representative Payees. This creditor / debtor relationship places the resident under the control of the ALF for all aspects of their life, preventing them from moving to another ALF or a more independent living environment.
5. Prohibit any binding arbitration agreement language in resident contracts. These contract clauses limit a resident's right to access due process whenever care disputes arise.
6. Enact legislation that encourages residents and families to establish independent groups within each ALF focused on improving conditions and care for residents without interference from staff.
7. Ensure an anonymous method of regularly seeking input from ALF residents about the nature of the care received in a facility without relying only on complaint investigations or on-site surveys. CARF provides such a mechanism, as does the LTCOC.
8. Clarify in statute that the ALF administrator is responsible for ensuring that the resident receives adequate care and services.
9. Enact public record exemption for AHCA complaints. Complaints filed with AHCA are not protected from disclosure. Consider adding confidentiality to AHCA complaints equivalent to Ombudsman. (AHCA recommendation)

### **ALF Information and Reporting**

1. Require ALFs to report quarterly to AHCA on occupancy rates, demographics, resident acuity, and the services rendered to the residents.
2. Require minimal online data submission to the Agency. ALFs currently submit data to the agency in a variety of online applications including adverse incident reporting, monthly liability claim reporting and participation in the Emergency Status System (over 85% of ALF have online accounts). ALF data submission to the Agency should include:  
 Number of residents (census)  
 Number of residents requiring specialty license services: Limited Nursing Services (LNS), Limited Mental Health (LMH), Extended Congregate Care (ECC)  
 Number of residents on Optional State Supplementation (OSS)  
 Number of Medicaid recipients whose care is funded through Medicaid by type of waiver  
 (AHCA recommendation)
3. Require maintenance of a resident roster available upon request including name, Medicaid ID, guardian or representative name and contact information, source of resident admission and care manager name and contact information. (AHCA recommendation)
4. If ALFs are required to report to the Agency occupancy rates and resident acuity (above), they need to have an online reporting system that requires no more than 30 minutes per quarter for data entry. ALFs will also need to be able to pull up congregate occupancy rates and resident

acuity compilation data for their area in order to compare their facility demographics to the average.

5. Require AHCA to investigate the types of technology currently available for cost effective methods of collecting, reporting, and analyzing client information and allow facilities to select the type of technology most appropriate to each individual facility. Easy to use swipe / scan handheld devices may be available. The fiscal impact of equipment, software, training, and staff time must be considered.
6. Require all ALF staff to collect and identify client information that would indicate a change of condition and notify the resident's case manager to enable early intervention and prevent escalation of symptoms that might result in a transfer, discharge, Baker Act, police involvement, injury to staff or resident, or other adverse event. Electronic collection and sharing of this information will improve timely response.
7. Require AHCA to examine the "Dashboard" technology used by DCF in measuring the outcomes of Community Based Care agencies serving dependent children. Some aspects of this oversight should be applicable to long-term care settings.
8. Use a document vault where all critical documents can be stored related to an individual resident. This prevents the loss of such documents, increases access to them by authorized persons to prevent duplication of effort, and reduces costs. Protection of such documents and criminal sanctions for misuse needs to be considered to prevent fraud by unauthorized persons or for unauthorized purposes.

## **Enforcement**

1. Enforce existing regulations, and retain due process protections for providers.
2. Utilize existing regulations to evict unethical or incompetent providers from the system. Recognize that most ALF residents are currently being well taken care of under the current regulatory environment. Do not undermine a social model of care that works.
3. Maintain current law that fines will only be imposed for low-level citations if uncorrected, to focus penalties on poor performers without adverse impact on competent providers.
4. Evaluate the ALF enforcement process beyond a punitive approach. Although the punitive approach is necessary for chronically poor performing facilities, it is not the best way to elevate quality across the ALF community. Examine the Wisconsin model for ALF regulation which is similar to the AHCA abbreviated survey with the addition of a consultative/collaborative regulatory model.
5. Give AHCA more power if necessary to place sanctions, fines, moratoriums, as well as deny, revoke or suspend licenses for poorly performing facilities. Fines for non-compliance should be increased and immediately paid. Such sanctions would be subject to due process through

existing appeal processes. Agency discretion on sanctions should be discouraged or eliminated as such discretion creates the appearance or reality of unequal application of regulatory powers.

6. Evaluate discretion of sanctions and determine if some should be removed, but allow some AHCA discretion. Removing discretion more broadly may cause unintended consequences and needs to be discussed much further
7. Require AHCA to assess certain administrative penalties such as increasing sanctions for recurrence of serious deficiencies affecting residents' health, safety, or welfare or failure to pay fine.
8. Fines – mandatory for certain violations, escalating fines for recurring deficiencies. Prescribe fine amounts for non-compliance rather than ranges.
9. Moratorium – mandatory for serious violations (Class I or II), and when an ALF fails to correct all outstanding deficiencies and reach full compliance at the time of a follow up visit or by the mandatory correction date.
10. Revocation or denial of renewal license – mandatory for certain violations including resident death at a facility because of intentional or negligent conduct on the part of the facility. Consider the degree of culpability.
11. Provide AHCA the authority to cite for past egregious violations (Class I) even if corrected upon inspection and a mechanism to address evidence presented after an AHCA investigation such as a DCF Abuse report or law enforcement investigation. (AHCA recommendation)
12. Authorize AHCA to cite violations for falsification of information. Current laws authorize licensure action for falsification of a license application [s. 408.815(1)(a)] or authorize criminal penalties for falsification of records (s. 429.49, F.S.), but do not address licensure violations for other falsified documentation submitted to AHCA. (AHCA recommendation)
13. Allow the monies from administrative fines be used in the facility to correct the deficiency allowing the facility to enhance the resident care standard.

## **Funding**

1. Evaluate the actual cost of the current regulatory program and any proposed changes and determine full costs of any law changes before raising fees.
2. Provide AHCA necessary resources to apply the statutory and regulatory measures necessary to protect vulnerable persons. These include political support by the Legislature through substantive laws and financially through appropriations to hire sufficient numbers and quality of staff in its field offices to provide the intensity and frequency of surveys and complaint investigations necessary to protect the public.

3. Consider options in the Senate Committee on Health Regulation Interim Report 2012-128, to fund required inspections including some combination of additional fees, especially higher fees or facilities that require greater regulatory oversight.
  - Require licensure fees for OSS beds. Florida law exempts facilities that designate their beds as OSS from licensure fees. The current fee for non-OSS beds is \$61 per bed in addition to the \$366 standard licensure fee. Some of the facilities that receive this exemption for the majority of their licensed beds require significant regulatory resources. There are currently 15,678 OSS beds in Florida, so revenues generated would be \$478,179 annually (15,678 x \$61/bed every 2 years for biennial licensure).
  - Increase the per-bed, per facility, and/or specialty licensure fees for all providers to offset program deficits.
  - Assess higher fees at renewal for those facilities that required greater regulatory oversight based on the number of complaint inspections, violations cited, follow up visits required to determine correction of violations, and adverse sanctions such as moratoria, suspension, fines, or other actions.<sup>186</sup>
  - Remove the prohibition on imposing an administrative fine when a Class III or Class IV violation is corrected within the time specified.
4. Reevaluate the assisted living fee structure as it relates to paying the cost of regulation.
5. Prohibit fines from going back to the Agency to offset the costs of the licensure program.
6. Address the 15,000 people on the waiting list when asking for additional ‘nursing home diversion’ slots.
7. Provide more financial support for ALF care and services including increased per diem rates and more funded slots (beds).
8. Provide a real-estate tax exemption to for-profit Assisted Living Facilities, as exists for non-profits in Chapter 196, F.S.

### **Resident Advocacy**

1. Assure independence of the Long-Term Care Ombudsman Program –issues cited by the federal Health and Human Services Administration on Aging in its “Compliance Review of the State of Florida Long-Term Care Ombudsman Program” dated September 1, 2011 should be remedied by Executive Branch practice or by legislative mandate.
2. Relocate the Ombudsman Program to either the Attorney General or the Auditor General, separate from DOEA, AHCA or DCF.
3. Focus Ombudsman oversight on resident advocacy. Focus on communication with each resident of each ALF monitored to elicit information on ways the facility can improve as well as ways in which the facility may excel. Train members on the requirements of and be alert to regulatory

requirements of ALFs so they can recognize obvious deficiencies and make complaints to regulators. Address allegations of excessive enthusiasm of Ombudsman and assure focus is on residents and not license regulation.

4. Enable the State Ombudsman to impose a civil penalty, following notice and an opportunity to be heard, on any facility that retaliates or discriminates against a resident who files a complaint with the program.
5. Ensure volunteers have the right to visit licensed programs at any time for purposes of monitoring as well as for complaint resolution. They should always be encouraged to look at any physical plant as well as other issues in addition to conducting resident interviews. All observations and findings should be submitted to AHCA and acted on in an expedited manner.
6. Contact former members of the State and Local Advisory Council members to expand Ombudsman efforts. These members have great knowledge and skill in mental health related issues that has been lost since the Councils were de-funded by the Legislature in 2010. Establish a sub-committee of each Council focused on ALF's with limited mental health licenses; members would be a resource to other Council members and staff for issues related to mental illness in other types of long-term care facilities.
7. Create an independent statewide ALF Council made up of residents, ombudsmen, and families (at least 2/3 of the membership), in addition to one member from each respective trade association, to meet periodically.
8. Increase funding for the Centers to expand the numbers of persons served and recognize the Centers for Independent Living as an essential part of the ALF statute. Their roles of information and referral, peer monitoring, independent living skills training, advocacy and other services are ideally suited for persons who are living in ALF's and those who wish to live more independently.
9. Require ALFs contact representatives of the Florida Peer Network to seek certified peer specialists for employment or at a minimum, encourage the peer specialists to visit the facilities to make recommendations that would improve the ability of the facility to better serve persons with severe mental illnesses.

## **Mental Health**

1. Require more education and experience for LMH facility administrators with a greater focus or specialization in mental health care such as a two year degree and two years of experience or a four year degree with coursework in a mental health related field seems reasonable. Consider a grandfather provision for current administrators.
2. Require a Limited Mental Health (LMH) license for ALFs with any mental health residents, rather than the current limited definition. Currently the definition of LMH license is an ALF that serves three or more mentally ill or disabled residents must obtain a limited mental health (LMH)

specialty license. For the purposes of assisted living licensure, a mental health resident is defined as an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS). This definition is limited as there may be other assisted living facility residents with severe and persistent mental illness who have a case manager but do not meet this specific definition.

3. Recognize the shift of placements for persons discharged from state hospitals, now residing in ALFs.
4. Conduct annual or quarterly regulatory inspections.
5. Identify the features or characteristics of a good LMH ALF for model of programs that best meet the needs of persons with serious mental illness and the associated behaviors.
6. Provide more case management services and advocacy for residents which could contribute more to the resident's quality of care and life.
7. Clarify oversight responsibilities of private case management and mental health treatment providers as it relates to Community Living Support Plans and Cooperative Agreements. Not all individuals in ALFs are served by DCF funded mental health providers, making DCF oversight of those providers difficult. (DCF SAMH recommendation)
8. Maintain the independence between mental health services and case management and assisted living facilities. Shifting services and case management to a facility-based model instead of resident-based may place the needs of the facility over the needs of the resident, and limits resident choice in case managers and living arrangements.
9. Retain role of the designated mental health providers to manage mental health clinical issues and do not shift this role of the ALF. While close working relationships between the ALF and the mental health provider are essential, it is equally essential that no inducements or other devices limit the choice of residents as to where or from whom they receive their mental health services.
10. Do not move the Medicaid Case Management program moved from community mental health centers to the ALF. This Medicaid program, limited to eligible services for eligible clients, requires extensive psychiatric oversight and linkage only available within a clinical context. This is not the "social service" program ALFs desire nor should it be facility-based and dependent on the residence where an individual lives.
11. Do not require DCF to contract with specialized CMHCs to provide case management and other mental health services to residents of ALFs. This would more likely meet the needs of the facility at the expense of the resident. Residents often move between ALFs or to more independent settings and they need to retain the continuity of care possible through the trusted relationship with their case manager.

12. Require DCF/Managing Entity evaluate the cooperative agreements in place to ensure that they are sufficient to meet the mental health needs of ALF/LMH facility residents and that the circuit plans are consistent with the DCF/SAMH district plans related to case management services, including access to consumer-operated drop-in centers, access to services during evenings, weekends, and holidays, supervision of clinical needs of residents, and access to emergency psychiatric care.
13. Require DCF/Managing Entity review a sample of the community living support plans at each ALF/LMH facility to ensure they represent adequate mental health supports as well as activities and services that represent the preferences of the consumers.
14. Require DCF/Managing Entity verify that each mental health resident is assigned a case management and that face-to-face contact has been documented as required by law and rule.
15. Require staff at the DCF to ensure consistency of LMH facility services and increase the monitoring responsibilities of mental resident case managers.
16. Amend Chapters 400 and 429, F.S., to require that before an ALF or nursing home or its agent can initiate an involuntary examination under the Baker Act that it must document a series of efforts have been attempted to prevent this action. The statutory amendment would require DOEA, AHCA and DCF to collaborate in the promulgation of rules defining what these efforts would be. The Florida Health Care Association's Quality First Credentialing Foundation has adopted a Best Practice Tool governing "behavior management/aggression control & involuntary Baker Act guidelines". This Tool is incorporated in the state's Baker Act Handbook (Appendix E-9 through E-12); it could provide the basis of such rules.

### **Multiple Regulators**

1. Form a workgroup involving all agencies involved in ALF regulation and stakeholder groups to develop a new organizational structure streamlining the regulatory process. Designate AHCA as the lead agency for all regulatory activities in the interim.
2. Improve coordination between the various federal, state and local agencies with any role in long-term care facilities oversight; especially ALFs. Including Agency for Health Care Administration, Long Term Care Ombudsman Program, local fire authorities, local health departments, Department of Children and Families Adult Protective Services and Substance Abuse and Mental Health Programs, Department of Elder Affairs Area Agencies on Aging, local law enforcement and the Attorney General's Office.
3. Agency responsibilities and lines of communication, coordination, and cooperation between agencies with oversight/regulatory responsibility for ALFs be clearly defined and formalized in written inter-agency agreements.
4. Limit the role of AHCA to regulatory oversight – consultation needed by the industry and its members can be obtained from organizations of their choice and at their own expense. AHCA

should promulgate rules establishing quality standards in collaboration with DOEA and DCF, and survey licensed facilities for full compliance with those laws and rules.

5. Cross-train regulatory staff to reduce duplication and increase effective oversight across agencies and address multitude of inspections by various agencies. Eliminate duplication between entities, only if reduction in oversight would not increase the threat of harm to vulnerable elders and persons with disabilities.
6. Require in law that AHCA staff and other agencies involved in ALF's report knowledge or suspicion of any resident abuse, neglect or exploitation to the central abuse hotline (DCF).
7. Allow AHCA to use DCF Adult Protective Services findings and pursue sanctions for repeated verified abuse findings in a facility. (APD recommendation)
8. Authorize for AHCA to deny, revoke or suspend a license if the licensee is a named perpetrator in a verify report of abuse, neglect, or exploitation, similar to APD licensure authority in section 393.0673, F.S. (APD recommendation)
9. Authorize use of DCF Adult Protective Services finding and investigations in employment matters. Section 415.107(8), F.S., states that "...information in the Central Abuse Hotline may not be used for employment screening." The current statutory construct allows for the verified perpetrators of abuse, neglect, or financial exploitation to continue working with vulnerable populations as long as none of those cases subsequently result in prosecution and conviction (under a disqualifying criminal offense). Allowing ALFs (and other providers) to use the information from the abuse registry to screen out such employees during the hiring process would necessitate a change in this law. Such a legislative change would require that DCF offer due process hearings for perpetrators prior to the closure of all abuse investigations with verified indicators.  
Modification of existing administrative rules should also be considered so that any licensee, direct service provider, volunteer, or any other person working in a residential facility who is an alleged named perpetrator in an active protective investigation of abuse, neglect, or exploitation of a vulnerable adult under Chapter 415, F.S., or abuse, abandonment, or neglect of a child under part II of Chapter 39, F.S., are prohibited from working directly with residents or being alone with residents until the investigation is closed. The only exception to this prohibition would be if the alleged perpetrator is under the constant visual supervision of other persons working in the facility who are not also alleged named perpetrators in the same investigation. This provision would only be applicable in situations where the licensee has been made aware of the investigation. (APD recommendation)
10. Enhance DCF Adult Protective Services electronic case management system (Florida Safe Families' Network) to identify trends in abuse, neglect and exploitation by modifying the system to coding investigations by resident setting (facility type). Currently, all institutional reports are lumped under one category. The system could be modified to capture discrete types of facilities, which would enhance our ability to look for patterns and plot frequencies. (DCF recommendation)

11. Improve ability to share information and data efficiently between DCF Adult Protective Services by enabling integration between the Agency for Health Care Administration's licensure data and the provider data which is used as an identifier in abuse reports. This integration would allow for more immediate identification of unlicensed facilities and would improve accuracy of reports particular to individual facilities. (DCF recommendation)
12. Improve ability to share information and data efficiently between APD and AHCA related to ALFs where APD clients reside. (APD recommendation)
13. Consider a document vault to allow off-site compliance review and share information between regulatory agencies.
14. Retain multiple visitors in non-compliant facilities.

### **Home and Community Based Care**

1. Assist people who need to know what choices are available and what supports are available to make the choice successful. Each person should have access to the most integrated setting that allows interaction with non-disabled persons to the fullest extent possible so they can live, work and receive services in the greater community. Opportunities must be available to receive services at times, frequencies, and with persons of an individual's choosing.
2. Promote the development of and expand the use of alternative housing options for older adults who needed housing supports/assisted care.
3. Enable housing choices beyond ALFs including independent and supported living settings with supports necessary to ensure success through the following:
  - Approve AHCA to implement the Money Follows the Person (MFP) funding and authorize the use of Medicaid-financed assistive care payments in facilities other than ALFs.
  - Allow Optional State Supplement (OSS) funding currently spent in facility settings to follow the person into the community.
  - Reinstate money cut from DCF institutional budgets and allow it to follow the person into the community.
  - Fund the Affordable Housing Trust Fund and eliminate funds sweeps.
  - Make supportive housing services available under Medicaid.
4. Create incentives for placement of disabled residents in Adult Family Homes and supported / independent living settings that may not have the economy of scale available to larger ALFs, but do have the ability to provide individualized attention to resident needs in a home-like setting.