

AGENCY FOR HEALTH CARE ADMINISTRATION
ASSISTED LIVING WORKGROUP

FINAL REPORT AND RECOMMENDATIONS

INTRODUCTION

In July 2011, Governor Rick Scott directed the Agency for Health Care Administration (AHCA) to examine the regulation and oversight of assisted living facilities in Florida. In response, AHCA created the Assisted Living Workgroup (AL Workgroup). The AL Workgroup's objective is to make recommendations to the Governor and Legislature that will improve the monitoring of safety in assisted living facilities to help ensure the well-being of residents.

The workgroup included Senator Ronda Storms, Representative Matt Hudson as well as health care association representatives, policy experts, the State Long-Term Care Ombudsman, advocates, and assisted living facility administrators. Dr. Larry Polivka, Director and Scholar in Residence at the Claude Pepper Foundation, served as Chairman of the workgroup and Agency Secretary Elizabeth Dudek and representatives from the Governor's Office participated in each meeting. State agency leadership participation included Charles Corley, Secretary of the Department of Elder Affairs, and representatives from each Agency involved in assisted living facility oversight. The Assisted Living Workgroup held three meetings around the state and heard testimony and presentations from more than seventy-five (75) individuals, including residents, family members, assisted living facility administrators and owners, provider associations, advocates and state agency representatives.

Meetings were held on August 8th in Tallahassee, September 23rd in Tampa and November 7th and 8th in Miami. In addition to public testimony and presentations, the AL Workgroup discussion focused on assisted living regulation, consumer information and choice, and long term care services and access.

The AL Workgroup recommendations are designed to ensure that all residents live in safe environments. The AL Workgroup supported several recommendations that could strengthen oversight and reassure the public that ALFs are safe places for their residents including:

- Increased administrator qualifications,
- Expanded and improved training for administrators and other staff,
- Increased survey and inspection activity with a focus on facilities with poor track records,
- A systematic appeal process for residents who want to contest a notice of eviction,
- Increased reporting of resident data by facilities,
- Enhanced enforcement capacity by state agencies,
- Creation of a permanent policy review and oversight council with members representing all stakeholder groups,
- Requiring all facilities with at least one resident receiving mental health care to be licensed as a limited mental health (LMH) facility and,
- Providing greater integration of information from all agencies involved in ALF regulation in order to identify potential problems sooner.

The AL Workgroup also noted that several other issues, requiring more time to evaluate, be addressed and recommended they be examined by a Phase II workgroup appointed by the Governor. Assisted living policy and regulation has not been addressed in a comprehensive fashion for several years and additional time is needed to successfully complete the task.

Workgroup discussion was detailed and thorough in all areas. Certain issues were not passed as recommendations by the AL Workgroup such as the placement of the Ombudsman Program; however, it was agreed this is an important issue and should be considered in more detail in future discussion and planning.

WORKGROUP MEMBERSHIP AND PARTICIPATION

Public officials, policymakers, advocates and members of the provider community participated on the workgroup as follows:

Larry Polivka, PhD., Chair, The Pepper Center Florida State University
Senator Ronda Storms, The Florida Senate
Representative Matt Hudson, The Florida House of Representatives
Larry Sherberg, Florida Assisted Living Association
Darlene R. Arbeit, Florida Association of Homes and Services for the Aging
Marilyn Wood, Florida Health Care Association
Jim Crochet, Long Term Care Ombudsman, Department of Elder Affairs
Bob Sharpe, Florida Council for Community Mental Health
Ken Plante, Academy of Florida Elder Law Attorneys
Brian Robare, The Villa at Carpenter's
Roxana Solano, Villa Serena I-V
Michael Bay, Eastside Care, Inc.
Martha Lenderman, Lenderman and Associates
Luis E. Collazo, MSW, Palm Breeze ALF

Senator Nan Rich, Senator Rene Garcia, and Senator Eleanor Sobel participated as guests at the Miami meeting.

State Agency Representatives, serving as resources to the AL Workgroup consisted of:

The Office of the Governor was represented by Jane Johnson, Health and Human Services Policy Coordinator

The Office of the Governor was represented by Danielle Scoggins.
Elizabeth Dudek, Secretary, Agency for Health Care Administration
Charles Corley, Secretary Department of Elder Affairs

David Sofferin, Assistant Secretary for Substance Abuse and Mental Health, Department of Children and Families

David Lewis, Director, Medicaid Fraud Control Unit, Attorney General's Office
George Cooper, State Fire Marshal, Department of Financial Services
Susan Rice, Deputy General Counsel, Department of Elder Affairs
Robert Anderson, Director Adult Protective Services, Department of Children and Families
Tom Rice, Operations Review Specialist, Agency for Persons with Disabilities
Molly McKinstry, Deputy Secretary for Health Quality Assurance, Agency for Health Care Administration
Polly Weaver, Chief, Bureau of Field Operations, Agency for Health Care Administration
Shaddrick Haston, Esq., Assisted Living Unit Manager, Agency for Health Care Administration

ASSISTED LIVING REGULATION BACKGROUND

The regulation of assisted living facilities (ALFs) began in Florida with the Legislature's 1975 adoption of the Adult Congregate Living Facilities (ACLF) Act. Since that time, amendments to the ACLF Act created specialty licenses that expanded the list of allowed services beyond basic personal services. In 1987, the Legislature authorized ACLFs to provide "limited nursing services" (LNS). In 1989, "limited mental health services" (LMH) were authorized. In 1991, the Legislature authorized ACLFs to provide "extended congregate care services" (ECC). In 1995, ACLFs were renamed "assisted living facilities" (ALF). In 2006, the regulation of ALFs was transferred from s. 400, F.S., to part I of s. 429, F.S., and named the Assisted Living Facilities Act.

Today, Florida Statute defines an *assisted living facility* as any building or residential facility that provides "housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator." When it created the Assisted Living Facilities Act in 2006, the Florida Legislature sought to promote the availability of services for elderly persons and adults with disabilities "in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decision-making ability of such persons."

CURRENT SITUATION

ALF Services

Today, Florida ALFs range in size from one resident to several hundred and can include individual apartments or rooms that a resident shares with another person. Basic ALF services include:

- Housing, nutritional meals, and special diets;
- Assistance with the activities of daily living (bathing, dressing, eating, walking);
- Administering medications (by a nurse employed at the facility or arranged by contract);
- Assisting residents to take their own medications;
- Supervising residents;
- Arranging for health care services;
- Providing or arranging for transportation to health care services;
- Health monitoring;
- Respite care (temporary supervision providing relief to the primary caregiver); and

- Social and leisure activities.

Some ALFs arrange or directly provide these services to their residents. Others require the resident to arrange their own services as agreed upon in the contract between the resident and the facility. An ALF may employ or contract with a nurse to take vital signs (blood pressure, pulse, respiration, and temperature), manage pill organizers, give medications and keep nursing progress notes. A resident can also contract with a licensed home health care provider for nursing and other health care services, as long as the resident does not become more ill than is allowed in an assisted living facility.

If an ALF in Florida would like to provide any services beyond those allowed in the standard license, a specialty license must be acquired. These licenses allow the ALF to accept residents who need more advanced nursing or mental health care. The specialty licenses are listed below.

Limited Nursing Services: A limited nursing services (LNS) specialty license enables an ALF to provide, directly or through contract, a select number of nursing services in addition to the personal services authorized by the standard license. The nursing services authorized to be provided under this license may only be provided as authorized by a licensed practitioner's order. A nursing assessment that describes the type, amount, duration, scope, and outcomes of services, and the general status of the resident's health, is required to be conducted at least monthly on each resident who receives a limited nursing service. An LNS licensee is subject to monitoring inspections by the AHCA or its agents at least twice a year.

An ALF with a limited nursing services license provides the basic services of an assisted living facility as well as additional nursing services. Some of the limited nursing services are:

- Nursing assessments;
- Care and application of routine dressings;
- Care of casts, braces, and splints;
- Administration and regulation of portable oxygen;
- Catheter, colostomy, and ileostomy care and maintenance; and
- Application of cold or heat treatments, passive range of motion exercises, ear and eye irrigations.

Limited Mental Health: 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.

The LMH license requires basic staff training in mental health issues and requires the ALF to ensure that the resident has a community living support plan, provides assistance to the resident in carrying out the plan, and maintains a cooperative agreement for handling emergency resident matters.

There may be residents with severe and persistent mental illness who have a Department of Community Affairs (DCF) case manager but do not otherwise meet the definition of a mentally ill ALF resident. Since the specialty license is only required if the ALF has three or more “mental health residents,” a facility can serve one or two mental health residents without a Limited Mental Health license (no requirement for mental health training of staff or assistance with the community licensing support plan).

Pursuant to s. 394.4574, F.S., the Department of Children and Families must assure that:

- A mental health resident has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse to be appropriate to reside in an assisted living facility;
- A cooperative agreement to provide case management, as required in s. 429.075 F.S, is developed between the mental health care services provider and the administrator of the ALF-LMH;
- A case manager is assigned for each mental health resident;
- The community living support plan, as defined in s. 429.02 F.S. has been prepared by the mental health resident and a case manager in consultation with the administrator of the facility; and
- The ALF is provided with documentation that the individual meets the definition of a mental health resident.

Each DCF Circuit Administrator develops, with community input, annual plans that demonstrate how the district will ensure the provision of state-funded mental health and substance abuse treatment services to residents of ALF-LMH facilities.

Extended Congregate Care: An assisted living facility with an extended congregate care license provides the basic services of an assisted living facility as well as:

- Limited nursing services and assessments,
- Total help with bathing, dressing, grooming and toileting,
- Measurement and recording of vital signs and weight,
- Dietary management, including special diets, monitoring nutrition and food and fluid intake,
- Supervision of residents with dementia and cognitive impairments,
- Rehabilitative services,
- Escort services to medical appointments,
- Educational programs to promote health and prevent illness.

An ALF is required to perform and document a monthly assessment for residents who are receiving nursing services, including any substantial changes in the resident’s status which may indicate the need for relocation to a nursing home, hospital or other specialized health care facility.

The ALF is required to notify a licensed physician within 30 days when a resident exhibits signs of dementia or cognitive impairment, or has a change of condition, in order to rule out the

presence of an underlying physical condition that may be contributing to the dementia or impairment.

The owner or administrator of a facility is responsible for determining the appropriateness of admission to the facility and for determining the appropriateness of a resident's continuing stay in the facility.

The Comprehensive Assessment and Review for Long-Term Care Services (CARES) program performs a federally mandated function of conducting nursing home pre-admission screening and assessment for Medicaid long term care programs. Persons who are applying for Medicaid-funded nursing home care are assessed by a CARES nurse or social worker, with medical review by a physician prior to approval. One of the program's functions is to assist Floridians in obtaining home and community services to avoid nursing home care. Another function is the continued education of the public, particularly health care providers, about less costly alternatives for long term care.

Medicaid reimbursement for assisted living services is limited to people who are eligible to participate in waiver programs or receive assistive care services. The Nursing Home Diversion Program is designed to provide home and community based services to older persons assessed as being frail, functionally impaired and at risk of nursing home placement. An array of long term care services, Medicaid-covered medical services and Medicare services are coordinated and delivered through managed care organizations (MCOs) contracted with the Department of Elder Affairs.

The facility is required to provide 45 days' notice of the need for relocation or termination of residency unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care, or the resident engages in a pattern of conduct that is harmful or offensive to other residents.

ALF Statistics

Since 2003, the number of Florida ALFs has grown by nearly a third (30.28%). In 2003, a Florida ALF was most likely to be mid-sized (25 beds or less) and serving a diverse resident population as indicated by the number of beds dedicated to extended congregate care (ECC) for medically complex residents, and the indigent as measured by participation in the Optional State Supplementation (OSS) program.

	Number of ALFs	Number of Beds	ALFs with ECC Beds	ECC Beds	ALFs with OSS Beds	OSS Beds
2011	2,960	82,951	277	14,480	1,521	15,686
2010	2,850	81,027	308	16,976	1,505	15,709
2009	2,783	79,302	306	16,882	1,454	15,436
2008	2,643	77,338	302	16,124	1,367	14,665
2007	2,442	75,958	306	15,064	1,249	14,161
2006	2,340	74,317	312	15,316	1,206	13,881
2005	2,291	74,282	327	16,144	1,205	13,992
2004	2,275	74,788	346	17,967	1,179	14,100
2003	2,272	76,714	398	18,853	1,176	14,171

In 2011, Florida ALFs are increasingly small (the majority now house six or fewer beds) and serve an increasingly diverse population after increases in the number of LMH and OSS beds. The number of Florida ALFs serving the limited mental health population increased by over 80% from 2003 to 2011. The number of facilities with OSS beds increased by nearly 30% during the same time period.

The steady increase in the annual total of licensed ALFs (as shown above) understates the impact of new licensees each year. While Florida has had an average annual net increase of 86 new ALFs since 2003, the Agency has also approved an annual average of 125 changes of ALF ownership during the same period. Data gathered since 2009 also documents that an average of 125 ALFs have been failing to renew their licenses each year. This pattern is continuing based on year-to-date information for 2011. All of these factors result in more than a 10% turnover of newly licensed ALFs each year.

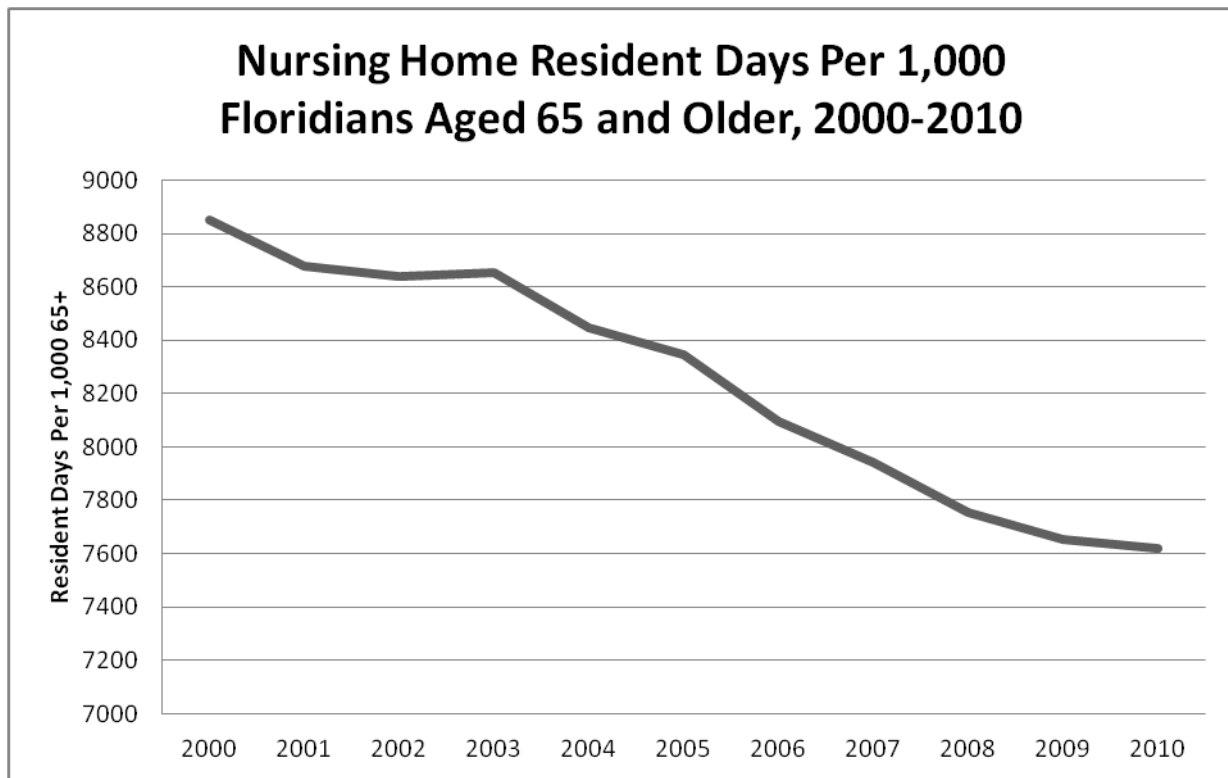
	ALF growth	Bed growth	ALFs ≤ 6 Beds	ALFs ≤ 25 Beds	ALFs with LMH Beds	ALFs with ECC Beds	ALFs with OSS Beds	ECC Beds	OSS Beds
2011	4%	2%	52%	72%	37%	9%	51%	17%	19%
2010	2%	2%	52%	73%	38%	11%	53%	21%	19%
2009	5%	3%	50%	70%	38%	11%	52%	21%	19%
2008	8%	2%	47%	69%	38%	11%	52%	21%	19%
2007	4%	2%	43%	67%	36%	13%	51%	20%	19%
2006	2%	0%	41%	67%	35%	13%	52%	21%	19%
2005	1%	-1%	37%	68%	34%	14%	53%	22%	19%
2004	0%	-3%	38%	66%	33%	15%	52%	24%	19%
2003			37%	65%	27%	18%	52%	25%	18%

ALF Residents

Originally, Florida ACLFs began as residential homes for elderly or developmentally disabled residents who needed limited assistance with daily tasks such as bathing, meals or medications. However, a detailed picture of current ALF residents is very difficult to create due to the lack of data. Assisted living's role as a less intensive residential alternative to skilled nursing facilities has been and continues to be based on assumptions about the resident population: they are those too frail to live alone but not yet in need of full-time skilled nursing care.

This attitude may be changing as the potential interest in resident protection grows. What is clear from existing sources is that the number of very small facilities is increasing rapidly, as is the mental health population. Both of these trends have major implications for assisted living facilities. Regulating a large facility of generally healthy seniors requires a different approach than regulating a five-bed facility serving primarily LMH residents.

It is presumed that Florida ALFs also house persons who once would have been more likely to live in skilled nursing facilities. While there is no Florida data source that can specifically document this trend, it is widely assumed. One of the main reasons for the assumption is the decrease in nursing home utilization that has occurred since 2000. Though the statewide average percent occupancy in nursing homes has remained relatively constant between 85 and 88 percent, the state's elder population has been growing and aging, masking the actual decline in nursing home utilization. The following graphic illustrates the decline by showing a steady drop in statewide nursing home resident days per 1,000 Floridians aged 65 and older.



This drop occurred during a statewide moratorium on the addition of new nursing home beds. When the moratorium began in 2001, there was an expectation, based on the use rates of the 1990s, that Florida nursing homes would be overcrowded by now. The fact that overcrowding has not occurred while the elder population has been growing leads many to conclude that ALFs are housing more frail individuals with diverse and complicated medical issues.

ALF Regulation

Agency licensure activities include processing initial, renewal and change of ownership applications; conducting licensure and complaint inspections; monitoring and citing violations; and sanctioning providers and facilities when serious or repeat violations are identified.

The goal of these activities is to assure compliance with the laws and regulations that safeguard Florida’s health care consumers. However, when the regulations are violated, the law specifies when sanctions are imposed and requires the consideration of several factors prior to imposing a penalty.

Historically, few of the violations cited by the Agency result in patient or resident harm and most are corrected expeditiously. However, any licensee that refuses or fails to achieve regulatory compliance risks closure, license revocation, denial of the renewal license or denial of a change of ownership to a new operator.

The regulation of assisted living facilities is governed by licensure statutes and rules. Basic requirements that are shared with other regulated health care facilities are found in s. 408, Part II, F.S. and Chapter 59A-35 of the Florida Administrative Code. Requirements that are specific to assisted living facilities are found in s. 429, Part I, F. S., and Chapter 58A-4, Florida Administrative Code.

The Agency’s approach to facility regulation centers on: identifying problems (through surveys, complaints or self-reporting); pinpointing their underlying cause(s); ensuring the facility has a plan to mitigate those causes and ensuring the facility effectively implements its plan.

The following tables provide basic statistics about regulatory actions the Agency has taken in ALFs. The first table shows the number of regulatory visits made by field staff in ALFs over the last five fiscal years. The visits include routine surveys, follow-up surveys and complaint investigations.

	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11
Number of Visits	6,274	6,892	6,060	6,455	6,327

Regulatory citations are documented in a Statement of Deficiencies sent to the licensee. Deficiencies are documented with a classification and scope to represent the severity of risk to residents on a scale of I to IV, Class I being most serious and Class IV being minor with no concern of resident risk. The most serious deficiencies are classified as “Class I” if they

represent immediate danger to clients or a substantial probability of death or serious harm. Classification is defined in Health Care Licensing Procedures Act, s. 408.813, F.S. and is uniform across all health care providers licensed by the Agency, except nursing homes which are aligned with the federal definitions.

Classifications are defined in s. 408.813 (2), F.S. as:

(a) Class “I” violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine as provided by law for a cited class I violation. A fine shall be levied notwithstanding the correction of the violation.

(b) Class “II” violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The agency shall impose an administrative fine as provided by law for a cited class II violation. A fine shall be levied notwithstanding the correction of the violation.

(c) Class III’ violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The agency shall impose an administrative fine as provided in this section for a cited class III violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, a fine may not be imposed.

(d) Class “IV” violations are those conditions or occurrences related to the operation and maintenance of a provider or to required reports, forms, or documents that do not have the potential of negatively affecting clients. These violations are of a type that the agency determines do not threaten the health, safety, or security of clients. The agency shall impose an administrative fine as provided in this section for a cited class IV violation. A citation for a class IV violation must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, a fine may not be imposed.

The following table shows the number of violations cited in ALFs over the last five fiscal years.

	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	Total
Surveys	1,726	1,897	1,725	2,114	2,105	9,567
Class I	60	41	55	25	109	290
Class II	256	242	260	215	351	1,324
Class III	11,151	12,025	10,262	12,506	11,696	57,640
Class IV	1,878	2,362	1,257	1,577	731	7,805
Total Class Violations	13,345	14,670	11,834	14,323	12,887	67,059

The amount of assisted living facility fines imposed by the Agency over the last five fiscal years is shown in the table below.

Fiscal Year	Fines Imposed
06/07	\$872,860.16
07/08	\$815,073.27
08/09	\$683,892.83
09/10	\$636,555.50
10/11	\$776,238.44

Shown in the following table is the annual number of ALF license revocations and suspensions from 2006 to the present. The table also contains facilities that have been denied a licensure application and the number of facilities that closed or failed to renew either with a history of legal sanction cases or while an action against the license was pending.

	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	Total
Suspensions	3	0	2	1	2	8
Revocations	3	5	4	12	7	31
Denials of Active Licenses	8	6	11	7	5	37
Closed or Failed to Renew with legal cases (subject of all Closed/ Failed to renew)	38	34	37	40	46	195

Roles of Government Agencies in Assisted Living

In addition to the regulatory oversight of licensure, several other government organizations are involved in assisted living facilities. The Agency works closely with each of these programs and communicates both at the local and headquarters offices. Primary agencies and their roles are described below followed by a chart of primary and other agencies involved in assisted living facilities.

Agency for Health Care Administration

- Health Quality Assurance: Licensing and regulatory oversight,
- Medicaid: State plan reimbursement for assistive care services (no reimbursement for residential ALF care), Medicaid reimbursement through long term care waivers including assisted living and nursing home diversion.

Department of Elder Affairs

- Rule development for assisted living and adult family care home,
- Assisted Living Trainer Certification,
- Comprehensive assessment and review of long-term care services (CARES) reviews.

Medicaid long term care placement

- Administration of the Nursing Home Diversion Medicaid Waiver,
- Statewide Public Guardianship Office assists in guardianship services as appropriate.

State Long-Term Care Ombudsman Program

- Engages volunteer resident advocates to assist residents and families in dialogue with representatives of long term care facilities.

Department of Children and Families

- Adult Protective Services: Investigates complaints of abuse, neglect or exploitation of vulnerable persons including those who live in long term care facilities,
- For mental health residents in ALFs, assists in rule development for Limited Mental Health ALFs, facilitates case management for clients living in ALFs,
- Administration of certain Medicaid waivers.

Agency for Persons with Disabilities

- Individuals with developmental disabilities who reside in ALFs and receive services from the Developmental Disabilities Home and Community Based Services Waiver.

Attorney General

- Medicaid Fraud Control Unit: The Attorney General's Office (AG) investigates allegations of Medicaid fraud. Administers the PANE Project, (Patient Abuse, Neglect and Exploitation), Operation Spot Check, and Attorney General staff may investigate abusive situations in long term care facilities.

Department of Health

- Health and sanitation inspections,
- Licensure and regulatory oversight of health care practitioners working in assisted living facilities.

Local Authorities (ALF)

- Fire and life/safety approval,
- Zoning /building code approval and enforcement.

ASSISTED LIVING REGULATION IN OTHER STATES

Nearly every state has experienced growth in similar types of “assisted living” facilities. Though use of the term “assisted living” is widespread, there is considerable state-to-state variation in the definition. The term is currently used by 41 states but refers to facilities licensed by states as personal care homes, residential care facilities, adult care homes, homes for the aged and other types of facilities. This variation in the definition of assisted living complicates any effort to compare regulatory approaches and outcomes across states.

Few states approach the regulation of assisted living facilities in the same manner. The Agency for Health Care Research and Quality (AHRQ) has found that while all states license and regulate what they call assisted living facilities, these regulations “differ significantly both within and among states, in part because of the lack of a uniform definition of assisted living.” In 1999, the U.S. Government Accountability Office (GAO) found that in general, “State reviews occur every 1 to 2 years, and the results of monitoring activities varied.” An AHRQ review of the Web sites of state licensing agencies found that 48 states post licensing regulations; 46 provide access to a database or list of licensed facilities; 12 post survey findings on their web site; and 14 states post a guide to help consumers learn about and choose a facility. Twenty six states offer information to facility administrators and staff on a web site. The information ranges from licensing application and renewal forms, administrator requirements, bulletins, information about the survey process, technical assistance materials, and incident and complaint forms.

EXECUTIVE SUMMARY

The assisted living community in Florida has witnessed exponential growth over the past eight years, increasing by 30%. Assisted living, a largely consumer choice driven industry, continues to be a home-like, residential model that thrives in the Sunshine State. Section 429, F.S. specifically states that ALFs should be operated and regulated as residences with supportive services and not as medical or nursing facilities. Further, regulations governing ALFs must be flexible enough to allow facilities to adopt policies that enable residents to age in place while accommodating their needs and preferences. When residents age in place, care becomes more complex. The challenge is balancing the provision of appropriate care without compromising the concept of a social or residential model.

This report and the recommendations contained herein, if passed into law, would increase some regulations that have been in place since the 1980’s and continue Florida's tradition of providing the home-like characteristics that have allowed for such growth. As the growth continues, the Agency for Health Care Administration must work with partners such as the Department of Elder Affairs, the Department of Children and Families, the Agency for Persons with Disabilities and the Attorney General’s Office, as well as the provider industry, advocates, families and

individuals to reduce regulation in areas that are overly burdensome, while implementing safeguards and regulations that protect the residents in assisted living facilities.

ASSISTED LIVING WORKGROUP RECOMMENDATIONS

The Assisted Living Workgroup compiled a series of recommendations based on public meetings and member input; all were considered at a final meeting in Miami, Florida. Issues which the Workgroup felt could be addressed immediately were considered Phase I Recommendations.

The workgroup also formulated issues identified separately as Phase II (see *attachment #2*). The Phase II issues are intended to allow an additional six to twelve months of evaluation and dialogue prior to being considered as formal recommendations. Although not all issues had full support of each member; the Phase I recommendations received approval by a majority of members.

Based on the AL Workgroup deliberations, the following recommendations are made:

Consumer Information

1. 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 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.

ALF Administrator Qualifications

1. Raise standards to become an ALF administrator including:
 - Take core training and pass the competency examination, and
 - Be at least 21 years of age, and
 - Have an associate degree or higher from an accredited college (in a health care related field) and (one year experience) working in a health care related field having direct contact with one or more of the client groups or,
 - Have 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,
 - Have a bachelor's degree in a field other than in health care from an accredited college and one year experience working in an ALF or,
 - Have at least two years' experience working in a health care related field having direct contact with one or more of the client groups or,

- Have a valid nursing home administrator's license, or
- Have valid registered nurse license, or
- Grandfather existing administrators with certain training and experience, and no Class I or Class II deficiencies in their past.

Training/Staffing

Core Training

1. Create ALF Core Trainer Oversight program.
2. Authorize DOEA in coordination with DCF related to LMH 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.
3. 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:
 - 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 at least 8 additional training hours for all administrators employed or to be employed in an Extended Congregate Care and Limited Mental Health licensed facility and,
 - Competency test available through a testing center, the cost of which is paid by the test fee.
4. Raise the passing score for the Core exam from 70% to 80%.
5. 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.

6. Develop supplemental core competency exams for ECC and LMH licensure.
7. Explore the use of a system similar to that used by the Department of Health to track compliance with statutory requirements and recognize continuing education requirements for licensed health care professionals toward assisted living requirements.

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 a two-year period in topics similar to the initial core curriculum.
4. Establish in statute a procedure similar to that used by the Department of Health in s. 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.
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. 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. Allow competency test to be made available through testing centers with the cost to be covered by the test fee.
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.

Limited Mental Health Training

1. Increase training for LMH facility staff, provided by mental health professionals and including an emphasis on aggression management and de-escalation techniques.
2. Require all staff members who have contact with residents with mental health issues 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. Increase the training hours for staff members working in facilities with an LMH license from 6 hours of limited mental health training to 8.
5. Require staff members to complete a test following their training in mental health and score a minimum of 80%.
6. Allow the Department of Elder Affairs to monitor and sanction trainers providing the mental health training course.
7. 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, as defined in statute, more frequently than once every two years. Require more frequent and extensive inspections of those facilities that have recurring or observed deficiencies.
2. Allow AHCA to approve accreditation 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.

3. Acknowledge CARF accreditation and allow lighter inspections.
4. 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.
5. Require a specific number of lead surveyors in each area office to specialize on ALF inspections and be dedicated to ALF inspections only.
6. Require dedicated AHCA staff to monitor surveyors and the field work to ensure consistency in inspections, citing deficiencies, and enforcement throughout the state.
7. Assess AHCA inspection forms. Create a workgroup that includes Ombudsman members and stakeholders to assess AHCA inspection forms to assure they adequately assess ALF compliance with the law, resident protection, and meeting resident needs.
8. 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.
9. Exercise caution when making changes to any business or industry to avoid having unintended consequences.

Licensure

1. 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.
2. Utilize the provisional license permitted in s. 429, F.S., for initial licensure, then followed up within a specified period after the facility has opened, to conduct the more complete survey.
3. 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. Align with the requirements in s. 408.815, F.S. that allow mitigation. This provision would require disclosure of property ownership.

Resident Discharge

1. Reduce the resident discharge notice from 45 to 30 days and provide an option for the resident to appeal with a decision within 10 days. The entire appeal process should take no longer than 45 days.

2. Clarify that a temporary transfer such as a Baker Act is not a discharge and the resident may return to the facility once released.
3. Mandate that social workers and discharge planners provide a completed AHCA 1823 Form to the assisted living facility administrator to ensure appropriateness of the resident's admission.

ALF Information and Reporting

1. Require minimal online data submission to the Agency on a quarterly basis. 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
2. 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.

Enforcement

1. Enforce existing regulations, and retain due process protections for providers.
2. 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.
3. Require a mandatory moratorium for serious violations (Class I or II), 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.
4. 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.
5. 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) F.S.] 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.

Resident Advocacy

1. 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.
2. An employee or volunteer of the Office of Long Term Care Ombudsman shall be required to report, with the resident's consent, all instances of resident retaliation exercising rights guarantee pursuant to s. 429.28, F.S., the resident bill of rights. The Agency is required to impose a sanction for this violation regardless of the deficiency classification. The Agency shall not be required to reinvestigate the incident if the Office of the LTCOC provides a certification that this was an investigation by the Office and the incident was confirmed.
3. Ensure volunteers have the right to visit licensed programs at any time for purposes of monitoring as well as for complaint resolution. All observations and findings should be submitted to AHCA and acted on in an expedited manner.
4. Contact former members of the State and Local Advisory Council 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.
5. 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.
6. Encourage ALFs to 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 a Limited Mental Health (LMH) license for ALFs with any mental health residents. The current 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. Change the definition to require an ALF that serves one or more mental health residents as defined in statute to obtain a limited mental health 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.

Multiple Regulators

1. 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.
2. 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 DCF abuse hotline.
3. Improve ability to share information and data efficiently between the Long Term Care Ombudsman Program, DCF Adult Protective Services and AHCA by enabling integration between Agency for Health Care Administration's licensure data and the provider data which is used as an identifier in abuse reports and the Ombudsman Program. This integration would allow for more immediate identification of unlicensed facilities and would improve accuracy of reports particular to individual facilities.
4. Improve ability to share information and data efficiently between APD and AHCA related to ALFs where APD clients reside.

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.