

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.

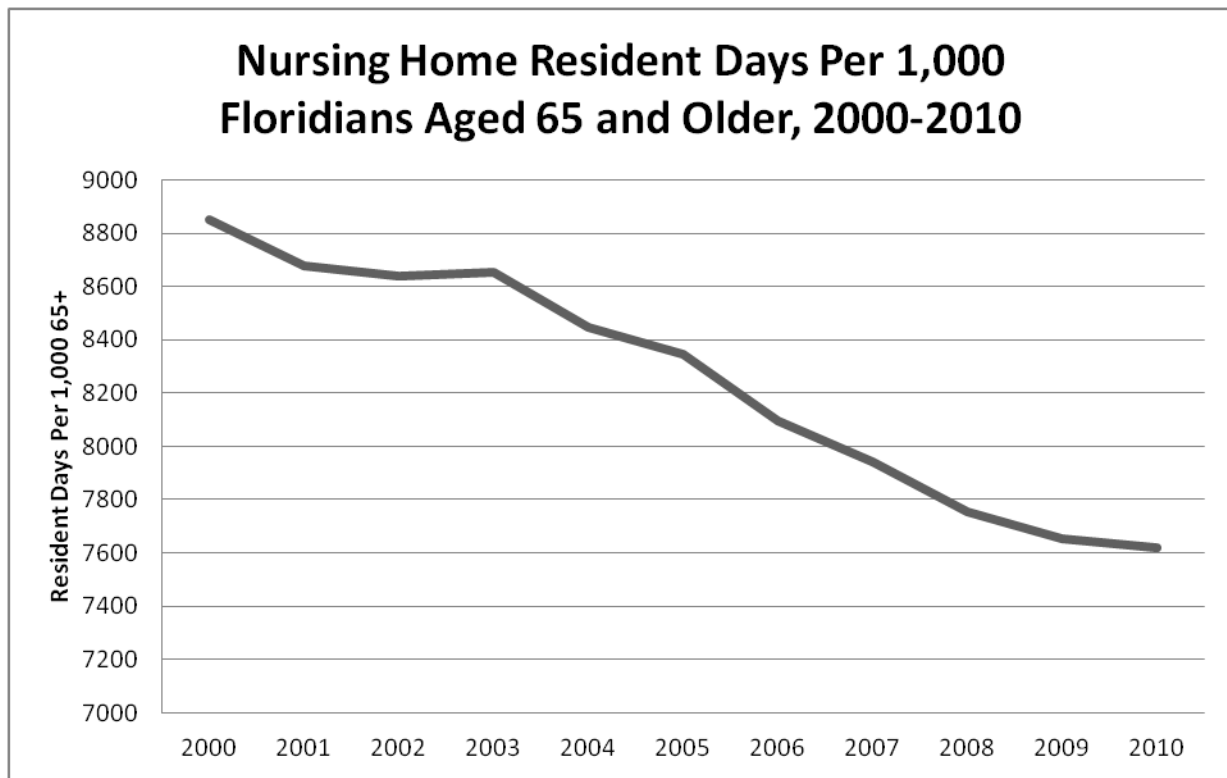
	ALF growth	Bed growth	ALFs ≤ 6 Beds	ALFs ≤ 25 Beds	ALFs with LMH Beds	ALFs with ECC Beds	ALFs with OSS Beds	ECC Beds	OSS Beds
2011	4%	2%	52%	72%	37%	9%	51%	17%	19%
2010	2%	2%	52%	73%	38%	11%	53%	21%	19%
2009	5%	3%	50%	70%	38%	11%	52%	21%	19%
2008	8%	2%	47%	69%	38%	11%	52%	21%	19%
2007	4%	2%	43%	67%	36%	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 ALFs 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.

AL WORKGROUP ACTIVITIES

The Agency for Health Care Administration hosted the first statewide meeting on August 8, 2011 in Tallahassee, Florida.

Members heard presentations from AHCA staff on The Sunshine Law and the AL Workgroup Charter.

Specific information is below:

Richard Shoop, AHCA Agency Clerk, gave a presentation of the Sunshine Law. He stated the Assisted Living Workgroup is subject to the Sunshine Law and explained the definition and history of what the Sunshine Law means. Mr. Shoop discussed basic requirements, how meetings are conducted and noticed, meeting minutes, public records and confidential information. He stated that meetings are open to the public, and reasonable notice must be given. Any gathering of two or more Assisted Living Workgroup members to discuss business of the workgroup constitutes a public meeting that must be properly noticed.

Molly McKinstry, Deputy Secretary, HQA, provided a review of the AL Workgroup Charter and priorities. State agency representatives are resources to the Assisted Living Workgroup, the term of the Assisted Living Workgroup is one year and a quorum is eight members. The duties of the Assisted Living Workgroup are to research and evaluate and make recommendations. There is no compensation for travel. The Assisted Living Workgroup will operate under Roberts Rules of Order.

Members heard the following stakeholder presentations with suggested recommendations:

American Association of Retired Persons (AARP). Mr. Jack McRay, Advocacy Manager, presented by telephone. Ms. Laura Cantwell represented AARP at the Assisted Living Workgroup. AARP is interested in a viable Assisted Living Facility community and the best place for consumers. These same problems existed 30 years ago and statutes are adequate but reality is different. AARP believes we need stronger credentials for owners, managers and controlling interests, and those consumers must have reliable and transparent information for good decision-making. Florida consumers also need more ombudsmen and better training for the volunteers. Disturbing trends, AARP noted, are tort reform that threatens consumer protections, and remedies and inappropriate assessments and placements. AARP supports greater use of Home and Community Based Services, but only if consumers are getting the care they need in those facilities.

AARP recommends:

- The Ombudsmen should be independent and not regulators,
- Focus should be on “early intervention” for problem assisted living facilities,
- The Legislature should consider establishing local or regionally-based rapid-response teams,

- Provide strong punitive actions for egregious and preventable harm to Assisted Living Facility residents and,
- S. 429.11(2) and 429.275(3), F. S., be amended to establish a minimum amount of liability insurance and, State attorneys need to be aware of elder abuse.

Disability Rights Florida, Dana Farmer, Director of Public Policy for Disability Rights. Ms. Farmer made a presentation on Residential Options for People with Disabilities, and stated that the organization's work is focused on assisted living facilities with a limited mental health license. Integrated and segregated settings were discussed, and information was provided on interviews with Assisted Living Facility/Limited Mental Health residents, residential options and informed choice and discharges from state mental health facilities.

Disability Rights Florida suggests the following recommendations:

- Develop an accurate count of people with mental illnesses with SSI/Medicaid/OSS (Optional State Supplementation) who reside in Assisted Living Facilities with Limited Mental Health,
- Move funds from the Florida Department of Children and Families (DCF) institutional budgets to follow the people being discharged into integrated residential options,
- Allow OSS funds now used in facility settings to follow the person into integrated settings,
- Permit AHCA to use the Money Follows the Person grant it was awarded and,
- Hedge the depletion of the Affordable Housing Trust Fund.

Florida Assisted Living Association (FALA). Alberta Granger, Assisted Living Specialist, presented information on fragmented regulations, flaws in the initial survey process, survey inconsistencies and problems with core training and trainers. Emphasis was on licensure requirements that are disseminated among various departments and agencies, such as, AHCA, DOH (Department of Health), DOEA, the local fire marshal and local zoning, and that providers are confused.

FALA recommends:

- Appropriately return place the Assisted Living Facility licensure and regulatory provisions to Part I, Chapter 429, F.S.,
- Make the Assisted Living Facility website more provider-friendly,
- Develop a financial statement that is appropriate for a residential program,
- Utilize the provisional license criteria in Part I, Chapter 429, F.S.,
- Require assisted living facility surveyors to take core training and the required 12 hours of continuing education,
- Re-evaluate the Assisted Living Facility training requirements for administrators and caregivers,
- Properly vet on-line training with DOEA, trainers and other stakeholders,
- Develop language in rule which will give enforcement authority to deal with non-compliant trainers and,

- Require trainers to meet a minimum number of trainings per year, as required by rule, and include in rule provisions that non-compliant trainers will be decertified.

Florida Association of Homes and Services for the Aging (FAHSA). Carol Berkowitz, Esq., Sr. Director of Compliance and Legal Affairs presented the following recommendations on behalf of FAHSA:

- Survey Process: Improve survey consistency; implement joint training for providers and surveyors, focus on Assisted Living Facilities with serious regulatory problems and implement an abbreviated survey process for better than average Assisted Living Facilities
- Consumer information: Strengthen information available to the public to allow informed decision making when selecting an Assisted Living Facility.
- Regulations while providing Quality of Care: Retain provider flexibility to offer diverse service packages and set residency criteria within parameters established by law, recognize that Assisted Living Facilities are not homogeneous, avoid increased regulations, focus on early detection of serious regulatory problems, evaluate current public policy to determine if Assisted Living Facilities should be given authority to provide services, eliminate LNS and allow Assisted Living Facilities with a nurse on staff to provide the same services, encourage coordinated communications among state agencies regarding resident care, increase communication between case managers to coordinate care and require Medicaid case managers to immediately report Assisted Living Facility quality of care problems to AHCA.

Florida Council for Community Mental Health. Dr. Jay Reeve, CEO, Apalachee Center and Chair, Florida Council for Community Mental Health, presented. There is concern about individuals with severe mental illnesses being warehoused in Assisted Living Facilities with limited mental health licenses that provide inadequate care. These individuals lack purposeful, daily activities.

The Florida Council for Community Mental Health recommends:

- Regulation of the Assisted Living Facility industry must be aggressive and by-the-book, and failure should result in fines and moratoriums. Repeated evidence of facility deficiencies should result in the loss of its license,
- Explore alternative mixed-housing models that take advantage of economies of scale, while diminishing the segregation and isolation of older adults and disabled individuals in separate housing,
- Study those facilities that provide excellent care with no more per-resident-revenues than those that provide substandard care,
- Identify and visit successful housing models in Florida and other areas of the country,
- Broaden the housing choices for people with mental illnesses, letting them choose how to use their housing and economic assistance supports,
- Challenge communities and the private housing sector to develop attractive and affordable housing alternatives (e.g., New Orleans new low-income and mixed housing communities) and,

- Revisit the level of OSS or other forms of subsidy needed for decent housing.

Florida Health Care Association (FHCA). Marilyn Wood, President and CEO, Opis Management Resources and FHCA Board of Directors, presented. Factors to consider are: concerns over quality; regulatory requirements and public expectations of long term care; the increasing complexities of residential long term care; consideration of boomers’ needs versus available resources; access to services; differences in assisted living services throughout the state; concern that Assisted Living Facilities do not become poorly-resourced nursing home; Medicaid waivers; Florida’s managed long term care system; Optional State Supplementation and, Medicaid funding for limited mental health assisted living facilities.

FHCA recommends:

- Consider the possible elimination of multiple licenses, except limited mental health,
- Work together to develop an improved oversight system that focuses the state surveyors’ work on the more troubled facilities rather than those Assisted Living Facilities with a history of providing good care and with satisfied residents and staff,
- The Assisted Living Facility “Residents’ Bill of Rights” and the decision-making of “appropriate placement” are the hallmarks of the discussion of good care and,
- There is an important need for more data on resident characteristics, services provided, quality of care and costs.

Florida Long Term Care Ombudsman. Colonel Don Herring presented. Colonel Herring offered that problems identified could have been avoided if providers were properly trained, specifically regarding medication administration and the Baker Act. He further stated that many residents are borderline nursing home residents.

Solutions:

- Design a program of instruction using the mental health field as a model,
- Raise the minimum passing score for core training to 80,
- Provide more mental health training.
- Administrators should be responsible for all situations in an Assisted Living Facility,
- Residents should be given appeal rights for terminations,
- All new Assisted Living Facility providers should be required to receive 40 hours of training including a component on culture change,
- License Assisted Living Facility administrators like nursing home administrators and,
- Provide more staff to AHCA to increase the number of surveyors

Florida Peer Network, Lin Rayner, Policy Director for Florida Peer Network, presented Rose Delaney’s paper, as Ms. Delaney was unable to attend. Ms. Delaney is a consumer advocate, a peer specialist and has personal experience with the issues.

Ms. Delaney suggests the following recommendations:

- Add consumers and family members to the workgroup. Specifically, four (4) members representing assisted living facilities need to step down and,

- Florida has over 1,000 peer specialists and they should monitor facilities on a monthly basis.
- Peer specialists indicate that peers are afraid to speak up for fear of retaliation.

Joan Andrade, mental health professional and consumer advocate presented on behalf of residents of assisted living facilities. Ms. Andrade’s presentation focused on advocacy, safety and well-being of residents, coordination with state advisory council members and ombudsmen, increased training requirements for assisted living facility staff and administrators, specifically relating to limited mental health facilities, residents receiving OSS, assisted living facility administrators as representative payees, residents’ fear of speaking out, residents being hungry and dietary issues in assisted living facilities, resident rights and strengthening and enforcing regulations.

National Association of Mental Illness, Florida (NAMI, Florida). Judi Evans, Executive Director, presented. Ms. Evans encouraged the workgroup to speak to Assisted Living Facility residents and look at their quality of life. She provided information on a NAMI pilot program, Personal Outcome Measures, funded by the Department of Children and Families. The findings of the pilot were that assisted living facility staff who had direct contact with persons who had a mental illness were not educated on the illness. They lacked empathy, communication skills, and an understanding of the biology of the illness. There was a lack of understanding that persons with a diagnosis were not in control of their behavior. This often results in frustration and anger. NAMI Florida would like to see better mental health education for Assisted Living Facilities.

Sean Cononie, Director, COSAC Homeless Shelter. Mr. Cononie’s presentation focused on homelessness and the needs of homeless people. Some of the issues in homeless shelters include: medication administration, the roles of the Attorney General’s Office and of Adult Protective Services investigators, fees paid by residents, health care surrogates and power of attorney.

Mr. Cononie suggests the following recommendations:

- License homeless shelters as Assisted Living Facilities,
- Develop a task force on homeless shelters and,
- Provide training on services provided in homeless shelters.

Florida Life Care Resident’s Association (FLiCRA), Charles Polk, President, Florida Life Care Residents Association, presented. FLiCRA has over 13,000 members, living in 53 community care retirement centers throughout the state.

FLiCRA suggests the following:

- Allow the provision of adequate floor plans that will allow an independent living spouse to reside in a living unit with their Assisted Living Facility qualified spouse,
- Consider adding a provision to the Assisted Living Facility statute that establishes a family/resident council similar to what is found in s.651, F.S.,
- Provide transparency of state monitoring reports and,
- Provide transparency of financial reports of provider organizations that own or operate the Assisted Living Facility.

The University of South Florida, Gibbons Alumni Center, Tampa, Florida, hosted the second statewide meeting on September 23, 2011.

The following presentations and public comment were made:

Doug Adkins, Administrator, Dayspring Village provided a presentation on Frontline Forecaster, a joint venture project to bring intuitive technologies to the frontline of care and to use the data to help forecast future trends in assisted living facilities.

Mr. Adkins provided testimony about ALFs with limited mental health specialty licenses. He described the cooperative agreements; the relationship between residents and staff; the use of technology; systems of care; supervision of clinical needs; real time training; identification of best standards/practices; competent qualified administrators; and suggested the workgroup look at other states for a quality regulatory model.

Austin Curry, Resident. Mr. Curry testified that he places the highest value on human life and is repelled by the horrible conditions of some assisted living facilities. He believes licenses should be revoked for a minimum of five years and that facilities and persons responsible for abuse and neglect should be incarcerated.

Susanne Matthiesen, Managing Director of Aging Services, Commission on Accreditation of Rehabilitation Facilities (CARF). Ms. Matthiesen provided a presentation on CARF, an international accreditation organization. She testified that providers that work toward accreditation implement standards within their organizations that address quality of care and good business practices with the goal of improving quality. Almost 800 providers are accredited in Florida in the areas of behavioral health, assisted living, continuing care retirement communities, home and community based services, rehabilitation and employment and community services. CARF is willing to work with the Assisted Living Workgroup, AHCA and all stakeholders to develop approaches that strongly prompt providers in Florida to achieve CARF accreditation as a way to improve the field in the short term and elevate it through performance improvement over the long term.

Henry Parra, Owner, Genesis Care Centers and founder, Assisted Living Member Association (ALMA). Mr. Parra described AHCA as being in disarray and stated ALMA was founded to cover the gaps in AHCA. He stated that Hispanic residents and providers of ALFs have needs that people don't understand. He stated there is a disconnect between providers and further described difficulties he has as a provider working with hospitals that are discharging residents back to the ALF. Mr. Parra appreciates that the next AL Workgroup meeting will be in Miami/Dade. He believes ALFs have been tarnished by the Miami Herald and all providers are not like what was described in the articles.

Lyn Dos Santos, previous volunteer, Long Term Care Ombudsman Council. Ms. Dos Santos testified that conditions in ALFs are deplorable and that the frequency of inspections should be increased. She urged the workgroup to read the Administration on Aging's compliance review

of the State of Florida Long-Term Care Ombudsman Program. She believes the ombudsmen should be autonomous and that ombudsmen are afraid to do their jobs.

Brian Lee, former Ombudsman and current director of Families for Better Care. Mr. Lee testified that the Miami Herald did a comprehensive investigation of ALFs and that there are many good, decent facilities but regulators have looked the other way. He believes that bad providers have soiled the good providers and that there needs to be increased scrutiny of a broken industry. He rejects the notion of an abbreviated survey and questioned the criteria used for determining which facilities are eligible. Mr. Lee testified that sanctions need to be paid within 30 days. He encouraged DOEA to finalize the rule regarding the Ombudsman assessment and recommends there be an assisted living facility guide.

Gloria Smith, Florida Gulf Coast Chapter of the Alzheimer's Association. Ms. Smith provided testimony about Alzheimer's disease and the impact on residents in ALFs. She stated that one in ten people develop Alzheimer's disease and that 50% of residents in ALFs. She provided examples of residents with Alzheimer's disease specifically with wandering, hiding and residents not answering to their names. She stated that training can prevent and solve many problems.

Roy Gifford, former ALF resident from Tampa, currently in supported living. Mr. Gifford testified that he has been in a number of ALFs through-out his life and he is currently 40 years old. There were a number of issues and some facilities were good and were not. He has also been in adult foster care. He wants his message to be that there needs to be more structured activities and things to do in ALFs. He believes that AHCA should check out facilities more frequently. He lived in an ALF in Dunedin and had a positive experience and believes that there should be a council to look over facilities more often. He is here to share his experience and hopes with ALFs.

Damon Thomas, Senior Regional Director, Emeritus Senior Living and VP Florida Assisted Living Association. Mr. Thomas provided background on Emeritus Senior Living and his personal background with aging family members, specifically his grandfather. He testified that he believes taking care of the elderly is why all stakeholders are here today at the workgroup meeting and he is disheartened to hear of the recent problems in ALFs. He believes better collaboration between all agencies is necessary as well as better enforcement of the regulations.

Charlie Paulk, Florida Life Care Residents Association (FLiCRA). Mr. Paulk testified that he is a resident of The Carpenters in Lakeland and he is president of FLiCRA, a continuing care advisory council. He stated that we need to protect seniors from providers that do not provide good service and the average age of a resident is 85. He urged the AL Workgroup not to make any recommendations that would duplicate s. 651, F.S. He further stated consumer choice is important in deciding where to live.

Krone Weidler, President, Florida Assisted Living Association (FALA) and owner, Royal Sun Park. Ms. Weidler testified that FALA is committed to cooperate. She stated that ALFs are in higher demand than in the past which has resulted in greater scrutiny and that the Miami Herald focused on atrocities and cases of abuse and neglect are unacceptable. She referenced the 84,000 residents in ALFs and the media focused on less than 1/2 of 1% of all facilities. Ms. Weidler

testified that the media coverage is unjust and offensive and that FALA has aggressively sought mechanisms to advocate for residents. She believes FALA has been misrepresented and referenced the medical review team legislation. She testified that Ombudsman think they are surveyors and regulators and she supports ombudsman as resident advocates. FALA does not support facilities that don't offer high quality of care.

Judith Turnbaugh, advocate. Ms. Turnbaugh testified from three perspectives; as a family member, advocate and provider of services. She has a brother with schizophrenia and additional family members with mental illness. She is a two term president of NAMI Pinellas County and has a passion for people who cannot represent themselves. She described ALFs as homes for individuals with mental and physical disabilities and that these individuals need a safe, clean home whether they are small ALFs or very elegant senior living facilities. Some residents require more care than others and many ALFs provide excellent care. Threatening residents not to speak up victimizes residents. It is difficult for small ALFs to stay in business and constant education is needed. Staff turnover is high. She recommends that the Ombudsman and Local Advocacy Council be cross trained to do regular inspections. She stated that NAMI could provide training to staff members at the ALFs.

Rose Delaney, advocate. Ms. Delaney began her testimony by stating that she is passionate about advocating for individuals with mental illness and feels like pounding her fists. She has lived with her mental illness her adult life and believes she had it since early childhood. She has heard some hurtful remarks about individuals with mental illness and believes they are thought of as cast offs. Ms. Delaney believes there should be a consumer representative on the workgroup and she asked workgroup members if any of them had every had a psychological breakdown, attempted suicide, been arrested, baker acted, homeless or have lost custody of their children because of a mental illness. She stated people with mental illness are human beings and need to be treated equally.

Alvin Dozier, former ALF resident. Mr. Dozier testified that he lived in ALFs all his life and in 2006 was in an ALF in Tampa. He got into an argument with one of the staff and was stabbed in the head with a pen and was Baker Acted. He testified that the facility stated the argument was his fault. He left the facility due to health reasons and is currently living independently and enjoys his freedom.

Jose Dunasso. Mr. Dunasso has lived in retirement homes and has found some conditions to be appalling. He testified that he could not place loved ones there and believes that AHCA fails to enforce regulations. He provided information about an administrator he believed ruled with an iron hand. He stated that the well-being of residents is his priority and advocates for more funding for the nursing home diversion and frail elder programs. He believes that a limited mental health waiver should be created.

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Alvin Dozier, former ALF resident. Mr. Dozier testified that he lived in ALFs all his life and in 2006 was in an ALF in Tampa. He got into an argument with one of the staff and was stabbed in the head with a pen and was Baker Acted. He testified that the facility stated the argument was his fault. He left the facility due to health reasons and is currently living independently and enjoys his freedom.

Jose Dunasso. Mr. Dunasso has lived in retirement homes and has found some conditions to be appalling. He testified that he could not place loved ones there and believes that AHCA fails to enforce regulations. He provided information about an administrator he believed ruled with an iron hand. He stated that the well-being of residents is his priority and advocates for more funding for the nursing home diversion and frail elder programs. He believes that a limited mental health waiver should be created.

Richard Durestein, professional guardian. Mr. Durestein has 60 wards and he provides independent oversight. He expressed the need for the local advocacy council to coordinate with a statewide council. He believes that ALFs were shut down because of his work as a professional guardian. He described ALFs with roaches throughout and testified that ombudsmen are the answer. He recommends having an ombudsmen council specific to mental health.

Ben Caretenuto. Mr. Caretenuto represents 53 facilities in Florida. He recommends better training and specifically Alzheimer's disease training. He testified that monetary damage is not the answer and that there have been massive cuts to the nursing home industry. He stated it is easy to point fingers unless someone has been where he has worked. He believes in taking care of people.

Anna Small, Assistant General Counsel, Regulatory Care, LaVie Care Center. Ms. Small commented on AHCA's administrative process and she believes the process is fair and that there is a check and balance in the system. She stated all providers that are regulated have the right to challenge any action AHCA takes. She is concerned that we may see the Agency's discretion taken away.

William Teague, former Ombudsman. Mr. Teague believes the vast majority of facilities are helping residents and a minority of facilities has damaged the image of ALFs. He focused on the following issues: lack of training; ALFs having residents that should be in a nursing home and problems with medication administration. He testified that limited mental health residents would historically be in a state hospital.

Sandra Hall. Ms. Hall testified that she owns two ALFs in the Florida Panhandle. She referenced current administrator requirements of being 21 years of age and believes that work experience should be able to substitute. She spoke of Ombudsmen needing to talk to residents

instead of reviewing paperwork and believes the cost of care in an ALF should be higher. She testified that residents pay approximately \$9 a day and \$1000 per month is the poverty level. She has had residents since 1999 and many have mental health problems. She currently has 75 residents and stated she cannot group everyone together as they are all different. She is currently awaiting approval from AHCA for additional beds.

Susan Lang, advocate. Ms. Lang is working on a system of care and has a mental illness. She has training and expertise in helping mental health residents and believes being a provider is more than being able to just pass a test and that life experience is needed.

Dr. Kathryn Hyer, Director of the Florida Policy Exchange Center on Aging, University of South Florida (USF). Dr. Hyer made a presentation on the University of South Florida's role in long term care and aging studies. She distributed a packet containing abstracts of different studies and policy briefs and stated that USF has the oldest program in the state for long term care administration. The program has been training nursing home administrators since 1983.

Dr. Hyer recommended expanding the jurisdiction and membership of the Board of Nursing Home Administrators to include establishing and enforcing new standards for Assisted Living Facilities.

She described various studies including:

- The type of individuals in nursing homes and,
- The mental health needs of residents, numbers and risk factors for unnecessary hospitalizations in ALFs and nursing homes as well as services needed.

She stated the needs of individuals in ALFs are greater than the number of staff hours required. Dr. Hyer urged the committee to provide consumers with information about making informed choices and to develop a web-site similar to the federal nursing home compare website. She also recommended that during the inspections AHCA collect information that helps consumers such as: name, age, payment source and diagnosis or information on ADL needs. Further, Dr. Hyer stated that Florida needs a minimum standard of ALF care and enough information routinely reported that consumers can use to make the market for assisted living work. She asked that the workgroup create better information, improve the inspections, consider increasing staffing levels, and improve staff training and make administrators more professional.

Douglas Coffee, owner Dunedin ALF/LMH. This facility was previously Rosalie Manor, a limited mental health facility. He testified that providing services to elders and individuals with mental health problems is like comparing apples to oranges. He stated that more focus needs to be on education and support for limited mental health. Mr. Coffee testified that he has received good support from AHCA.

Mr. Valdez, State Fire Marshal's Office, Regional Supervisor, SW Region. The local fire marshal testified that the current standards follow the 1994 code and 69A-40, Florida Administrative Code.

Brad Lamb, ALF resident. Mr. Lamb testified that he has been attending mental health programs for 16 years and he receives treatment for a bi-polar disorder. He currently resides at Castle Court ALF and has been “stuck” there for years. He stated that he would like to get involved with classes at USF and attend work programs.

Benjamin Voss, resident, Shady Oaks ALF. Mr. Voss has lived at Shady Oaks ALF for 3 years and stated he is satisfied he has had a hard time adjusting. He heard of a case in Plant City where a developmentally disabled person stepped in a pile of ants and they “came down” on him.

Terrence Dixon, ALF resident. Mr. Dixon has resided at Castle Court ALF for 8 years and he is satisfied with it. He would like to receive all of his personal needs allowance at one time so that he can purchase items such as soap, towels and rags.

Rosie Adams, ALF resident. Ms. Adams lives at Shady Oaks ALF and has been out of the hospital for 10 years and is proud of it. Her husband died a few years ago and they provided her a place to stay. She has seizures but helps the staff out when they need it. She spends a lot of time in her room alone.

Deon Crouch, resident. Ms. Crouch lives at Jeannette Boston ALF in Tampa and testified that she had a horrible experience this morning. Ms. Crouch receives medications that every four hours as needed. She took her 6:00 am medications and asked the med tech for them at 10:00 and the response was that she did not need it. The med tech looked in the med book and told Ms. Crouch to do it herself and threw the med card at her.

She testified that she called DCF and stated the woman that answered the phone did not take her seriously and did not take the report. She then called AHCA to file the report and to report that the facility does not have a resident phone, only a business phone. She told the staff she was talking with a state agency and the staff member unplugged the phone. Ms. Crouch came from an ALF in Plant City where she was given a 45 day discharge notice. She has been out of one of her medications for 5 days and staff at the ALF failed to notice. Her diagnosis is major depression.

Molly McKinstry, Deputy Secretary, Health Quality Assurance. Ms. McKinstry provided a presentation on AHCA’s ALF regulatory and licensure process. She described the state and local government responsibilities and introduced other state agency representatives: Susan Rice, DOEA, Robert Anderson, DCF, Betty Zahcam, AG’s Office, Tom Rice, APD and, Polly Weaver, AHCA.

The presentation included information about:

Assisted Living Growth,
AHCA Inspections,
Regulatory Oversight Revisions,
The revised Assisted Living Survey,
The Abbreviated Survey,
Regulatory Violations and Deficiencies
Regulatory Sanctions

Consumer Information and Outreach and,
Outreach Activities.

Ms. McKinstry also made a Medicaid presentation for Darcy Abbott who was not in attendance. The presentation included information about Medicaid Reimbursements in Assisted Living Facilities, specifically:

Assistive Care Services,
The Assisted Living Waiver and,
The Nursing Home Diversion Waiver.

Robert Anderson, Deputy Secretary, Department of Children and Families, Adult Protective Services. Mr. Anderson provided a high level presentation of the adult protective services law, s. 415, F.S. and the APS system and how it interfaces with AHCA and ALFs.

David Sofferin, Deputy Secretary, Department of Children and Families, Substance Abuse and Mental Health. Mr. Sofferin provided a high level overview of DCFs role in the ALF process. He spoke of the interagency agreement between DCF and AHCA. He stated that housing for individuals with behavioral health issues is the next initiative for the Substance Abuse and Mental Health Program and the goal is community inclusion.

Florida International University (FIU), Miami, Florida, hosted the third AL Workgroup meeting at the Stadium Club at Alfonso Field, November 7-8, 2011.

Public testimony from the following individuals was heard:

Dr. Bill Lanpher, Dr. Lanpher is a resident at Shell Point ALF in Ft. Myers, Florida. Shell Point is a Continuing Care Retirement Community and is the home of twenty-three hundred residents. He reports that he and his wife enjoy high quality of care and he is astonished at the findings in the newspaper articles. Shell Point ALF is a full service retirement community and he has a right to transfer or leave at any time.

Mrs. Jean Field, Mrs. Field has lived the last one and one-half years at Shell Point ALF in Ft. Myers, Florida. She is a Registered Nurse with a Master's Degree and receives great care at the ALF. Mrs. Field works in the store at Shell Point and all of her customers are satisfied. She is "shocked" at the recent press reports. She believes the facilities providing good care should not be tarnished by those that provide poor care.

Jerome Silverberg, Mr. Silverberg is a professional guardian and a second generation Floridian. He believes people in Florida should be protected and that professional guardians need to be in a number of facilities.

Pam Ford, Ms. Ford is a peer services coordinator and works with severely and persistently mentally ill persons. She reports that private providers, not community mental health services, are billing Medicaid for services they have not provided.

Linda McClamma, Ms. McClamma oversees an 83 unit assisted living facility and stressed the importance of the social model, allowing a flexible management process. She spoke of the minimum staffing hours per resident for direct care, nursing services coverage, increased educational requirements for ALF administrators and the bed hold policy.

Stacy Daniels-Dattilo , RN Manager of The Arbor at Shell Point Retirement Community in Ft. Myers, Florida, Ms. Dattilo and supports stronger educational requirements of ALF administrators. She believes nurses should be able to work to the fullest extent of their licenses in a standard ALF.

Jose Duasso, owner and operator, Assisted Living Retirement Homes I, II, II and Cutler Bay Village, ALF. Mr. Duasso's facilities total 68 beds and he has been in industry for 19 years. Mr. Duasso has concerns about surveyors and believes he should be in partnership with AHCA. He expressed that the Ombudsman Program was created for resident advocacy and the volunteers should not act as surveyors. He further expressed concern with funding and the need to have better training.

Marlene Hunter, M.S., CHCRM, ALF Trainer, Consultant and Risk Management Expert. Ms. Hunter advocated strengthening ALF administrator training and staff in-service training.

Carol Berkowitz, Florida Association of Homes and Services for the Aging (FAHSA). FAHSA stresses the importance of social model of care for ALFs and the establishment of residency criteria within the law. There is concern about access to care and case management coordination between waivers. ALF provider qualifications should be strengthened and surveyors should be more efficient.

Conchy Bretos, Former Assistant Secretary for Aging and Adult Services. Ms. Bretos represents Mia Senior Living Solutions, providing low income seniors public housing in assisted living facilities. Ms. Bretos recommends centralizing all operations to one agency, giving AHCA the power to act and revoke licenses accordingly and increasing Medicaid reimbursement rates.

Greg Hopcroft, ALF Owner. Mr. Hopcroft advocated for small ALFs that are successful. He believes that life experience should count toward qualifications for an ALF administrator.

Olga Golik. Ms. Golik testified that more housing options are needed for individuals with mental illness and that ALFs are not always appropriate. People need to be offered more choices and conditions need to be improved with provision of necessary services and increased funding. The OSS personal needs allowance of \$54 per month is not sufficient.

Scott Eller. Mr. Eller is the owner of Renaissance Manor ALF/LMH in Sarasota. He testified that funding is low and he believes that residents are living at the federal poverty level. He believes providers have been set up to fail and a system should be designed for quality assurance.

Don Herring, Ombudsman Program. Mr. Herring provided testimony about adult family care homes and does not believe that model is the answer. He believes rules must be flexible and minimal.

Berta Jaffee. Ms. Jaffee owns a six bed ALF and advocates for small ALFs that are successful. She receives \$670 per month for her residents and states it is difficult to make ends meet with that amount of money.

Jeffery Fenster. Mr. Fenster is a private attorney who represents residents injured in ALFs. He provided testimony that an ALF owner was fraudulent and neglectful and he believes this is a statewide problem.

Artinais Alarcom is an ALF administrator and is very worried about the future of ALFs as they are underfunded.

Henry Parra, owner, Genesis ALF. Mr. Parra testified about patient brokering and how difficult it is for him to obtain residents for his six bed ALF. He stated about the black market in South Florida of receiving residents. Mr. Parra is the founder of an organization that represents small facilities in Miami/Dade with English as a second language. He believes the provider industry needs to be better educated and appropriate information needs to be available for success.

Bill Hearn, Ombudsman Program. Mr. Hearn does not agree with the new Ombudsman assessment forms.

Brian Lee, Families for Better Care. Mr. Lee is a former Ombudsman and provided testimony supporting a more stringent survey and inspection process for facilities.

Soul Chaprich, Century ALF. Mr. Chaprich testified that problems in ALFs are because of lack of vision and foresight to provide a safety net.

Linda Cole. Ms. Cole is the owner of a six bed facility in Central Florida. She testified that ALF owners are under tremendous pressure and have a responsibility to run facilities well. She spoke of the difficulty facilities have keeping residents and she is aware that some companies charge up to \$2,000 to place residents. Her facility is CARF certified.

Amerillis Isque, owner of a small 6 bed facility in Miami/Dade. She has difficulty with family members who refuse to pay for her residents.

Ms. Montero. Ms. Montero provided testimony in support of the former owner of Grand Court Village, Mr. Arturo Godinez.

Judy Rosenbaum. Ms. Rosenbaum is a retired AHCA employee and became an ombudsman. She saw gross negligence in ALFs when she was a volunteer.

Axel Mercado. Mr. Mercado is a physician assistant, wound clinician. He provided testimony in support of ALFs accepting residents with stage III or IV pressure ulcers.

Adine Kaufman. Mr. Kaufman is the administrator of Anchin Pavilion in Sarasota. Anchin Pavilion has an excellent reputation and is always full. He does not believe there should be an appeal process for discharges and the notice of relocation should be 30 days.

Ralph Garcia. Mr. Garcia owns a six bed ALF and disputed earlier testimony that ALFs are not required to have liability insurance. Liability insurance is required for licensure.

PHASE 2 ISSUES

Consumer Information

1. Develop, in an electronic format, a consumer ALF guide similar to the nursing home guide, and considering inclusion of an ALF rating system and an ALF watch list. These documents will assist people by providing important facts such as deficiencies found at inspection, the number of beds, the languages spoken, inspection results, rates charged for a standard set of services and whether the facility accepts Medicaid waivers.

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. Require administrators to have a two year mentorship under an ALF administrator with no Class I or II violations.
3. Increase administrator requirements for an ECC facility. Allow a registered nurse license to satisfy the requirement.
4. Create ALF administrator licensure with a Department of Health board to track and monitor discipline and core training. No exceptions for small facilities.
5. If there are increased requirements for ALF Administrators, consider accepting licensure as a nursing home administrator or a registered nurse to satisfy requirements.
6. 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 where they were previously employed.

Licensure

1. Seek legislative changes to s. 429, F.S. 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 s. 429, F.Ss) yet streamlined where appropriate (advertising – use of “ALF”, combined adverse incidents reporting).
2. Revise regulations to be appropriate for specific persons served in an ALF including persons with serious mental illness and those serving geriatric or medical needs.
3. The ALF licensure and regulatory provisions be placed back into Part I of s. 429, F.S.
4. Examine the current array of ALF specialty licenses and determine if they are still needed or should be modified.

5. Evaluate expectations for quality of life and care in an ALF. Focus cannot 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.

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 discharge protection that mandates specific reasons for relocation, provides ample notice to residents, and provides residents with an administrative appeal hearing process.

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. Examine ALF staffing ratios.
3. 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.
4. 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.

5. 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.
6. 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.
7. Clarify in statute that the ALF administrator is responsible for ensuring that the resident receives adequate care and services.
8. Enact public record exemption for AHCA complaints. Complaints filed with AHCA are not protected from disclosure. Consider adding confidentiality to AHCA complaints equivalent to that of the Ombudsman.

ALF Information and Reporting

1. If ALFs are required to report to the Agency occupancy rates and resident acuity, 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.
2. 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.
3. 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.
4. 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.
5. 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. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. Revocation or denial of renewal license should be 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.
7. Allow the monies from administrative fines to be used in the facility to correct the deficiency allowing the facility to enhance the standard of resident care.

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 the 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 for facilities that require greater regulatory oversight.

4. 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).
5. Increase the per-bed, per facility, and/or specialty licensure fees for all providers to offset program deficits.
6. 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.
7. Remove the prohibition on imposing an administrative fine when a Class III or Class IV violation is corrected within the time specified.
8. Reevaluate the assisted living fee structure as it relates to paying the cost of regulation.
9. Prohibit fines from going back to the Agency to offset the costs of the licensure program.
10. Address the 15,000 people on the waiting list when asking for additional “nursing home diversion.”
11. Provide more financial support for ALF care and services including increased per diem rates and more funded slots/beds.
12. Evaluate the actual cost of assisted living facility care and apply for access to federal funds through Medicaid. Utilize the pay for performance methodology.

Resident Advocacy

1. Increase funding for the Centers for Independent Living 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.

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. Recognize the shift of placements for persons discharged from state hospitals, now residing in ALFs.
3. Identify the features or characteristics of a good LMH for model of programs that best meet the needs of persons with serious mental illness and the associated behaviors.
4. Provide more case management services and advocacy for residents which could contribute more to the resident's quality of care and life.
5. 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.
6. Maintain the independence between mental health services and case management in 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.
7. 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.
8. Do not move the Medicaid case management program from community mental health centers to the ALF. The Medicaid program is limited to eligible services for Medicaid clients. It 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.
9. Do not require DCF to contract with specialized community mental health centers 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.
10. Require DCF/Managing Entity evaluate the cooperative agreements in place to ensure that they are sufficient to meet the mental health needs of LMH facility residents and that the circuit plans are consistent with the DCF/substance abuse and mental health 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.

11. Require DCF/Managing Entity review a sample of the community living support plans at each LMH facility to ensure they represent adequate mental health supports as well as activities and services that represent the preferences of the consumers.
12. 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.
13. Require staff at the DCF to ensure consistency of LMH facility services and increase the monitoring responsibilities of mental resident case managers.
14. Amend s.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.
15. Develop a process for persons with severe and persistent mental illness whose care is subsidized to allow that subsidy to follow that person in alternative residential settings.
16. Conduct a study to explore the methods of enhancing care for persons with severe and persistent mental illness in assisted living facilities.

Multiple Regulators

1. Form a workgroup of 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. This includes the Agency for Health Care Administration; the Long Term Care Ombudsman Program; local fire authorities; local health departments; the Department of Children and Families', Adult Protective Services and Substance Abuse and Mental Health Programs; the 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. Allow AHCA to use DCF Adult Protective Services findings and pursue sanctions for repeated verified abuse findings in a facility.
6. Authorize for AHCA to deny, revoke or suspend a license if the licensee is a named perpetrator in a verified report of abuse, neglect, or exploitation, similar to APD licensure authority in s. 393.0673, F.S.
7. Authorize use of DCF Adult Protective Services finding and investigations in employment matters. s. 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.
8. 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 s. 415, F.S., or abuse, abandonment, or neglect of a child under part II of s.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.
9. 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.
10. Consider a document vault to allow off-site compliance review and share information between regulatory agencies.
11. Retain multiple visitors in non-compliant facilities.

Home and Community Based Care

1. 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.
2. 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.
3. Eliminate the waiting list for waiver programs and have open enrollment for Medicaid waiver providers. Make assisted living funding readily available similar to how institutional care is funded through the long-term care system (Medicaid reimbursement for nursing homes). Expand the assisted living waiver program and focus on facilities that prove they meet significantly higher quality of care standards.