

# 2009 REPORT EXTENDED CONGREGATE CARE

*E. Douglas Beach, Secretary*  
**Charlie Crist, Governor**

December 2009

# Extended Congregate Care in Assisted Living Facilities in Florida 2009

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## 1.0 Statutory Directive

This report on extended congregate care facilities is directed by §429.07 (3) (b) 9, Florida Statutes, which states:

No later than January 1 of each year, the department, in consultation with the agency, shall prepare and submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the chairs of appropriate legislative committees, a report on the status of, and recommendations related to, extended congregate care services. The status report must include, but need not be limited to, the following information:

- a. A description of the facilities licensed to provide such services, including total number of beds licensed under this part.
- b. The number and characteristics of residents receiving such services.
- c. The types of services rendered that could not be provided through a standard license.
- d. An analysis of deficiencies cited during licensure inspections.
- e. The number of residents who required extended congregate care services at admission and the source of admission.
- f. Recommendations for statutory or regulatory changes.
- g. The availability of extended congregate care to state clients residing in facilities licensed under this part and in need of additional services, and recommendations for appropriations to subsidize extended congregate care services for such persons.
- h. Such other information as the department considers appropriate.

Following a short introduction on assisted living facilities and extended congregate care facilities, this report follows the order of the statute from “a” through “g.” Item “h,” such other information as the department considers appropriate, is incorporated throughout the various sections of the report.

## 1.1 Executive Summary

This report focuses on the characteristics of assisted living facilities operating with an extended congregate care license and the residents who use these services.

The data used to produce this report came from the Agency for Health Care Administration's Florida Regulatory and Enforcement System (FRAES) and a survey conducted by the Department of Elder Affairs. Response to the survey was voluntary.

Some key findings from these sources are as follows:

- There were 2,834 assisted living facilities (ALFs) in operation during state fiscal year 2008-2009.
- Of the 2,834 ALFs, 314 were licensed to provide extended congregate care (ECC).
- There were 17,315 licensed ECC beds in state fiscal year 2008-2009.
- Survey results show that over half of the ECC residents were over the age of 80, and 23 percent were over the age of 90.
- Survey results show that thirty-nine percent of ECC residents needed total help with two or more activities of daily living (ADL).
- Survey results show that forty-five percent of ECC residents required total help with bathing, and 37 percent needed total help with dressing. Over 27 percent of ECC residents required total help with transferring and almost 37 percent required total help with toileting.
- Survey results show that almost 40 percent of the ECC residents needed help with two or more activities of daily living (ADLs).
- Survey results show that over 43 percent of the ECC residents stayed in facilities with 50 or more beds.
- Survey results show that about 60 percent of the ECC residents transitioned from a non-ECC bed in the same facility.
- Survey results show that over 50 percent of ECC residents were diagnosed with Alzheimer's disease/dementia.

Recommendation: To address the issue of elders being placed in forensic facilities under the Baker or Marchman Acts, or who are found wandering and confused, the Legislature should consider allowing secure units within Extended Congregate Care ALFs to provide revenue neutral short-term acute care by specially trained licensed psychiatric physicians and nurses. Transfers would be made by physician-to-physician orders and would not require the use of the Baker Act or forensic facilities. A revenue neutral demonstration project instituted by the Legislature with oversight provided by Elder Affairs and AHCA is recommended.

## 2.0 Background

Extended Congregate Care (ECC) is a specialty license for assisted living facilities (ALFs). All ECC facilities are ALFs. All ECC beds are licensed ALF beds. However, not all ALFs are licensed to provide ECC services. Facilities with an ECC license might have only a portion of their beds licensed for ECC services.

The ECC license was developed in 1991. The concept of ECC services in ALFs evolved from Florida legislators recognizing the need to allow residents the option to “age in place” as they become more impaired. Thus, ALF residents could remain in the ALF longer, and nursing home stays could be reduced or eliminated.

There are two other specialty licenses for ALFs, namely, Limited Mental Health (LMH) and Limited Nursing Services (LNS). Limited mental health facilities are licensed to provide for the health, safety and welfare of mentally ill residents. Limited nursing services facilities are authorized to provide a number of nursing services including conducting passive range of motion exercises and applying ice caps or collars. (The complete list of authorized services is detailed in Rule 58A – 5.031 (1), F.A.C.) Some assisted living facilities have all three specialty licenses, some have one or two specialty licenses, and others do not have any specialty license. In order to participate in the Medicaid Assisted Living for the Elderly (ALE) Waiver, facilities must have an ECC license, a LNS license or both.

Besides specialty licenses, all assisted living facility beds are designated as being either a private pay (private) bed or an Optional State Supplementation (OSS) bed. Each bed in an assisted living facility must be designated as one or the other; however, an ALF may have some OSS beds and some private beds, and it may apply to change the designation during the course of the year.

This report focuses on the characteristics of assisted living facilities with extended congregate care and the residents who use these services. There are two main data sources for this report: *Florida Regulatory and Enforcement System (FRAES)* and a survey of ECC facilities conducted by the Florida Department of Elder Affairs. The FRAES data comes from Florida’s Agency for Health Care Administration (AHCA) and includes information on all assisted living facilities including the number of licensed beds, whether the facility has an ECC license and the facility name. An analysis was made of deficiencies reported for each inspection. The survey was sent to each ECC licensed ALF. Although a great effort was made to obtain responses from these facilities, the survey was voluntary and not all facilities responded. The survey included demographic information about the ECC residents served in the facilities.

Since licensing inspections occur biennially, some facilities were not inspected during state fiscal year 2008-2009. Facilities that were not inspected during the state fiscal year are excluded from the deficiency analysis.

### **3.0 A Description of the Facilities**

During state fiscal year 2008-2009, Florida had 2,834 ALFs, of which 314 were licensed to provide ECC services. Overall, 11 percent of ALFs in Florida are licensed to provide extended congregate care. However, the distribution of ECC services is not uniform across all assisted living facilities. For example, assisted living facilities with 50 or more beds are much more likely to have an ECC license than assisted living facilities with fewer than 10 licensed beds.

Table 1 below shows the number of assisted living facilities by size, type and region. The table also shows the percentage of assisted living facilities with extended congregate care licenses by size and region.

**Table 1**  
**Number of ALFs by Size, ECC Status Type and Region**

Region	Facility Type	Small (Under 10 Beds)	Medium (10-24 Beds)	Large (25-49 Beds)	Extra Large (Over 49 Beds)	Total
North Florida	Non-ECC ALFs	146	75	56	85	362
	ECC ALFs	10	8	16	65	99
	All ALFs	156	83	72	150	461
	Percent ECC	6%	10%	22%	43%	21%
Central Florida	Non-ECC ALFs	285	153	68	147	653
	ECC ALFs	15	15	16	54	100
	All ALFs	300	168	84	201	753
	Percent ECC	5%	9%	19%	27%	13%
South Florida	Non-ECC ALFs	1,094	165	78	168	1,505
	ECC ALFs	25	23	13	54	115
	All ALFs	1,119	188	91	222	1,620
	Percent ECC	2%	12%	14%	24%	7%
Statewide	Non-ECC ALFs	1,525	393	202	400	2,520
	ECC ALFs	50	46	45	173	314
	All ALFs	1,575	439	247	573	2,834
	Percent ECC	3%	10%	18%	30%	11%

During state fiscal year 2008-2009, Florida had 80,758 licensed assisted living facility beds, of which 17,315 were licensed to provide extended congregate care. While 11 percent of assisted living facilities in Florida are licensed to provide extended congregate care, 21.4 percent of ALF beds are licensed for ECC. Again, a disproportionate number of ECC licensed facilities are in larger ALFs.

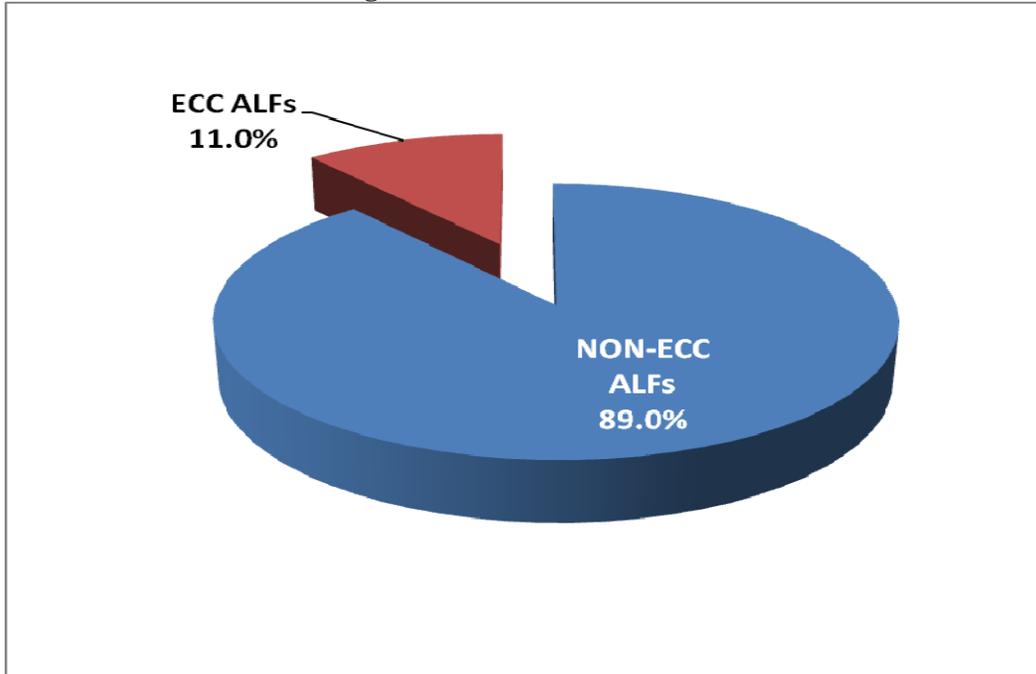
Table 2 shows the number of assisted living facility beds by size of ALF, type and region. The table also shows the percentage of assisted living facility beds with extended congregate care licenses by size and region.

**Table 2  
Number of ALF Beds by Size, ECC Status Type and Region**

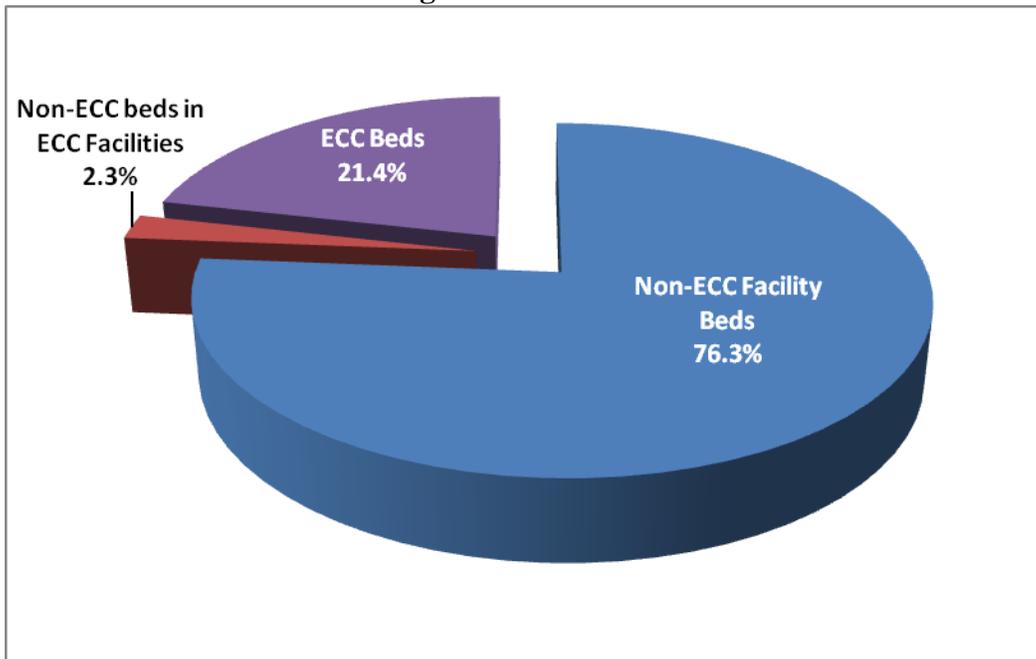
Region	Bed Type	Small (Under 10 Beds)	Medium (10-24 Beds)	Large (25-49 Beds)	Extra Large (Over 49 Beds)	Total
North Florida	Non-ECC Facility Beds	883	1,086	2,019	7,708	11,696
	Non-ECC beds in ECC Facilities	27	9	60	751	847
	ECC Beds	33	104	502	4,857	5,496
	All Beds	943	1,199	2,581	13,316	18,039
	Percent ECC Beds	3.5%	8.7%	19.4%	36.5%	30.5%
Central Florida	Non-ECC Facility Beds	1,744	2,149	2,433	14,558	20,884
	Non-ECC beds in ECC Facilities	1	14	29	720	764
	ECC Beds	91	238	560	4,925	5,814
	All Beds	1,836	2,401	3,022	20,203	27,462
	Percent ECC Beds	5.0%	9.9%	18.5%	24.4%	21.2%
South Florida	Non-ECC Facility Beds	6,601	2,381	2,726	17,300	29,008
	Non-ECC beds in ECC Facilities	15	41	45	143	244
	ECC Beds	140	349	446	5,070	6,005
	All Beds	6,756	2,771	3,217	22,513	35,257
	Percent ECC Beds	2.1%	12.6%	13.9%	22.5%	17.0%
Statewide	Non-ECC Facility Beds	9,228	5,616	7,178	39,566	61,588
	Non-ECC beds in ECC Facilities	43	64	134	1,614	1,855
	ECC Beds	264	691	1,508	14,852	17,315
	All Beds	9,535	6,371	8,820	56,032	80,758
	Percent ECC Beds	2.8%	10.8%	17.1%	26.5%	21.4%

Figures 1A and 1B graphically depict the statewide distribution of the ECC status of assisted living facilities and their beds.

**Figure 1A**  
**Percentage of ALFs with an ECC License**



**Figure 1B**  
**Percentage of ECC Beds in ALFs**



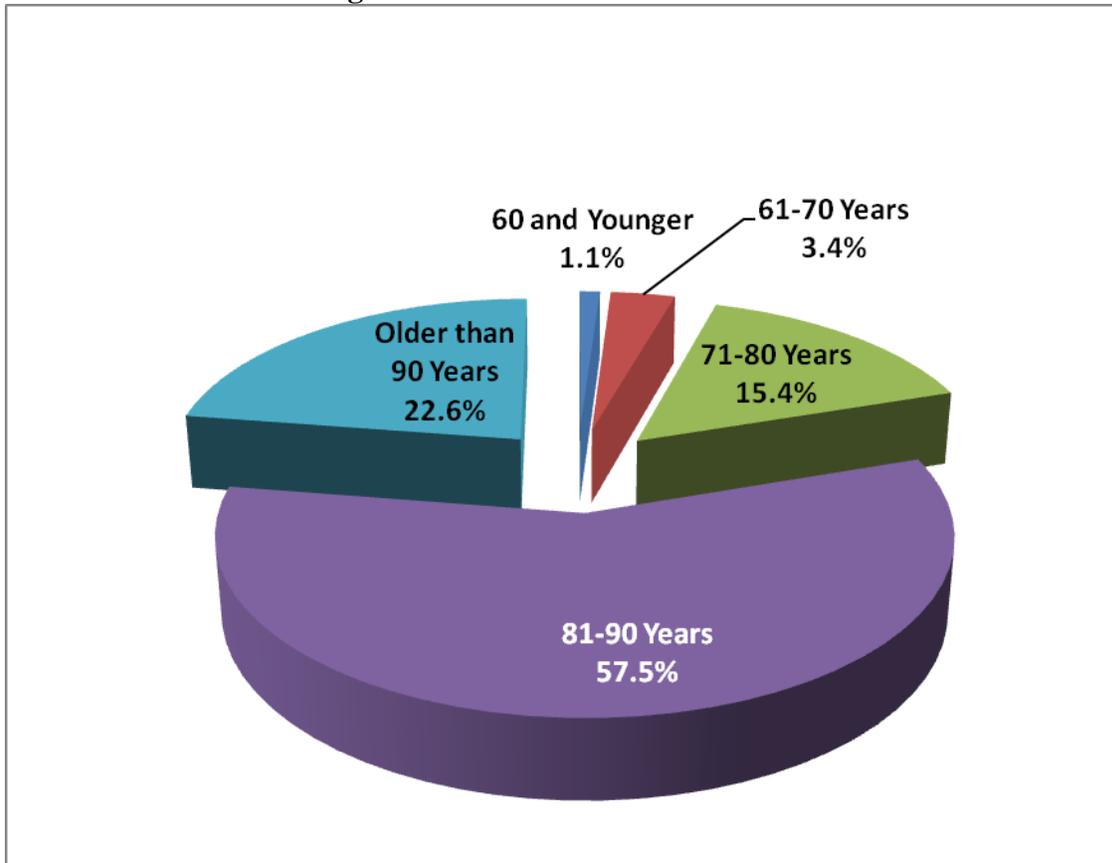
## 4.0 Characteristics of Residents Receiving Services

The information in this section includes estimates based on a facility survey conducted by the Department of Elder Affairs. The survey instrument is included in Appendix I.

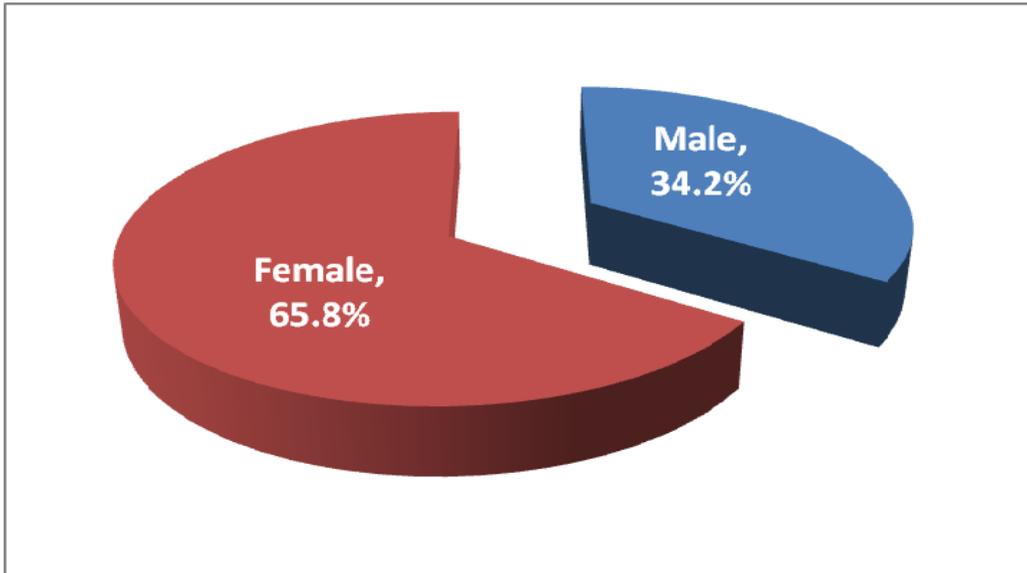
### 4.1 Demographic Characteristics

Fifteen percent of the ECC residents were between age 71 and 80, about 58 percent were between 81 and 90 and 22 percent were older than 90. Nearly, 66 percent of the residents were women. Over 94 percent of the residents were white. Over 43 percent of the ECC residents resided in ALFs with 50 or more beds. These characteristics are displayed graphically in Figures 2 through 5.

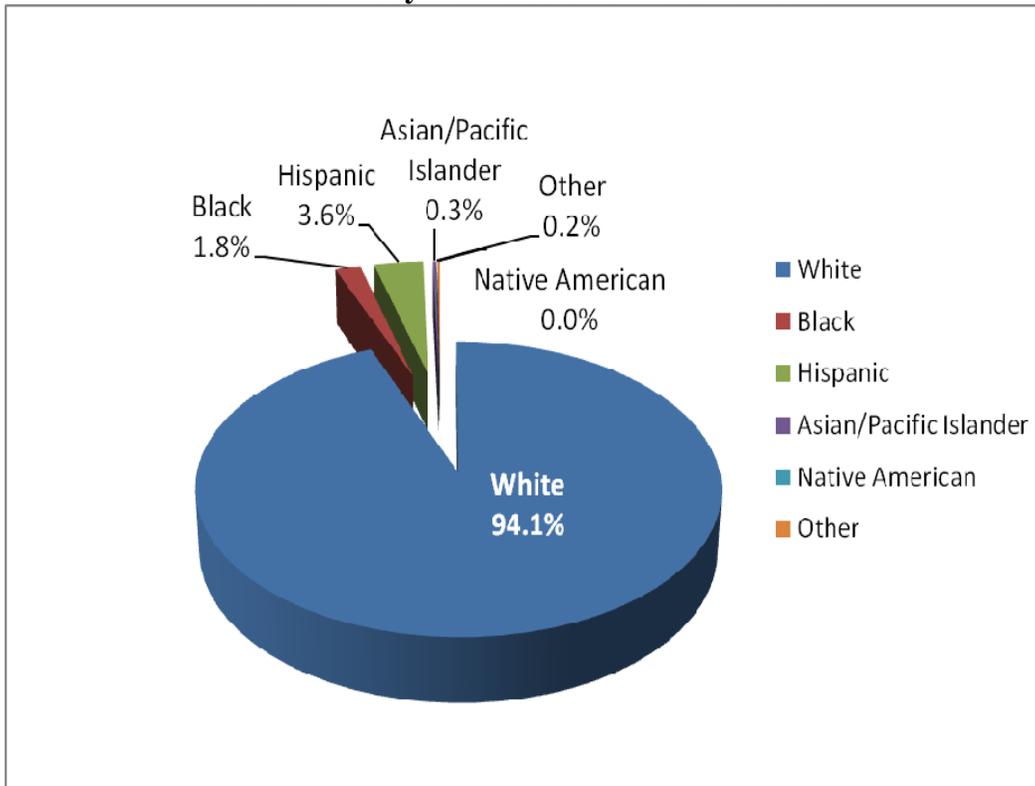
**Figure 2**  
**Age Distribution of ECC Residents**



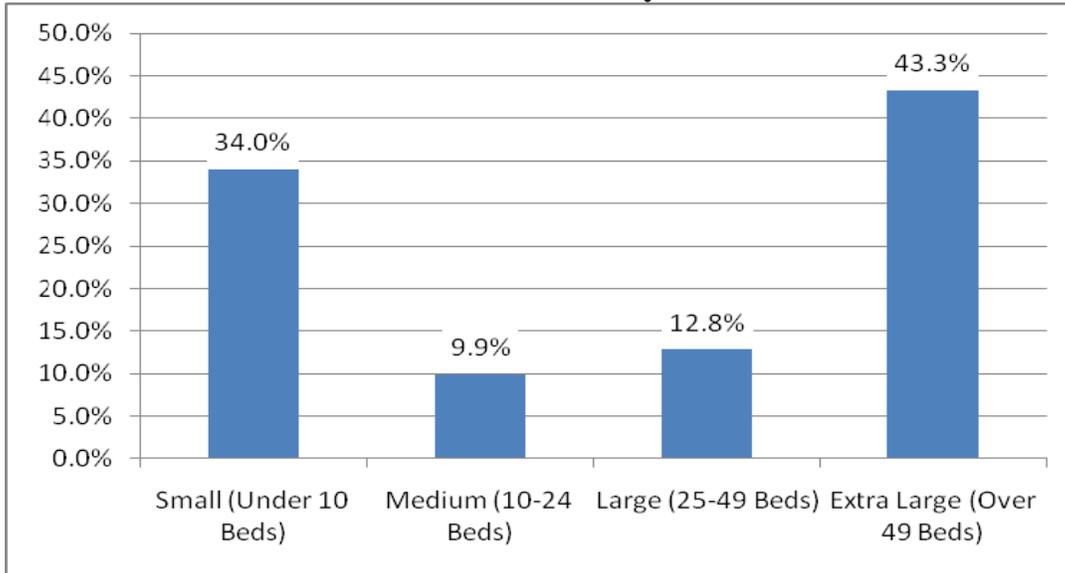
**Figure 3**  
**Gender Distribution of ECC Residents**



**Figure 4**  
**Race/Ethnicity Distribution of ECC Residents**



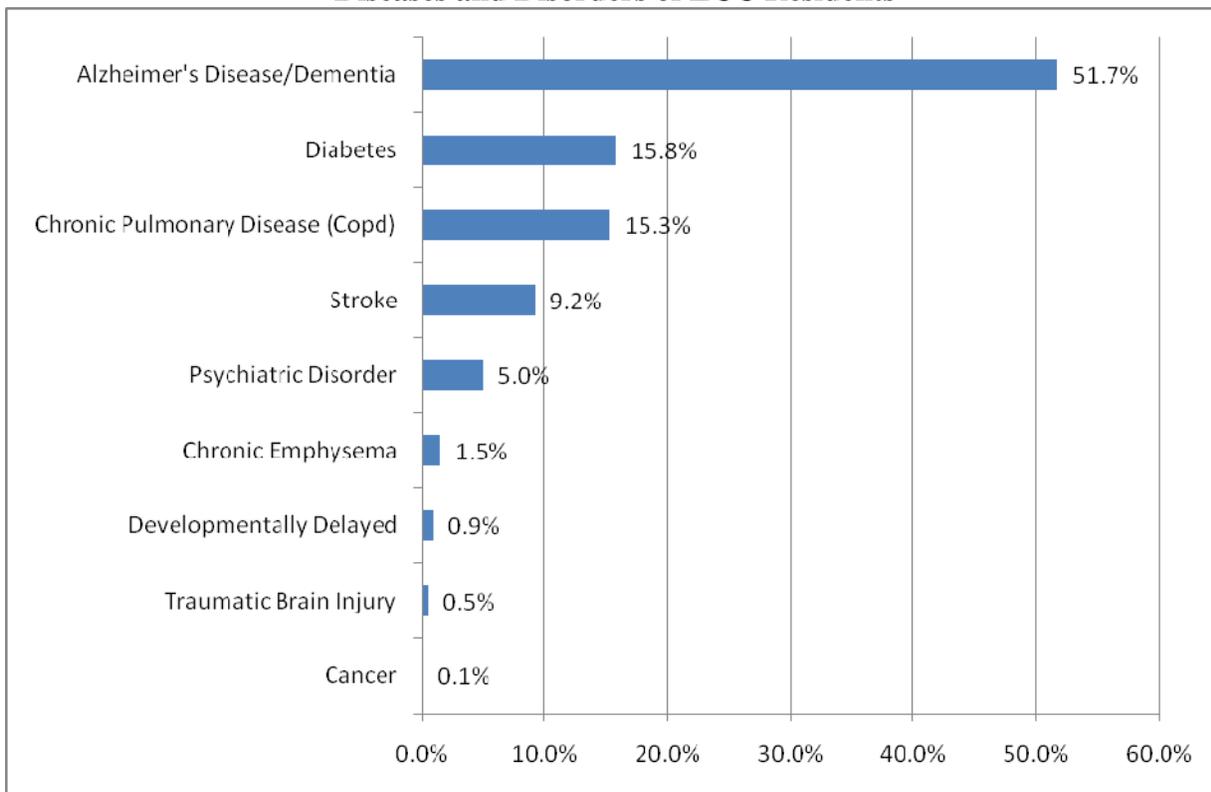
**Figure 5**  
**Distribution of ECC Residents by Size of the ALF**



## 4.2 Disease and Disorders

Figure 6 shows the percentage of ECC residents with various diseases and disorders. A resident might have multiple diseases or disorders. The list of disorders was included on the survey and might not represent all disorders affecting ECC residents. About 52 percent of ECC residents surveyed were diagnosed with Alzheimer’s or other dementia. Almost 16 percent of ECC residents have diabetes. Chronic pulmonary disease is the third most identified disorder (15.3 percent).

**Figure 6**  
**Diseases and Disorders of ECC Residents**

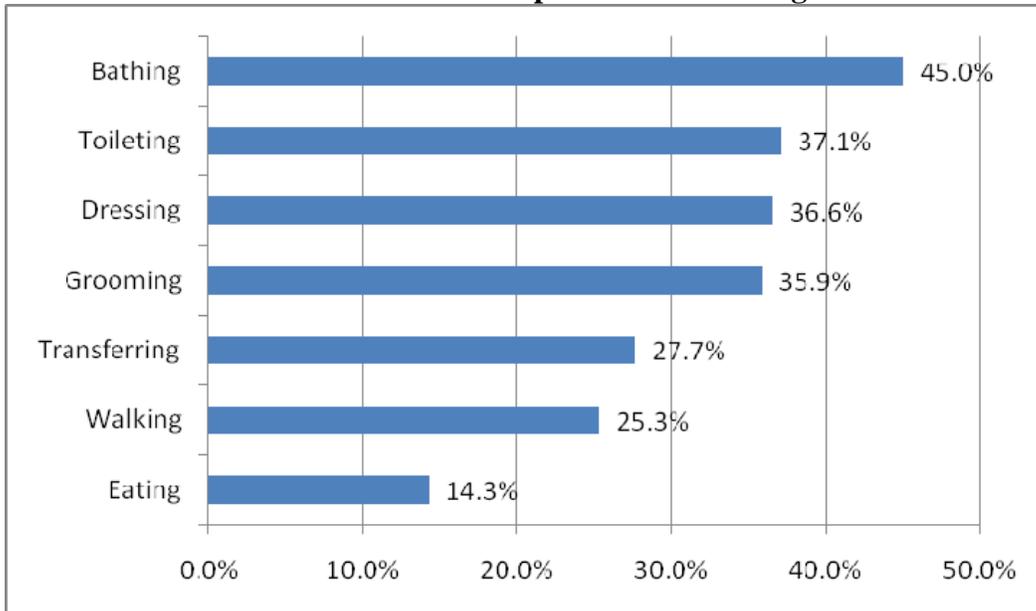


## 4.3 Impairments

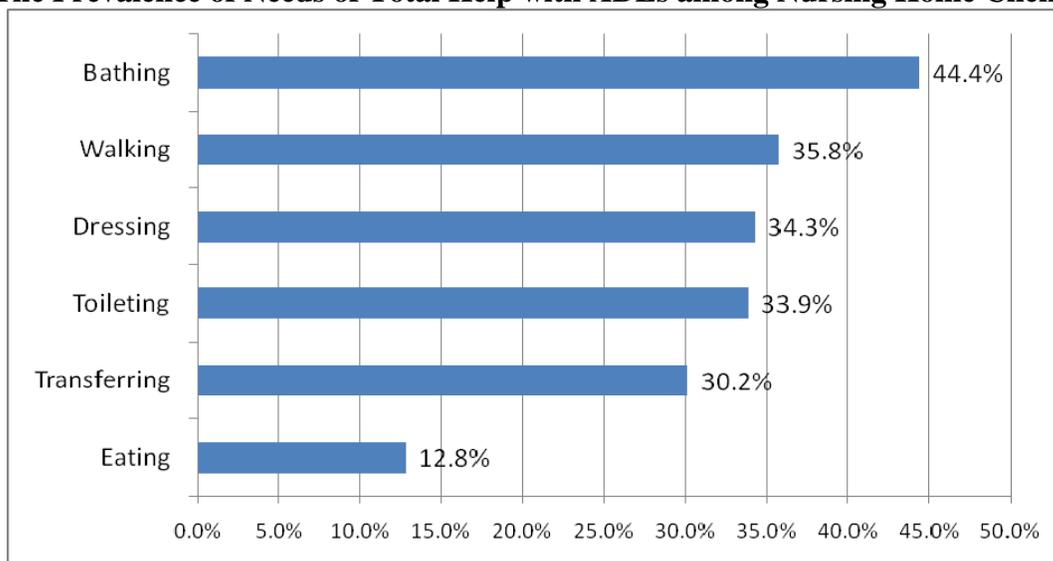
ECC residents often need assistance with their Activities of Daily Living (ADLs). Forty-five percent of ECC residents required total help with bathing, and 37 percent needed help with dressing. Almost 28 percent of ECC residents required total help with transferring, and almost 37 percent required total assistance with toileting.

The need for total help among ECC residents is shown in Figure 7A. For comparison purposes, Figure 7B shows the need for total help by Medicaid nursing home residents. It is worth pointing out that ECC residents are, on average, almost as impaired as their nursing home counterparts. Statutorily, ALFs with an ECC license cannot provide services to individuals who are bedridden for a period longer than two weeks.

**Figure 7A**  
**The Prevalence of Needs of Total Help with ADLs among ECC Residents**



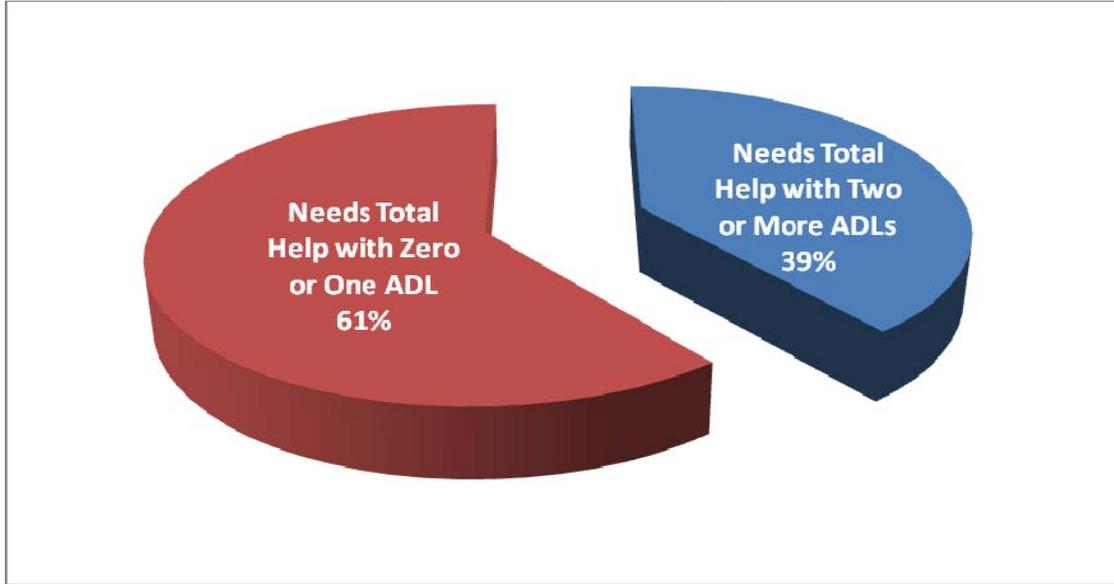
**Figure 7B**  
**The Prevalence of Needs of Total Help with ADLs among Nursing Home Clients**



Source: Department of Elder Affairs' Client Information and Registration Tracking System (CIRTS)

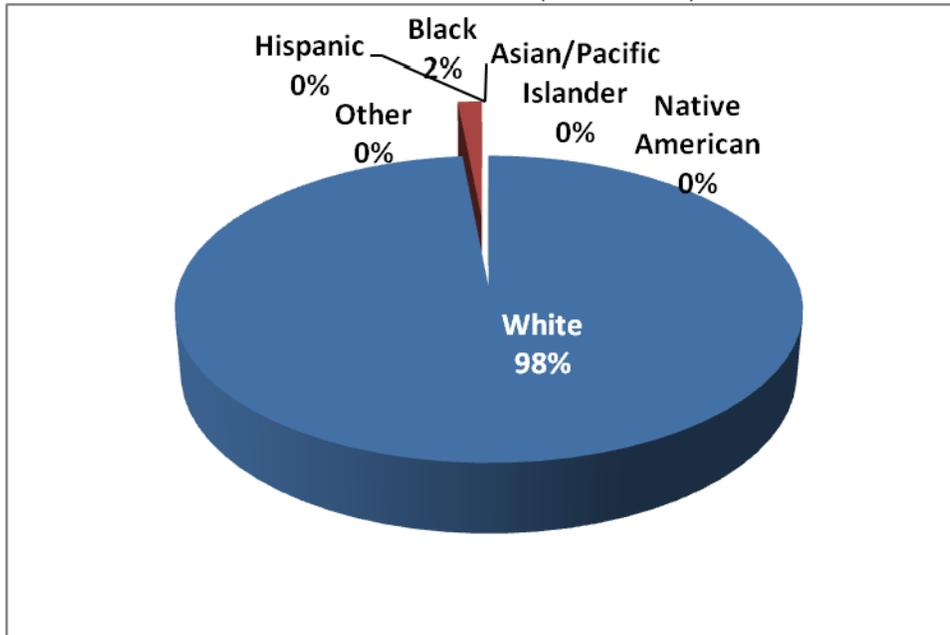
Often residents need assistance with multiple ADLs. Figure 8 shows that 39 percent of ECC residents needed total help with two or more ADLs.

**Figure 8**  
**The Distribution of ECC Residents by ADL Needs**



The racial and ethnic distribution of ECC residents in large ECC facilities (those with 25-49 beds) is shown in Figure 9.98 percent of the residents are non-Hispanic Whites. Blacks comprise the second largest group (2 percent).

**Figure 9**  
**Racial/Ethnic Distribution of Small ALFs (25-49 beds) With an ECC License**



## 5.0 ECC Services That Could Not Be Provided Through a Standard License

Rules in the Florida Administrative Code describe the level of need limits for residents in both standard and ECC ALFs. The differences in these criteria identify ECC residents who would not be qualified to stay in a standard assisted living facility. The admission criteria for standard, limited nursing or limited mental health assisted living facilities are stated in Rule 58A – 5.0181 (1), F.A.C. The admission and continued residency requirements for extended congregate care in an assisted living facility are stated in Rule 58A – 5.030, F.A.C. Most requirements are identical; however, some criteria for admissions to standard ALFs are not required for ECC facilities. Unlike standard licensed ALFs, ECC facilities may admit people with the following needs:

- Require total help with bathing, dressing, grooming and toileting; and
- Need assistance with (non-nasogastric) tube feeding.

Although bedridden residents may not be admitted to any ALF, residents of an ECC facility may remain even if they become bedridden for up to 14 consecutive days. In standard ALFs, current residents must leave if they become bedridden for more than seven days.

A standard ALF can only provide services that the facility is licensed to provide. ECC facilities may also provide any service that its staff is licensed to provide if the services are consistent with residency requirements and the facility's policies and procedures.

All ALFs, including those with an ECC license, may adopt stricter admission policies. For example, a facility may opt to deny admissions to residents who require assistance in taking medication. A standard licensed ALF may discharge a resident once a resident begins to require additional services. However, an ECC facility may not discharge residents who need certain services addressed in Rule 58A – 5.030 (8), F.A.C., which are reproduced below.

(8) EXTENDED CONGREGATE CARE SERVICES. All services shall be provided in the least restrictive environment, and in a manner that respects the resident's independence, privacy, and dignity.

- (a) An extended congregate care program may provide supportive services including social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. Family or friends shall be encouraged to provide supportive services for residents. The facility shall provide training for family or friends to enable them to provide supportive services in accordance with the resident's service plan.
- (b) An extended congregate care program shall make available the following additional services if required by the resident's service plan:
  - 1. Total help with bathing, dressing, grooming and toileting;
  - 2. Nursing assessments conducted more frequently than monthly;
  - 3. Measurement and recording of basic vital functions and weight;
  - 4. Dietary management including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
  - 5. Assistance with self-administered medications, or the administration of medications and treatments pursuant to a health care provider's order. If the individual needs assistance with self-administration the facility must inform the resident of the qualifications of staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's informed consent to provide such assistance as required under Section 429.256, F.S.;
  - 6. Supervision of residents with dementia and cognitive impairments;
  - 7. Health education and counseling and the implementation of health-promoting programs and preventive regimes;
  - 8. Provision or arrangement for rehabilitative services; and
  - 9. Provision of escort services to health-related appointments.

- (c) Licensed nursing staff in an extended congregate care program may provide any nursing service permitted within the scope of their license consistent with the residency requirements of this rule and the facility's written policies and procedures, and the nursing services are:
  - 1. Authorized by a health care provider's order and pursuant to a plan of care;
  - 2. Medically necessary and appropriate for treatment of the resident's condition;
  - 3. In accordance with the prevailing standard of practice in the nursing community;
  - 4. A service that can be safely, effectively and efficiently provided in the facility;
  - 5. Recorded in nursing progress notes; and
  - 6. In accordance with the resident's service plan.
- (d) At least monthly, or more frequently if required by the resident's service plan, a nursing assessment of the resident shall be conducted.

## **6.0 An Analysis of Deficiencies Cited During Licensure Inspections**

Florida's Agency for Health Care Administration is responsible for the inspection and licensing of assisted living facilities. As part of the inspection process, the facilities are cited for specific deficiencies called "tags." There are hundreds of specific tags that are grouped under twelve categories. These categories are as follows:

- 1. General license standards,
- 2. Fiscal standards,
- 3. Facility records standards,
- 4. Resident records standards,
- 5. Residency and admissions standards,
- 6. Staffing standards,
- 7. Medication standards,
- 8. Resident care standards,
- 9. Nutrition and dietary standards,
- 10. Emergency management,
- 11. Physical plant standards, and
- 12. Staff records standards.

During an inspection, a facility may be cited for none, one or multiple specific tags. However, a single facility can only be cited for a specific tag once for a given inspection. Therefore, the citing for a specific tag does not differentiate between isolated or widespread occurrence of the deficiency.

Since the deficiencies are registered at the facility level, the analysis shows the incidence rates of deficiencies. Figure 10 compares the incidence rates of deficiency tags between assisted living facilities with extended congregate care licenses and those without extended congregate care licenses.

About 12 percent of non-ECC facilities had over 10 deficiencies compared to 8.5 percent of ECC facilities. About 24 percent of non-ECC facilities had one or more deficiencies, compared to almost 56 percent for ECC facilities.

**Figure 10**  
**Analysis of Distribution of Number of Citations Received by Facility Type**

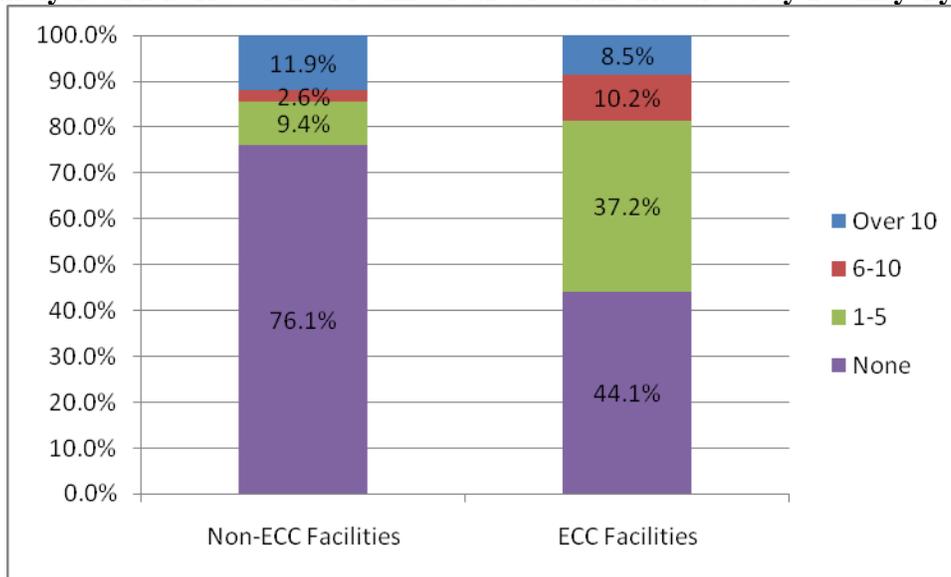


Table 3 lists the 10 most frequently cited deficiencies among assisted living facilities during state fiscal year 2008-2009. Also included in the table is the frequency at which each deficiency was cited at both ECC and non-ECC facilities.

**Table 3**  
**Most Common Deficiencies Cited in ALFs**

Tag	Title	Text	All	Non-ECC	ECC
1103	STAFF RECORDS STANDARDS	Freedom from tuberculosis must be documented on an annual basis. A person with a false positive tuberculosis test must submit a health care provider's statement that the person does not constitute a risk of communicating tuberculosis. 58A-5.019(2)(a), F.A.C.	306 (2.74%)	273 (2.82%)	33 (2.23%)
0615	MEDICATION STANDARDS	The facility must maintain a daily medication observation record (MOR) for each resident who receive assistance with self-administration of medications or medication administration. 58A-5.0185(5)(b), F.A.C.	279 (2.50%)	245 (2.53%)	34 (2.30%)
1101	STAFF RECORDS STANDARDS	Personnel records contain verification of freedom from communicable disease including tuberculosis. 429.275(4), F.S. 58A-5.024(2)(a), F.A.C.	250 (2.24%)	221 (2.28%)	29 (1.96%)
1104	STAFF RECORDS STANDARDS	New facility staff must obtain an initial training on HIV/AIDS within 30 days of employment, unless the new staff person previously completed the initial training and has maintained the biennial continuing education requirement. All facility employees must complete biennially, a continuing education course on HIV and AIDS. 429.275(2), F.S. 58A-5.0191(3), F.A.C. 58A-5.024(2)(a)1., F.A.C. 58A-5.0191(11), F.A.C.	226 (2.03%)	196 (2.02%)	30 (2.03%)
1115	STAFF RECORDS STANDARDS	Personnel records contain documentation of compliance with level 1 background screening for all staff subject to screening requirements. 429.275(2), F.S. 58A-5.019(3), F.A.C. 58A-5.024(2)(a)3., F.A.C.	225 (2.02%)	207 (2.14%)	18 (1.22%)
0514	STAFFING STANDARDS	All facility staff must receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 58A-5.0191(2)(f), F.A.C.	217 (1.94%)	191 (1.97%)	26 (1.76%)

**Table 3 (continued)**  
**Most Common Deficiencies Cited in ALFs**

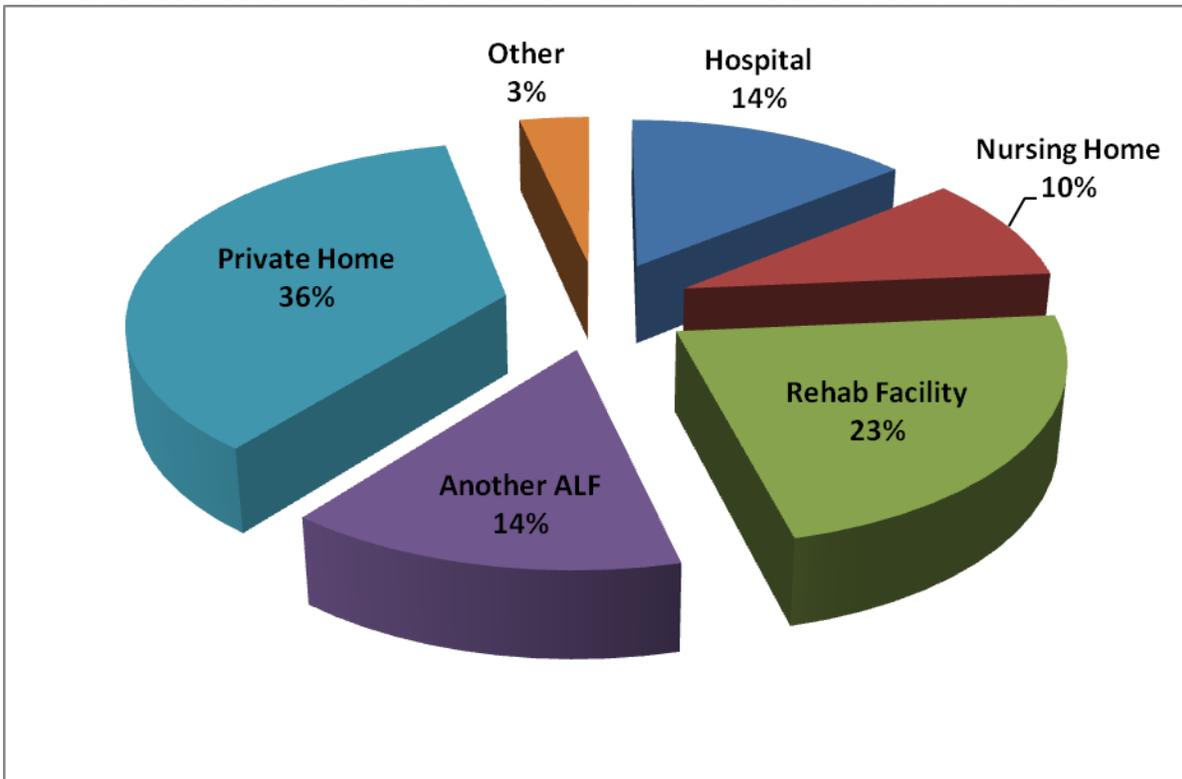
Tag	Title	Text	All	Non-ECC	ECC
0417	ADMISSIONS CRITERIA STANDARDS	The medical examination report shall address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 58A-5.0181(2) (a) 1, F.A.C. 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 58A-5.0181(2)(a)2, F.A.C.	214 (1.92%)	188 (1.94%)	26 (1.76%)
0223	FACILITY RECORDS STANDARDS	The facility conducts a minimum of two resident elopement prevention and response drills per year. 429.41(1) (a) 3., F.S. 429.41(1) (l), F.S. 58A-5.0182(8)(c), F.A.C.	193 (1.73%)	172 (1.78%)	21 (1.42%)
0718	RESIDENT CARE STANDARDS	The facility will comply with the Resident's Bill of Rights. 429.28(1), F.S.	188 (1.68%)	156 (1.61%)	32 (2.17%)
0511	STAFFING STANDARDS	Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting of major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain of command and staff roles relating to emergency evacuation. 58A-5.0191(2) (b), F.A.C. 58A-5.0191(11) (a), F.A.C.	171 (1.53%)	147 (1.52%)	24 (1.62%)

## 7.0 The Source of Admission for ECC Residents

About 60 percent of the ECC residents transitioned from non-ECC beds within the same ALF, achieving the goal of residents aging in place. Figure 11 graphically depicts the 40 percent who were admitted from other locations.

Thirty-six percent of the ECC residents whom did not transition from the same ECC facility came from private homes. Ten percent of residents came from nursing homes. Twenty-three percent of residents transitioned from rehabilitation facilities. Individuals who were able to remain in the community due to the ECC services available represent probable nursing home diversions.

**Figure 11**  
**Admission Sources of ECC Residents Admitted From Locations Other Than Own ALF**



## 8.0 Recommendations for Statutory or Regulatory Changes

Four recommendations are being proposed. The first three recommendations were submitted by ECC facilities in response to a request for recommendations on the survey. The fourth recommendation is made in response to an acute problem facing Florida's elders, their families and the residential facilities that try to meet their needs.

1. Facilities stated that ECC licenses are costly. Recommendations included increasing funding to supplement the cost associated with a higher level of care and lowering the ECC license fee.
2. A number of facilities recommended reducing and simplifying the required paperwork.
3. Facilities recommended reevaluating the ECC or Limited Nursing Services licensure requirement for the Assisted Living for the Frail Elderly Medicaid Waiver.
4. The Department is concerned about the disposition of ALF, nursing home and community-housed elders who are removed from their residence by the Baker or Marchman Acts, or who are found wandering and confused. We find that these elders are the recipients of the unnecessary use of forensic facilities, hospital emergency rooms or county crisis stabilization units, all of which are generally inappropriate for this vulnerable population as well as extremely expensive. Too frequently the stress of this sudden upheaval and the heavy doses of atypical psychotropic drugs cause the patient's brain dysfunction to accelerate, and he or she never recovers, often becoming incontinent or losing mobility, which causes subsequent care to be much more costly<sup>1</sup>. We ask that legislation be drafted as an addition to the ALF law establishing a revenue-neutral five-year pilot program to prove the efficacy of the model to do the following:
  - A. Treat demented and disruptive elders in a cost-effective innovative way;
  - B. Allow a secure unit to be placed at an extended congregate care facility to provide short term acute care by licensed psychiatric physicians and nurses;
  - C. Diagnose and stabilize these elders and then return them to their admitting residences.

<sup>1</sup>*Short Term Involuntary Examination of Older Adults in Florida*

Behavioral Sciences and the Law 25: 615-628 (2007)

Annette Christy, PhD, Jennifer Bond, Psy.D. and M. Scott Young, Ph.D, and

*OPPAGA Report #96-57: Review of Assisted Living Facilities Serving Residents With Severe Mental Illnesses*

Recommendation number three was included in the Department's 2007 ECC Report and raised by the Office of Program Policy Analysis and Government Accountability (OPPAGA) in 1997 to address the potential for the displacement of thousands of elder Floridians with brain disorders who were living in assisted living facilities that did not have and did not plan to acquire Limited Mental Health licenses.

## **Appendices**

- Appendix I      ECC Survey
- Appendix II     ECC Rule (58A-5.030, F.A.C.)
- Appendix III    ALF Residency Criteria and Admission Procedures Rule (58A-5.0181, F.A.C.)
- Appendix IV    ALF Resident Care Standards Rule (58A-5.0182, F.A.C.)
- Appendix V     ALF Medication Practices Rule (58A-5.0185, F.A.C.)

## Appendix I - ECC Survey, September 2009

Please answer the following questions. **If you are unsure, give us your best guess.** Thank you for your cooperation.

1. How many licensed ECC beds did this facility have on June 30, 2009? \_\_\_\_\_
2. What was the occupancy rate among your ECC beds in your facility? \_\_\_\_\_%
3. Between July 1, 2008 and June 30, 2009, what was the total number of ECC residents in this facility for any length of time? \_\_\_\_\_  
*This number includes all ECC residents in the facility on June 30, 2008 plus all ECC residents discharged between July 1, 2007 and June 30, 2008.*  
***If this number is zero, please skip to question 12.***
4. Of the ECC residents identified in question 3, how many were in each of the following age categories? *The sum of these numbers should equal the number in question 3.*  

_____ 60 and Younger	_____ 61-70 Years	_____ 71-80 Years
_____ 81-90 Years	_____ Older than 90 Years	
5. Of the ECC residents identified in question 3, how many were male and female?  
*The sum of these numbers should equal the number in question 3.*  

_____ Male	_____ Female
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6. Of the ECC residents identified in question 3, how many were of the following racial groups? *The sum of these numbers should equal the number in question 3.*  

_____ White	_____ Black	_____ Hispanic
_____ Asian/Pacific Islander	_____ Native American	_____ Other
7. Of the ECC residents identified in question 3, how many needed ECC services? *The sum of these numbers should equal the number in question 3.*  

_____ After they transitioned from a standard ALF bed in this facility	_____ At the time they were admitted to your ALF
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8. Of the number of ECC residents identified in question 7 as needing ECC services “at the time they were admitted to your ALF,” how many were admitted from the

following sources? *The sum of these numbers should equal the number for “at the time they were admitted to your ALF in question 7.*

\_\_\_\_\_ Hospital                      \_\_\_\_\_ Nursing Home                      \_\_\_\_\_ Rehab Facility  
\_\_\_\_\_ Another ALF                      \_\_\_\_\_ Private Home                      \_\_\_\_\_ Other

9. How many ECC residents identified in question 3 have the following disease or disorders? *Multiple responses are possible. The sum of these numbers can be greater than the number in question 3.*

\_\_\_\_\_ Alzheimer’s disease/dementia                      \_\_\_\_\_ Chronic emphysema                      \_\_\_\_\_ Diabetes  
\_\_\_\_\_ Chronic Obstructive Pulmonary Disease (COPD)                      \_\_\_\_\_ Traumatic brain injury                      \_\_\_\_\_ Stroke  
\_\_\_\_\_ Developmentally Delayed                      \_\_\_\_\_ Psychiatric disorder

10. How many ECC residents identified in question 3 required total help with the following Activities of Daily Living (ADL) when they were admitted as an ECC resident? *Multiple responses possible. The sum of these numbers can be greater than the number in question 3.*

\_\_\_\_\_ Walking                      \_\_\_\_\_ Dressing                      \_\_\_\_\_ Eating  
\_\_\_\_\_ Transferring                      \_\_\_\_\_ Bathing                      \_\_\_\_\_ Toileting  
\_\_\_\_\_ Grooming

11. How many ECC residents identified in question 3 required total help with 2 or more of the ADLs listed in question 10? *This number should not be greater than the number in question 3.*

12. List your recommendations for changes to laws and regulations regarding ECCs.

13. List any other comments you may have regarding ECC services.

## **Appendix II – ECC Rule (58A-5.030, F.A.C.)**

### **58A-5.030 Extended Congregate Care Services.**

(1) LICENSING.

- (a) Any facility intending to establish an extended congregate care program must meet the license requirements specified in Section 429.07, F.S., and obtain a license from the agency in accordance with Rule 58A-5.014, F.A.C.
- (b) Only that portion of a facility which meets the physical requirements of subsection (3) and which is staffed in accordance with subsection (4) shall be considered licensed to provide ECC services to residents, which meet the admission and continued residency requirements of this rule.

(2) EXTENDED CONGREGATE CARE POLICIES. Policies and procedures established through an extended congregate care program must promote resident independence, dignity, choice, and decision-making. The program shall develop and implement specific written policies and procedures, which address:

- (a) Aging in place.
- (b) The facility's residency criteria developed in accordance with the admission and discharge requirements described in subsection (5) and ECC services listed in subsection (8).
- (c) The personal and supportive services the facility intends to provide, how the services will be provided, and the identification of staff positions to provide the services including their relationship to the facility.
- (d) The nursing services the facility intends to provide, identification of staff positions to provide nursing services, and the license status, duties, general working hours, and supervision of such staff.
- (e) Identifying potential unscheduled resident service needs and mechanism for meeting those needs including the identification of resources to meet those needs.
- (f) A process for mediating conflicts among residents regarding choice of room or apartment and roommate.
- (g) How to involve residents in decisions concerning the resident. The program shall provide opportunities and encouragement for the resident to make personal choices and decisions. If a resident needs assistance to make choices or decisions a family member or other resident representative shall be consulted. Choices shall include at a minimum:
  - 1. To participate in the process of developing, implementing, reviewing, and revising the resident's service plan;
  - 2. To remain in the same room in the facility, except that a current resident transferring into an ECC program may be required to move to the part of the facility licensed for extended congregate care, if only part of the facility is so licensed;
  - 3. To select among social and leisure activities;
  - 4. To participate in activities in the community. At a minimum the facility shall arrange transportation to such activities if requested by the resident; and
  - 5. To provide input with respect to the adoption and amendment of facility policies and procedures.

- (3) **PHYSICAL SITE REQUIREMENTS.** Each extended congregate care facility shall provide a homelike physical environment which promotes resident privacy and independence including:
- (a) A private room or apartment, or a semi-private room or apartment shared with roommate of the resident's choice. The entry door to the room or apartment shall have a lock, which is operable from the inside by the resident with no key needed. The resident shall be provided with a key to the entry door on request. The resident's service plan may allow for a non-locking entry door if the resident's safety would otherwise be jeopardized.
  - (b) A bathroom, with a toilet, sink, and bathtub or shower, which is shared by a maximum of four (4) residents for a maximum ratio of four (4) residents to one (1) bathroom.
    - 1. A centrally located hydro-massage bathtub may substitute for a bathtub or shower and be considered equivalent to two bathrooms, increasing the resident to bathroom ratio from four (4) to one (1) to eight (8) to one (1). The substitution of a centrally located hydro-massage bathtub for a bathtub or shower that increases the resident to bathroom ratio above four (4) to one (1) may occur only once in a facility. The one time substitution of a centrally located hydro-massage bathtub does not preclude the installation of multiple hydro-massage bathtubs in the facility. The limitation applies only to the one-time reduction in the total number of bathrooms in the facility.
    - 2. The entry door to the bathroom shall have a lock that the resident can operate from the inside with no key needed. The resident's service plan may allow for a non-locking bathroom door if the resident's safety would otherwise be jeopardized.
- (4) **STAFFING REQUIREMENTS.** Each extended congregate care program shall:
- (a) Specify a staff member to serve as the extended congregate care supervisor if the administrator does not perform this function. If the administrator supervises more than one facility, he/she shall appoint a separate ECC supervisor for each facility holding an extended congregate care license.
    - 1. The extended congregate care supervisor shall be responsible for the general supervision of the day-to-day management of an ECC program and ECC resident service planning.
    - 2. The administrator of a facility with an extended congregate care license and the ECC supervisor, if separate from the administrator, must have a minimum of two years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting or agency serving elderly or disabled persons. A baccalaureate degree may be substituted for one year of the required experience. A nursing home administrator licensed under Chapter 468, F.S., shall be considered qualified under this paragraph.
  - (b) Provide, as staff or by contract, the services of a nurse who shall be available to provide nursing services as needed by ECC residents, participate in the development of resident service plans, and perform monthly nursing assessments.
  - (c) Provide enough qualified staff to meet the needs of ECC residents in accordance with Rule 58A-5.019, F.A.C., and the amount and type of services established in each resident's service plan.
  - (d) Regardless of the number of ECC residents, awake staff shall be provided to meet resident scheduled and unscheduled night needs.
  - (e) In accordance with agency procedures established in Rule 58A-5.019, F.A.C., the agency shall require facilities to immediately provide additional or more qualified staff, when the

agency determines that service plans are not being followed or that residents' needs are not being met because of the lack of sufficient or adequately trained staff.

- (f) Ensure and document that staff receive extended congregate care training as required under Rule 58A-5.0191, F.A.C.

(5) ADMISSION AND CONTINUED RESIDENCY.

- (a) An individual must meet the following minimum criteria in order to be admitted to an extended congregate care program.
  1. Be at least 18 years of age.
  2. Be free from signs and symptoms of a communicable disease which is likely to be transmitted to other residents or staff; however, a person who has human immunodeficiency virus (HIV) infection may be admitted to a facility, provided that he would otherwise be eligible for admission according to this rule.
  3. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted.
  4. Not be a danger to self or others as determined by a health care provider, or mental health practitioner licensed under Chapters 490 or 491, F.S.
  5. Not be bedridden.
  6. Not have any stage 3 or 4 pressure sores.
  7. Not require any of the following nursing services:
    - a. Oral or nasopharyngeal suctioning;
    - b. Nasogastric tube feeding;
    - c. Monitoring of blood gases;
    - d. Intermittent positive pressure breathing therapy;
    - e. Skilled rehabilitative services as described in Rule 59G-4.290, F.A.C.; or
    - f. Treatment of a surgical incision, unless the surgical incision and the condition which caused it have been stabilized and a plan of care developed.
  8. Not require 24-hour nursing supervision.
  9. Have been determined to be appropriate for admission to the facility by the facility administrator. The administrator shall base his/her decision on:
    - a. An assessment of the strengths, needs, and preferences of the individual, the health assessment required by subsection (6) of this rule, and the preliminary service plan developed under subsection (7);
    - b. The facility's residency criteria, and services offered or arranged for by the facility to meet resident needs; and
    - c. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established under Section 429.41, F.S., and Rule Chapter 4A-40, F.A.C.
- (b) Criteria for continued residency in an ECC program shall be the same as the criteria for admission, except as follows:
  1. A resident may be bedridden for up to 14 consecutive days.

2. A terminally ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
  - a. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice, which coordinates and ensures the provision of any additional care and services that may be needed;
  - b. Continued residency is agreeable to the resident and the facility;
  - c. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service within the scope of their license including 24-hour nursing supervision, and total help with the activities of daily living; and
  - d. Documentation of the requirements of this subparagraph is maintained in the resident's file.
- (6) HEALTH ASSESSMENT. Prior to admission to an ECC program, all persons including residents transferring within the same facility to that portion of the facility licensed to provide extended congregate care services, must be examined by a physician or advanced registered nurse practitioner pursuant to Rule 58A-5.0181, F.A.C. A health assessment conducted within 60 days prior to admission to the ECC program shall meet this requirement. Once admitted, a new health assessment must be obtained at least annually.
- (7) SERVICE PLANS.
  - (a) Prior to admission the extended congregate care supervisor shall develop a preliminary service plan which includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical and psycho social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs.
  - (b) Within 14 days of admission the congregate care supervisor shall coordinate the development of a written service plan which takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical and psycho social needs and preferences; and how the facility will meet the resident's needs including the following if required:
    1. Health monitoring;
    2. Assistance with personal care services;
    3. Nursing services;
    4. Supervision;
    5. Special diets;
    6. Ancillary services;
    7. The provision of other services such as transportation and supportive services; and
    8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences.
  - (c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in Section 429.02, F.S., the service plan shall be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, the facility designee, and shall reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences.

- (d) The service plan shall be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment.
- (8) EXTENDED CONGREGATE CARE SERVICES. All services shall be provided in the least restrictive environment, and in a manner, which respects the resident's independence, privacy, and dignity.
- (a) An extended congregate care program may provide supportive services including social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. Family or friends shall be encouraged to provide supportive services for residents. The facility shall provide training for family or friends to enable them to provide supportive services in accordance with the resident's service plan.
  - (b) An extended congregate care program shall make available the following additional services if required by the resident's service plan:
    - 1. Total help with bathing, dressing, grooming and toileting;
    - 2. Nursing assessments conducted more frequently than monthly;
    - 3. Measurement and recording of basic vital functions and weight;
    - 4. Dietary management including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
    - 5. Assistance with self-administered medications, or the administration of medications and treatments pursuant to a health care provider's order. If the individual needs assistance with self-administration the facility must inform the resident of the qualifications of staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's informed consent to provide such assistance as required under Section 429.256, F.S.;
    - 6. Supervision of residents with dementia and cognitive impairments;
    - 7. Health education and counseling and the implementation of health-promoting programs and preventive regimes;
    - 8. Provision or arrangement for rehabilitative services; and
    - 9. Provision of escort services to health-related appointments.
  - (c) Licensed nursing staff in an extended congregate care program may provide any nursing service permitted within the scope of their license consistent with the residency requirements of this rule and the facility's written policies and procedures, and the nursing services are:
    - 1. Authorized by a health care provider's order and pursuant to a plan of care;
    - 2. Medically necessary and appropriate for treatment of the resident's condition;
    - 3. In accordance with the prevailing standard of practice in the nursing community;
    - 4. A service that can be safely, effectively, and efficiently provided in the facility;
    - 5. Recorded in nursing progress notes; and

6. In accordance with the resident's service plan.
  - (d) At least monthly, or more frequently if required by the resident's service plan, a nursing assessment of the resident shall be conducted.
- (9) RECORDS.
- (a) In addition to the records required under Rule 58A-5.024, F.A.C., an extended congregate care program shall maintain the following:
    1. The service plans for each resident receiving extended congregate care services;
    2. The nursing progress notes for each resident receiving nursing services;
    3. Nursing assessments; and
    4. The facility's ECC policies and procedures.
  - (b) Upon request, a facility shall report to the department such information as necessary to meet the requirements of Section 429.07(3)(b)9., F.S.
- (10) DISCHARGE. If the facility and the resident are unable to agree on a service plan, or if the facility is unable to meet the resident's needs as identified in the service plan, or if the resident no longer meets the criteria for continued residency, the resident shall be discharged in accordance with Sections 429.26(8) and 429.28(1), F.S.

Specific Authority 429.07, 429.41 FS. Law Implemented 429.02, 429.07, 429.255, 429.26, 429.28, 429.41 FS. History—New 9-30-92, Formerly 10A-5.030, Amended 10-30-95, 6-2-96, 4-20-98, 11-2-98, 10-17-99, 7-30-06.

## **Appendix III – ALF Residency Criteria and Admission Procedures Rule (58A-5.0181, F.A.C.)**

### **58A-5.0181 Residency Criteria and Admission Procedures.**

- (1) **ADMISSION CRITERIA.** An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing or limited mental health license.
  - (a) Be at least 18 years of age.
  - (b) Be free from signs and symptoms of any communicable disease which is likely to be transmitted to other residents or staff; however, a person who has human immunodeficiency virus (HIV) infection may be admitted to a facility, provided that he would otherwise be eligible for admission according to this rule.
  - (c) Be able to perform the activities of daily living, with supervision or assistance if necessary.
  - (d) Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted.
  - (e) Be capable of taking his/her own medication with assistance from staff if necessary.
    1. If the individual needs assistance with self-administration the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance, and if unlicensed staff will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's written informed consent to provide such assistance as required under Section 429.256, F.S.
    2. The facility may accept a resident who requires the administration of medication, if the facility has a nurse to provide this service, or the resident or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact contracts with a licensed third party to provide this service to the resident.
  - (f) Any special dietary needs can be met by the facility.
  - (g) Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under Chapters 490 or 491, F.S.
  - (h) Not require licensed professional mental health treatment on a 24-hour a day basis.
  - (i) Not be bedridden.
  - (j) Not have any stage 3 or 4 pressure sores. A resident requiring care of a stage 2 pressure sore may be admitted provided that:
    1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care;
    2. The condition is documented in the resident's record; and
    3. If the resident's condition fails to improve within 30 days, as documented by a licensed nurse or physician, the resident shall be discharged from the facility.
  - (k) Not require any of the following nursing services:
    1. Oral, nasopharyngeal, or tracheotomy suctioning;
    2. Assistance with tube feeding;

3. Monitoring of blood gases;
  4. Intermittent positive pressure breathing therapy; or
  5. Treatment of surgical incisions or wounds, unless the surgical incision or wound and the condition which caused it have been stabilized and a plan of care developed.
- (l) Not require 24-hour nursing supervision.
  - (m) Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C.
  - (n) Have been determined by the facility administrator to be appropriate for admission to the facility. The administrator shall base the decision on:
    1. An assessment of the strengths, needs, and preferences of the individual, and the medical examination report required by Section 429.26, F.S., and subsection (2) of this rule;
    2. The facility's admission policy, and the services the facility is prepared to provide or arrange for to meet resident needs; and
    3. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established under Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C.
  - (o) Resident admission criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
- (2) HEALTH ASSESSMENT.
- (a) The medical examination report completed within 60 days prior to the individual's admission to a facility pursuant to Section 429.26(4), F.S., shall address the following:
    1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations;
    2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living;
    3. Any nursing or therapy services required by the individual;
    4. Any special diet required by the individual;
    5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication;
    6. Whether the individual has signs or symptoms of a communicable disease, which is likely to be transmitted to other residents or staff;
    7. A statement that in the opinion of the examining physician or ARNP, on the day the examination is conducted, the individual's needs can be met in an assisted living facility; and
    8. The date of the examination, and the name, signature, address, phone number, and license number of the examining physician or ARNP. The medical examination may be conducted by a currently licensed physician or ARNP from another state.
  - (b) Medical examinations completed after the admission of the resident to the facility must be completed within 30 days of the date of admission and must be recorded on the Resident Health Assessment For Assisted Living Facilities (ALF), AHCA Form 1823, January 2006, which is incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central

Office or its website at <http://ahca.myflorida.com> DOEA. Previous versions of this form completed up to six (6) months after 7-30-06 are acceptable.

- (c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual's admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
- (d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
- (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
- (f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the physician or ARNP conducting the medical examination may be attached to the health assessment. A physician may attach a do-not-resuscitate order for residents who do not wish cardiopulmonary resuscitation to be administered in the case of cardiac or respiratory arrest.
- (g) A resident placed on an temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility's admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.

(3) **ADMISSION PACKAGE.**

- (a) The facility shall make available to potential residents a written statement or statements which includes the following information. A facility promotional brochure or a copy of the facility resident contract form containing all of the required information shall meet this requirement:
  - 1. The facility's residency criteria;
  - 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provide by the facility for that rate;
  - 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any;
  - 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any;
  - 5. Food service and the ability of the facility to accommodate special diets;
  - 6. The availability of transportation and additional costs to the resident, if any;
  - 7. Any other special services that are provided by the facility and additional cost if any;
  - 8. Social and leisure activities generally offered by the facility;
  - 9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any;

10. A statement of facility rules and regulations that residents must follow as described in Rule 58A-5.0182, F.A.C.;
  11. A statement of the facility policy concerning Do Not Resuscitate Orders pursuant to Section 429.255, F.S., and Advance Directives pursuant to Chapter 765, F.S.
  12. If the facility also has an extended congregate care program, the ECC program's residency criteria; a description of the additional personal, supportive, and nursing services provided by the program; additional costs; and any limitations, if any, on where ECC residents must reside based on the policies and procedures described in Rule 58A-5.030, F.A.C.; and
  13. If the facility advertises that it provides special care for persons with Alzheimer's disease or related disorders, a written description of those special services as required under Section 429.177, F.S.
- (b) Prior to or at the time of admission the resident, responsible party, guardian, or attorney in fact, if applicable, shall be provided with the following:
1. A copy of the resident's contract, which meets the requirements of Rule 58A-5.025, F.A.C.;
  2. A copy of the facility statement described in paragraph (a) if one has not already been provided;
  3. A copy of the resident's bill of rights as required by Rule 58A-5.0182, F.A.C.; and
  4. A Long-Term Care Ombudsman Council brochure, which includes the telephone number and address of the district council.
- (c) Documents required by this subsection shall be in English. If the resident is not able to read, or does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident.
- (4) CONTINUED RESIDENCY. Criteria for continued residency in a facility holding a standard, limited nursing services, or limited mental health license shall be the same as the criteria for admission, except as follows:
- (a) The resident may be bedridden for up to 7 consecutive days.
- (b) A resident requiring care of a stage 2 pressure sore may be retained provided that:
1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a physician, or the resident contracts directly with a licensed home health agency or a nurse to provide care;
  2. The condition is documented in the resident's record; and
  3. If the resident's condition fails to improve within 30 days, as documented by a licensed nurse or physician, the resident shall be discharged from the facility.
- (c) A terminally ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice, which coordinates and ensures the provision of any additional care and services that may be needed;
  2. Continued residency is agreeable to the resident and the facility;

3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living; and
  4. Documentation of the requirements of this paragraph is maintained in the resident's file.
- (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
  - (e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
- (5) **DISCHARGE.** If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

*Specific Authority 429.07, 429.26, 429.41 FS. Law Implemented 429.02, 429.07, 429.075, 429.26, 429.41 FS. History--New 9-17-84, Formerly*

*10A-5.181, Amended 10-20-86, 6-21-88, 8-15-90, 9-30-92, Formerly 10A-5.0181, Amended 10-30-95, 6-2-96, 10-17-99, 7-30-06.*

## Appendix IV – ALF Resident Care Standards Rule (58A-5.0182, F.A.C.)

### 58A-5.0182 Resident Care Standards.

An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility.

- (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following:
  - (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C.
  - (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual.
  - (c) General awareness of the resident's whereabouts. The resident may travel independently in the community.
  - (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
  - (e) A written record, updated as needed, of any significant changes as defined in 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.
- (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community.
  - (a) The facility shall provide an ongoing activities program. The program shall provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests.
  - (b) The facility shall consult with the residents in selecting, planning, and scheduling activities. The facility shall demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility.
  - (c) Scheduled activities shall be available at least six (6) days a week for a total of not less than twelve (12) hours per week. Watching television shall not be considered an activity for the purpose of meeting the twelve (12) hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required twelve (12) hours per week of scheduled activities. An activities calendar shall be posted in common areas where residents normally congregate.
  - (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to three (3) hours may be counted toward the required activity time.

- (3) **ARRANGEMENT FOR HEALTH CARE.** In order to facilitate resident access to needed health care, the facility shall, as needed by each resident:
- (a) Assist residents in making appointments and remind residents about scheduled appointments for medical, dental, nursing, or mental health services.
  - (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxicabs, public buses, and agencies providing transportation for persons with disabilities.
  - (c) The facility may not require residents to see a particular health care provider.
- (4) **ACTIVITIES OF DAILY LIVING.** Facilities shall offer supervision of or assistance with activities of daily living as needed by each resident. Residents shall be encouraged to be as independent as possible in performing ADLs.
- (5) **NURSING SERVICES.**
- (a) Pursuant to Section 429.255, F.S., the facility may employ or contract with a nurse to:
    - 1. Take or supervise the taking of vital signs;
    - 2. Manage pill-organizers and administer medications as described under Rule 58A-5.0185, F.A.C.;
    - 3. Give prepackaged enemas pursuant to a physician's order; and
    - 4. Maintain nursing progress notes.
  - (b) Pursuant to Section 464.022, F.S., the nursing services listed in paragraph (a) may also be delivered in the facility by family members or friends of the resident provided the family member or friend does not receive compensation for such services.
- (6) **RESIDENT RIGHTS AND FACILITY PROCEDURES.**
- (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.
  - (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.
  - (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with Disabilities, 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
  - (d) The statewide toll-free telephone number of the Florida Abuse Hotline "1(800) 96-ABUSE or 1(800) 962-2873" shall be posted in full view in a common area accessible to all residents.
  - (e) The facility shall have written statement of the facility's house rules and procedures, which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's alcohol and tobacco policy,

medication storage, the delivery of services to residents by third party providers, and other administrative and housekeeping practices, schedules, and requirements.

- (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
  - (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
  - (h) Pursuant to Section 429.41, F.S., the use of physical restraints shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, shall not be considered a physical restraint.
- (7) **THIRD PARTY SERVICES.** Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, contracting, and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies may require the third party to coordinate with the facility regarding the resident's condition and the services being provided. Pursuant to subsection (6), the facility shall provide the resident with the facility's policy regarding the provision of services to residents by non-facility staff.
- (8) **OTHER STANDARDS.** Additional care standards for residents residing in a facility holding a limited mental health, extended congregate care or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

*Specific Authority 429.02, 429.41 FS. Law Implemented 429.02, 429.255, 429.256, 429.26, 429.28, 429.41 FS. History—New 9-17-84, Formerly*

*10A-5.182, Amended 10-20-86, 6-21-88, 8-15-90, 9-30-92, Formerly 10A-5.0182, Amended 10-30-95, 4-20-98, 11-2-98, 10-17-99, 7-30-06.*

## **Appendix V – ALF Medication Practices Rule**

### **(58A-5.0185, F.A.C.)**

#### **58A-5.0185 Medication Practices.**

Pursuant to Sections 429.255 and 429.256, F.S., and this rule, facilities holding a standard, limited mental health, extended congregate care, or limited nursing services license may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule.

- (1) SELF ADMINISTERED MEDICATIONS.
  - (a) Residents who are capable of self-administering their medications without assistance shall be encouraged and allowed to do so.
  - (b) If facility staff note deviations which could reasonably be attributed to the improper self-administration of medication, staff shall consult with the resident concerning any problems the resident may be experiencing with the medications; the need to permit the facility to aid the resident through the use of a pill organizer, provide assistance with self-administration of medications, or administer medications if such services are offered by the facility. The facility shall contact the resident's health care provider when observable health care changes occur that may be attributed to the resident's medications. The facility shall document such contacts in the resident's records.
- (2) PILL ORGANIZERS.
  - (a) A "pill organizer" means a container which is designed to hold solid doses of medication and is divided according to day and time increments.
  - (b) A resident who self-administers medications may use a pill organizer.
  - (c) A nurse may manage a pill organizer to be used only by residents who self-administer medications. The nurse is responsible for instructing the resident in the proper use of the pill organizer. The nurse shall manage the pill organizer in the following manner:
    1. Obtain the labeled medication container from the storage area or the resident;
    2. Transfer the medication from the original container into a pill organizer, labeled with the resident's name, according to the day and time increments as prescribed;
    3. Return the medication container to the storage area or resident; and
    4. Document the date and time the pill organizer was filled in the resident's record.
  - (d) If there is a determination that the resident is not taking medications as prescribed after the medicinal benefits are explained, it shall be noted in the resident's record and the facility shall consult with the resident concerning providing assistance with self-administration or the administration of medications if such services are offered by the facility. The facility shall contact the resident's health care provider regarding questions, concerns, or observations relating to the resident's medications. Such communication shall be documented in the resident's record.
- (3) ASSISTANCE WITH SELF-ADMINISTRATION.
  - (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least 18 years old, trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription

label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.

- (b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.
  - (c) Staff shall observe the resident take the medication. Any concerns about the resident's reaction to the medication shall be reported to the resident's health care provider and documented in the resident's record.
  - (d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
    - 1. The health care provider may prescribe a medication schedule, which coincides with the resident's presence in the facility;
    - 2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident's medication record;
    - 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record; or
    - 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
  - (e) Pursuant to Section 429.256(4)(h), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
  - (f) Pursuant to Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.
- (4) **MEDICATION ADMINISTRATION.**
- (a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider's order or prescription label.
  - (b) Unusual reactions or a significant change in the resident's health or behavior shall be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider shall also be documented in the resident's record.
  - (c) Medication administration includes the conducting of any examination or testing such as blood glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff.
  - (d) A facility which performs clinical laboratory tests for residents, including blood glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State

Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' own equipment. Information about the State Clinical Laboratory License and CLIA Certificate is available from the Clinical Laboratory Licensure Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850) 487-3109.

(5) MEDICATION RECORDS.

- (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use.
- (b) The facility shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known allergies the resident may have; the name of the resident's health care provider, the health care provider's telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.
- (c) For medications which serve as chemical restraints, the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.

(6) MEDICATION STORAGE AND DISPOSAL.

- (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their rooms or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the rooms or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:
  - 1. The facility administers the medication;
  - 2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;
  - 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
  - 4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
  - 5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or
  - 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.

- (b) Centrally stored medications must be:
    - 1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, room, or area at all times;
    - 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;
    - 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and
    - 4. Kept separately from the medications of other residents and properly closed or sealed.
  - (c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident's request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked "discontinued medication." Such medication may be reused if re-prescribed by the resident's health care provider.
  - (d) When a resident's stay in the facility has ended, the administrator shall return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications shall be considered abandoned and may be disposed of in accordance with paragraph (e).
  - (e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
  - (f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.
- (7) MEDICATION LABELING AND ORDERS.
- (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:
    - 1. The resident's name; and
    - 2. Identification of each medicinal drug product in the container.
  - (b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another.
  - (c) If the directions for use are "as needed" or "as directed," the health care provider shall be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the

medication and any limitations shall be specified; for example, “as needed for pain, not to exceed 4 tablets per day.” The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.

- (d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident’s health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident’s medication observation record. The facility may then place an “alert” label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.
  - (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident’s medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed copy of a signed order is acceptable.
  - (f) The facility shall make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
  - (g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer’s packaging, which shall also include the practitioner’s name, the resident’s name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer’s labeled package, they shall be kept in a container that bears a label containing the following:
    - 1. Practitioner’s name;
    - 2. Resident’s name;
    - 3. Date dispensed;
    - 4. Name and strength of the drug;
    - 5. Directions for use; and
    - 6. Expiration date.
  - (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident’s health care provider shall provide the resident with a written prescription, or a fax copy of such order.
- (8) OVER THE COUNTER (OTC) MEDICATIONS.
- (a) A stock supply of OTC medications for multiple resident use is not permitted in any facility.
  - (b) Non-prescription over-the-counter drugs, when centrally stored, shall be labeled with the resident’s name, and the manufacturer’s label with directions for use shall be kept with the medication.
  - (c) When an over-the-counter medication is prescribed by a health care provider, the medication becomes a prescription medication and shall be managed in accordance with prescription medication under this rule.

*Specific Authority 429.256, 429.41 FS. Law Implemented 429.255, 429.256, 429.41 FS.  
History—New 10-17-99, Amended 7-30-06.*