The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Storms, Chair
Senator Rich, Vice Chair

MEETING DATE: Thursday, November 3, 2011
TIME: 10:30 a.m.—12:15 p.m.
PLACE: *James E. "Jim" King, Jr. Committee Room,* 401 Senate Office Building

MEMBERS: Senator Storms, Chair; Senator Rich, Vice Chair; Senators Detert, Dockery, Gibson, and Latvala

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 274** Sachs (Identical H 419)	Child Care Facilities; Cites this act as the "Haile Brockington Act;" requiring vehicles used by child care facilities and large family child care homes to be equipped with an alarm system that prompts the driver to inspect the vehicle for children before exiting the vehicle; requiring the Department of Children and Family Services to adopt rules and maintain a list of approved alarm systems, etc. CF 11/03/2011 Fav/CS BC	Fav/CS Yeas 6 Nays 0
2	**SB 316** Wise	Alzheimer's Disease; Directing the Department of Elderly Affairs to develop and implement a public education program relating to screening for Alzheimer's disease; providing criteria for awarding grants; requiring grant recipients to submit an evaluation of certain activities to the department; authorizing the department to provide technical support; providing for implementation of the public education program to operate within existing resources of the department; providing that implementation of the memory-impairment screening grant program is contingent upon an appropriation of state funds or the availability of private resources; specifying the types of facilities where an employee or direct caregiver providing care for persons with Alzheimer's disease may begin employment without repeating certain training requirements, etc. CF 11/03/2011 Fav/CS BC	Fav/CS Yeas 6 Nays 0
3	iBudget Progress Report Presented by Michael Hansen, Director, Agency for Persons with Disabilities		Presented
4	Discussion on Issues Relating to Assisted Living Facilities in Florida		Discussed
5	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Children, Families, and Elder Affairs Committee

BILL:	CS/SB 274
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Sachs
SUBJECT:	Child Care Facilities
DATE:	November 3, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Farmer	CF	**Fav/CS**
2.			BC	
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This bill creates the "Haile Brockington Act" and provides that on or before January 1, 2013, vehicles used by child care facilities and large family child care homes to transport children must be equipped with an alarm system approved by the Department of Children and Families (DCF or department) that prompts the driver to inspect the vehicle for children before exiting. The bill provides that DCF shall adopt rules to administer the new provision of law and shall maintain a list of alarm manufacturers and alarm systems that are approved to be installed in such vehicles.

This bill substantially amends section 402.305, Florida Statutes.

II. Present Situation:

Licensing Standards for Child Care Facilities

The Department of Children and Families (DCF or department) establishes licensing standards that each licensed child care facility in the state must meet.[1] A child care facility is defined in

[1] See s. 402.305, F.S.

Florida law as "any child care center or child care arrangement which provides child care for more than five children unrelated to the operator and which receives a payment, fee, or grant for any of the children receiving care, wherever operated, and whether or not operated for profit."[2] The department currently regulates 7,791 child care arrangements, including child care facilities, large family child care homes, family day care homes, and registered homes.[3] In addition, as of January 2010, six counties in the state which conduct their own licensure of homes currently license 4,292 child care arrangements.[4]

The statutory licensing standards for child care facilities are extensive and include standards for transportation and vehicles; however, current standards for licensed child care providers do not address alarm systems in vehicles. Rule 65C-22.001(6) of the Florida Administrative Code provides requirements for licensed child care facilities to follow in relation to vehicles that are owned, operated, or regularly used by the child care facility, as well as vehicles that provide transportation through a contract or agreement with an outside entity. Specifically:

- The driver of any such vehicle must have a valid driver's license and must have an annual physical exam granting the driver medical approval to drive;
- All child care facilities must comply with insurance requirements;
- All vehicles must be inspected annually;
- The maximum number of individuals transported may not exceed the manufacturer's designated seating capacity or the number of factory installed seat belts;
- Each child must be wearing a factory installed seat belt when riding in the vehicle;
- When transporting children, the staff-to-child ratios must be maintained;
- Each vehicle must have the contact information of each child being transported;
- Providers must maintain a driver's log for all children being transported. This log includes the child's name, date, time of departure, time of arrival, signature of driver, and signature of second staff member to verify the driver's log and that all children have left the vehicle;
- Upon arrival at the destination, the driver of the vehicle must mark each child off the log as the child departs the vehicle; conduct a physical inspection and visual sweep of the vehicle; and sign, date, and record the driver's log immediately to verify all children were accounted for and that the sweep was conducted;
- Upon arrival at the destination, a second staff member must also conduct a physical inspection and visual sweep of the vehicle and sign, date, and record the driver's log to verify all children were accounted for and that the driver's log is complete.

There are similar requirements for family day care homes and large family child care homes.[5]

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[2] Section 402.302(2), F.S.
[3] Florida Dep't of Children and Families, *DCF Quick Facts*, 7 (Jan. 31, 2011), *available at* http://www.dcf.state.fl.us/newsroom/docs/quickfacts.pdf (last visited Oct. 19, 2011).
[4] Health Care Servs. Policy Comm., Florida House of Representatives, *Staff Analysis on HB 487*, 2 (Jan. 26, 2010), *available at* http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=h0487.HCS.doc&DocumentType=Analysis&BillNumber=0487&Session=2010 (last visited Oct. 19, 2011).
[5] See Rules 65C-20.10(8) and 65C-20.13(8), F.A.C.

Children and Vehicles

In August 2010, 2 1/2 year old Haile Brockington died after being left in her car seat for nearly six hours in the back of a van employed by a Palm Beach County child care facility. According to the National Weather Service in Miami, the weather that day reached a high of 91 degrees.[6] The child care facility was licensed by DCF and had no violations against it at the time of the incident.[7]

"Death by hyperthermia" (or overheating of the body) has become much more prevalent since Federal law required that children ride in the backseat due to the danger of front passenger seat airbags.[8] Between 1998 and 2010, there have been approximately 495 child hyperthermia deaths, with 49 during the year 2010.[9] Thirty-one percent of hyperthermia deaths involve children under the age of one.[10] According to a Miami newspaper, roughly one-sixth of hyperthermia cases occur in Florida.[11] Approximately 60 children have died in Florida from being left in a vehicle and more than 150 have been injured.[12] Prosecutions and penalties vary widely and in total, charges were filed in 58 percent of Florida cases.[13]

III. Effect of Proposed Changes:

This bill creates the "Haile Brockington Act" and provides that on or before January 1, 2013, vehicles used by child care facilities and large family child care homes to transport children must be equipped with an alarm system approved by the Department of Children and Families (DCF or department) that prompts the driver to inspect the vehicle for children before exiting. The bill provides that DCF shall adopt rules to administer the new provision of law and shall maintain a list of alarm manufacturers and alarm systems that are approved to be installed in such vehicles.

The bill provides an effective date of July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[6] Julius Whigham II and Eliot Kleinberg, *Girl, 2 1/2, found dead in van at Delray Beach day care center*, THE PALM BEACH POST, Aug. 5, 2010 (updated Aug. 12, 2010), *available at* http://www.palmbeachpost.com/news/girl-1-1-2-found-dead-in-van-843774.html (last visited Oct. 19, 2011).
[7] *Id*.
[8] See Kids and Cars.org, *Fact Sheet*, http://www.kidsandcars.org/userfiles/dangers/heat-stroke/heat-stroke-fact-sheet.pdf (last visited Oct. 19, 2011); *see also* Gene Weingarten, *Fatal Distraction: Forgetting a Child in the Backseat of a Car is a Horrifying Mistake. Is it a Crime?*, THE WASHINGTON POST, Mar. 8, 2009, at W08, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2009/02/27/AR2009022701549.html (last visited Oct. 19, 2011).
[9] Kids and Cars.org, *supra* note 8.
[10] *Id*.
[11] Michael J. Mooney, *Babies left in hot cars: Accident or crime?*, MIAMI NEW TIMES, Oct. 14, 2010, *available at* http://www.miaminewtimes.com/2010-10-14/news/babies-left-in-hot-cars-accident-or-crime/# (last visited Oct. 19, 2011).
[12] *Id*.
[13] *Id*.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill requires owners and operators of child care facilities and large family day care homes to purchase and install an alarm system in all vehicles used by the facility or home to transport children that alerts the driver to inspect the vehicle for children before exiting the vehicle. According to the Department of Children and Families (DCF or department), there are two products that may currently be used that meet the requirements of the bill. The estimated cost related to the first product for owners and operators of child care facilities statewide is approximately $838,814 for the first year and $162,750 each additional fiscal year thereafter.[14] With regards to the second product, the estimated cost for owners and operators is $976,500 for the first year.[15] There is not an annual re-certification required with the second product, therefore no ongoing cost is associated with it at this time. See breakdown of cost below per product.

Product 1:

Unit Price of Device	$289.95 per vehicle
Installation Cost	$85.00 per vehicle
Shipping Cost	$11.60 per unit
Manufacturer's Annual Required Re-certification Cost*	$75.00
Total Cost for One Facility	$461.55
Total Cost for 2,170 Facilities	**$838,814**[16]

*Recurring cost

[14] Dep't of Children and Families, *Staff Analysis and Economic Impact SB 274* (Sept. 21, 2011) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[15] *Id*.
[16] The total cost does not include the manufacturer's annual re-certification of the unit for the first year. Additionally, the estimated costs do not take into account if a facility has more than one vehicle requiring a device.

Product 2:

Unit Price of Device	$450.00
Total Cost for One Facility	$450.00
Total Cost for 2,170 Facilities	**$976,500**[17]

C. Government Sector Impact:

The department will be responsible for writing rules to regulate this new requirement, as well as creating and maintaining manufacturer and alarm system approval protocols and compliance enforcement methodology.

VI. Technical Deficiencies:

The title of the bill provides that the bill requires vehicles used by child care facilities *and large family child care homes* to be equipped with an alarm system prompting the driver to check for children before exiting the vehicle (lines 4-5 of the bill). According to the Department of Children and Families (DCF or department), most large family child care homes use a personal vehicle if transporting children and the alarm devices may not be practical for personal vehicles.[18]

VII. Related Issues:

According to DCF, the implementation date of the bill may not provide the department with enough time to research the types of alarm systems available, to craft rules and compliance enforcement methodology, and to prepare licensing staff to enforce and provide technical assistance.[19] Additionally, DCF does not maintain the expertise to "approve" these devices. This task may be more appropriate for the Consumer Product Safety Council. The department recommends only requiring that DCF maintain a list of available products, without providing approval for the actual product.[20]

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on November 3, 2011:
The committee substitute clarifies that on or *before* January 1, 2013, vehicles used by child care facilities and large family child care homes to transport children must be equipped with an alarm system that prompts the driver to inspect the vehicle for children before exiting.

[17] The total estimated cost does not take into account if a facility has more than one vehicle requiring a device.
[18] Dep't of Children and Families, *supra* note 14.
[19] *Id*.
[20] *Id*.

B. Amendments:

None.

553542

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/03/2011	.	
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The Committee on Children, Families, and Elder Affairs (Rich) recommended the following:

Senate Amendment

Delete line 26
and insert:
(b)1. On or before January 1, 2013, such vehicles must be

By Senator Sachs

30-00049-12 2012274__

A bill to be entitled

An act relating to child care facilities; providing a short title; amending s. 402.305, F.S.; requiring vehicles used by child care facilities and large family child care homes to be equipped with an alarm system that prompts the driver to inspect the vehicle for children before exiting the vehicle; requiring the Department of Children and Family Services to adopt rules and maintain a list of approved alarm systems; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act may be cited as the "Haile Brockington Act."

Section 2. Subsection (10) of section 402.305, Florida Statutes, is amended to read:

402.305 Licensing standards; child care facilities.—

(10) TRANSPORTATION SAFETY.—

(a) Minimum standards shall include requirements for child restraints or seat belts in vehicles used by child care facilities and large family child care homes to transport children, requirements for annual inspections of the vehicles, limitations on the number of children in the vehicles, and accountability for children being transported.

(b)1. On or after January 1, 2013, such vehicles must be equipped with an alarm system approved by the department which prompts the driver to inspect the vehicle for children before exiting the vehicle.

30-00049-12 2012274__

2. The department shall adopt rules to administer this paragraph and shall maintain a list of alarm manufacturers and alarm systems that are approved to be installed in such vehicles.

Section 3. This act shall take effect July 1, 2012.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/3/11
Meeting Date

Topic _____ Bill Number SB 274 *(if applicable)*

Name SAM BELL Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 1298 MILLSTREAM N Phone 222-3533
Street

TALLAHASSEE, FL 32312 E-mail shell@pennington.us
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Children's Service Council

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Children, Families, and Elder Affairs Committee

BILL:	CS/SB 316
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Wise
SUBJECT:	Alzheimer's Disease
DATE:	November 3, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Farmer	CF	**Fav/CS**
2.			BC	
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This bill directs the Department of Elder Affairs (DOEA or "the department") to establish a public education program relating to screening for memory impairment. The bill also creates the memory-impairment screening grant program and authorizes DOEA to award grants in support of programs which provide information and education on the importance of memory screening as well as memory screening services. The bill establishes criteria for selecting grant recipients and requires that the department give preference to entities meeting certain requirements. Each grantee must submit an annual evaluation of its activities to the department. Additionally, DOEA must submit an annual report to the President of the Senate and the Speaker of the House of Representatives documenting the activities authorized by the bill.

Additionally, the bill makes technical changes relating to staff training requirements for persons assisting those with Alzheimer's disease.

The bill amends the following sections of the Florida Statutes: 400.1755, 400.6045, and 429.178. This bill creates section 430.5025, Florida Statutes.

II. Present Situation:

Alzheimer's Disease

Alzheimer's disease is a progressive, degenerative disorder that attacks the brain's nerve cells and results in loss of memory, thinking, and language skills, and behavioral changes.[1] There are approximately 5.4 million Americans currently living with Alzheimer's disease, and that number is projected to rise to 16 million by 2050.[2] As the life expectancy for Americans has continued to rise, so has the number of new cases of Alzheimer's disease. For instance, in 2000 there were an estimated 411,000 new cases of Alzheimer's disease in the United States, and in 2010 that number was estimated to be 454,000 – a 10 percent increase.[3] That number is expected to rise to 959,000 new cases of Alzheimer's disease by 2050, a 130-percent increase from 2000.[4] Specifically in Florida, approximately 360,000 people age 65 or older had Alzheimer's disease in 2000 and in 2010, that number had risen to 450,000.

As the number of people with Alzheimer's disease increases, so does the cost of caring for these individuals. In 2011, the aggregate cost for health care, long-term care, and hospice for persons with Alzheimer's and other dementias was estimated to be $183 billion. That number is projected to be $1.1 trillion by 2050.[5] A major contributing factor to the cost of care for persons with Alzheimer's is that these individuals have more hospital stays, skilled nursing home stays, and home healthcare visits than older persons who do not have Alzheimer's. Research shows that 22 percent of individuals with Alzheimer's disease who have Medicare also have Medicaid coverage, which pays for nursing home care and other long-term care services.[6] The total Medicaid spending for people with Alzheimer's disease (and other dementia) was estimated to be $37 billion in 2011.[7]

In addition to the cost of health care, there is a significant cost associated with unpaid caregivers. An unpaid caregiver is primarily a family member, but can also be other relatives or friends. Such caregivers often provide assistance with daily activities, such as shopping for groceries, preparing meals, bathing, dressing, grooming, assisting with mobility, helping the person take medications, making arrangements for medical care, and performing other household chores. Nationally, in 2010, nearly 15 million unpaid caregivers provided an estimated 17 billion hours of unpaid care, valued at $202.6 billion.[8] In 2010, there were 960,037 caregivers in Florida with an estimated value of unpaid care reaching nearly $13.5 million.[9]

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[1] Alzheimer's Foundation of America, *About Alzheimer's, Definition of Alzheimer's,* http://www.alzfdn.org/AboutAlzheimers/definition.html (last visited Aug. 2, 2011).
[2] Alzheimer's Assn., *Fact Sheet: 2011 Alzheimer's Disease Facts and Figures* (March 2011), *available at* http://www.alz.org/documents_custom/2011_Facts_Figures_Fact_Sheet.pdf (last visited Aug. 3, 2011).
[3] Alzheimer's Assn., *2011 Alzheimer's Disease Facts and Figures*, 7 ALZHEIMER'S & DEMENTIA (Issue 2) at 17, *available at* http://www.alz.org/downloads/Facts_Figures_2011.pdf (last visited Oct. 27, 2011).
[4] *Id*.
[5] *Id.* at 35.
[6] *Id*.
[7] *Id*. at 44.
[8] This number was established by using an average of 21.9 hours of care a week with a value of $11.93 per hour. *Id.* at 27.
[9] *Id*. at 32.

Alzheimer's disease is the nation's sixth leading cause of death with an average life expectancy of four to eight years after diagnosis.[10] In Florida, 4,644 people died of complications related to Alzheimer's disease in 2007.[11]

Memory Screening and Early Diagnosis

Alzheimer's disease can only be confirmed by an autopsy; however, clinicians can attempt to diagnose the disease by taking a complete medical history and conducting lab tests, a physical exam, brain scans, and neuro-psychological tests that gauge memory, attention, language skills, and problem-solving abilities. Using these methods, clinicians are able to diagnose Alzheimer's disease with up to 90-percent accuracy.[12] Although there is no known cure for Alzheimer's disease, the U.S. Food and Drug Administration has approved a few medications that have been found to help control symptoms or slow the progression of the disease.[13] Thus, early detection of the disease enhances the possibility of effective treatment. Early diagnosis can also enable patients to participate in decisions regarding their care.

Memory screenings consist of a series of questions or tasks designed to test memory and other intellectual functions. They are not used to diagnose any particular illness, but can be very helpful in indicating whether an individual would benefit from further testing to identify Alzheimer's disease, related dementias, or other possible causes of symptoms which mimic Alzheimer's disease.[14] These screenings are typically provided by professionals such as social workers, pharmacists, nurses, and doctors.

Alzheimer's Disease Initiative

The Alzheimer's Disease Initiative (ADI) was legislatively created in 1985 to provide a continuum of services to meet the changing needs of individuals with, and families affected by, Alzheimer's disease and related disorders. The Initiative has four objectives: (1) to provide supportive services; (2) to establish memory disorder clinics; (3) to provide model day care programs to test new care alternatives; and (4) to establish a research database and brain bank to support research.[15] There are 15 memory disorder clinics throughout the state, 13 of which are state funded.[16] The purpose of these clinics is to conduct research related to diagnostic technique, therapeutic interventions, and supportive services for persons with Alzheimer's disease and to develop caregiver-training materials.[17] According to ADI, the memory disorder clinics are required to:

- Provide services to persons suspected of having Alzheimer's disease or other related dementia;

[10] *Id.* at 23.
[11] *Id.* at 22.
[12] Alzheimer's Foundation of America, *About Alzheimer's, Diagnosis*, http://www.alzfdn.org/AboutAlzheimers/diagnosis.html (last visited Aug. 2, 2011).
[13] To see a list of FDA approved medications, go to the Alzheimer's Foundation of America, *About Alzheimer's Treatment,* http://www.alzfdn.org/AboutAlzheimers/treatment.html (last visited Aug. 3, 2011).
[14] Alzheimer's Foundation of America, *Brain Health,* http://www.alzfdn.org/BrainHealth/memoryscreenings.html (last visited Oct. 24, 2011).
[15] Dep't of Elder Affairs, *Alzheimer's Disease Initiative*, http://elderaffairs.state.fl.us/english/alz.php (last visited Aug. 16, 2011).
[16] *Id*.
[17] Section 430.502(2), F.S.

- Provide four hours of in-service training during the contract year to all ADI respite and model day care service providers and develop and disseminate training models to service providers and the Department of Elder Affairs;
- Develop training materials and educational opportunities for lay and professional caregivers and provide specialized training for caregivers and caregiver organizations;
- Conduct service-related applied research;
- Establish a minimum of one annual contact with each respite care and model day care service provider to discuss, plan, develop, and conduct service-related research projects; and
- Plan for the public dissemination of research findings through professional papers and to the general public.[18]

Multi-disciplinary teams provide comprehensive evaluations, treatment recommendations, long-term care strategies, and follow-up services to patients, caregivers, and families. The memory disorder clinics offer a full range of tests to determine whether thinking difficulties and symptoms of forgetfulness are a result of everyday life pressures, or the sign of a memory disorder. The memory disorder clinics offer free and confidential memory screenings, medical evaluations, follow-up resources, and educational material about memory concerns and successful aging. In addition, each November during "National Memory Screening Day," the clinics participate in a collaborative effort with the Alzheimer's Foundation of America to promote early detection of Alzheimer's disease and related illnesses and to encourage appropriate intervention.[19]

Individuals diagnosed with or suspected of having Alzheimer's disease are eligible for memory disorder clinic services. In fiscal year 2009-2010, Florida's memory disorder clinics received nearly $3 million in state funds and served just over 5,000 clients.[20]

III. Effect of Proposed Changes:

This bill directs the Department of Elder Affairs (DOEA or department) to develop and implement a public education program relating to screening for memory impairment and the importance of early diagnosis and treatment of Alzheimer's disease.

The bill also creates the memory-impairment screening grant program and authorizes DOEA to award grants to qualifying entities to support programs that provide information and education on the importance of memory screening for early diagnosis and treatment of Alzheimer's disease and related disorders and that provide screenings for memory impairment. The bill defines the term "qualifying entities" as any "public or nonprofit private entities that provide services and care to individuals who have Alzheimer's disease or related disorders and their caregivers and families."

The bill provides that DOEA shall give preference to applicants that:

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[18] Dep't of Elder Affairs, *Summary of Programs and Services*, 87-88 (Feb. 2011), *available at* http://elderaffairs.state.fl.us/english/pubs/pubs/sops2011/Files/2011_SOPS_full%20web.pdf (last visited Aug. 16, 2011).
[19] Dep't of Elder Affairs, *2012 Legislative Bill Analysis, SB 316* (Oct. 26, 2011) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[20] *Summary of Programs and Services*, *supra* note 18, at 91.

- Have demonstrated experience in promoting public education and awareness of the importance of memory screening or providing memory-screening services;
- Have established arrangements with health care providers and other organizations to provide screenings for memory impairment in a manner that is convenient to individuals in the communities served by the applicants; and
- Provide matching funds.

The bill requires each entity that receives a grant to submit an annual evaluation to the department describing the activities carried out with the funds received and the long-term effectiveness of such activities in promoting early detection of memory impairment. Additionally, DOEA must submit an annual report to the President of the Senate and the Speaker of the House of Representatives describing the activities carried out, including provisions describing the extent to which the activities have affected the rate of screening for memory impairment and have improved outcomes for patients and caregivers.

The bill authorizes DOEA to set aside up to 15 percent of the total amount appropriated to the memory-impairment screening grant program for the fiscal year to provide technical assistance to the grantees.

The bill provides an implementation section, specifying that the public education program created by the bill shall operate within existing resources of DOEA and the memory-impairment screening grant program is contingent upon appropriation of state funds or the availability of private resources.

Finally, the bill makes technical changes relating to staff training requirements for persons assisting those with Alzheimer's disease.

The bill has an effective date of July 1, 2012.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill will provide public and nonprofit private entities that provide services and care to individuals who have Alzheimer's disease or related disorders the opportunity to apply for a state grant to support the development, expansion, or operation of programs that provide screenings for memory impairment and information and education on the importance of memory screening.[21]

C. Government Sector Impact:

The Department of Elder Affairs (DOEA or department) currently contracts with 13 memory disorder clinics to provide services to individuals with memory problems and to their families and caregivers. Accordingly, the department can develop and implement the public education program portion of this bill within existing resources. However, a specific appropriation will be necessary for the department to award grants to entities as specified in the bill.[22]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on November 3, 2011:
The committee substitute specifically creates the memory-impairment screening grant program, which is to be administered by the Department of Elder Affairs (DOEA or department). Additionally, the committee substitute provides that a qualifying entity receiving a grant shall submit an evaluation to DOEA annually describing the activities carried out with the funds.

B. Amendments:

None.

[21] *2012 Legislative Bill Analysis*, *supra* note 19.
[22] *Id*.

881696

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/03/2011	.	
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The Committee on Children, Families, and Elder Affairs (Rich) recommended the following:

Senate Amendment (with title amendment)

Delete lines 91 - 97
and insert:
(2)(a) The memory-impairment screening grant program is created and shall be administered by the department.
(b) The department may award grants to qualifying entities to support the development, expansion, or operation of programs that provide:
1. Information and education on the importance of memory screening for early diagnosis and treatment of Alzheimer's disease and related disorders.

881696

2. Screenings for memory impairment.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete line 6

and insert:

creating the memory-impairment screening grant program; providing criteria for awarding grants; providing a

121934

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/03/2011	.	
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The Committee on Children, Families, and Elder Affairs (Rich) recommended the following:

Senate Amendment

Delete line 113
and insert:
section shall submit to the department an annual evaluation that

By Senator Wise

5-00317-12 2012316__

A bill to be entitled

An act relating to Alzheimer's disease; creating s. 430.5025, F.S.; directing the Department of Elderly Affairs to develop and implement a public education program relating to screening for Alzheimer's disease; providing criteria for awarding grants; providing a definition; requiring grant recipients to submit an evaluation of certain activities to the department; authorizing the department to provide technical support; requiring an annual report to the Legislature; providing for implementation of the public education program to operate within existing resources of the department; providing that implementation of the memory-impairment screening grant program is contingent upon an appropriation of state funds or the availability of private resources; amending s. 400.1755, F.S.; specifying the types of facilities where an employee or direct caregiver providing care for persons with Alzheimer's disease may begin employment without repeating certain training requirements; amending s. 400.6045, F.S.; requiring direct caregivers to comply with certain continuing education requirements; amending s. 429.178, F.S.; specifying the types of facilities where an employee or direct caregiver providing care for persons with Alzheimer's disease may begin employment without repeating certain training requirements; providing an effective date.

Florida Senate - 2012 SB 316

5-00317-12 2012316__

WHEREAS, Alzheimer's disease is a slow, progressive disorder of the brain which results in loss of memory and other cognitive functions, is the eighth leading cause of death in the United States, and currently affects an estimated 5 million Americans, with that number expected to increase to 16 million by mid-century, and

WHEREAS, Alzheimer's disease strikes approximately 1 in 10 people over the age of 65 and nearly one-half of those who are age 85 or older, although some people develop symptoms as young as age 40, and

WHEREAS, Alzheimer's disease takes an enormous toll on family members who are the caregivers for individuals having the disease, and

WHEREAS, caregivers for individuals who have Alzheimer's disease suffer more stress, depression, and health problems than caregivers for individuals who have other illnesses, and

WHEREAS, Alzheimer's disease costs United States businesses more than $60 billion annually due to lost productivity and absenteeism by primary caregivers and increased insurance costs, and

WHEREAS, recent advancements in scientific research have demonstrated the benefits of early medical treatment for persons who have Alzheimer's disease and the benefits of early access to counseling and other support services for their caregivers, and

WHEREAS, research shows that several medications have been developed which can reduce the symptoms of Alzheimer's disease, that persons begin to benefit most when these medications are taken in the early stages of a memory disorder, and that this intervention may extend the period during which patients can be

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

cared for at home, thereby significantly reducing the costs of institutional care, and

WHEREAS, with early diagnosis, patients can participate in decisions regarding their care and their families can take advantage of support services that can reduce caregiver depression and related health problems, and

WHEREAS, in direct response to research breakthroughs, National Memory Screening Day was established as a collaborative effort by organizations and health care professionals across the country to promote awareness and early detection of memory impairments, and

WHEREAS, on National Memory Screening Day, which is held on the third Tuesday of November in recognition of National Alzheimer's Disease Month, health care professionals administer free memory screenings at hundreds of sites throughout the United States, and

WHEREAS, memory screening is used as an indicator of whether a person might benefit from more extensive testing to determine whether a memory or cognitive impairment exists and identifies persons who may benefit from medical attention, but is not used to diagnose any illness and in no way replaces examination by a qualified physician, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 430.5025, Florida Statutes, is created to read:

430.5025 Memory-impairment screening; grants.—

(1) The Department of Elderly Affairs shall develop and

implement a public education program relating to screening for memory impairment and the importance of early diagnosis and treatment of Alzheimer's disease and related disorders.

(2) The department may award grants to qualifying entities to support the development, expansion, or operation of programs that provide:

(a) Information and education on the importance of memory screening for early diagnosis and treatment of Alzheimer's disease and related disorders.

(b) Screenings for memory impairment.

(3) As used in this section, the term "qualifying entities" means public and nonprofit private entities that provide services and care to individuals who have Alzheimer's disease or related disorders and their caregivers and families.

(4) When awarding grants under this section, the department shall give preference to applicants that:

(a) Have demonstrated experience in promoting public education and awareness of the importance of memory screening or providing memory-screening services.

(b) Have established arrangements with health care providers and other organizations to provide screenings for memory impairment in a manner that is convenient to individuals in the communities served by the applicants.

(c) Provide matching funds.

(5) A qualifying entity that receives a grant under this section shall submit to the department an evaluation that describes activities carried out with funds received under this section, the long-term effectiveness of such activities in promoting early detection of memory impairment, and any other

information that the department requires.

(6) The department may set aside an amount not to exceed 15 percent of the total amount appropriated to the memory-impairment screening grant program for the fiscal year to provide grantees with technical support in the development, implementation, and evaluation of memory-impairment screening programs.

(7) A grant may be awarded under subsection (2) only if an application for the grant is submitted to the department and the application is in the form, is made in the manner, and contains the agreements, assurances, and information that the department determines are necessary to carry out the purposes of this section.

(8) The department shall annually submit to the President of the Senate and the Speaker of the House of Representatives a report on the activities carried out under this section, including provisions describing the extent to which the activities have affected the rate of screening for memory impairment and have improved outcomes for patients and caregivers.

Section 2. Implementation.—

(1) Implementation of the public education program created under s. 430.5025, Florida Statutes, shall operate within existing resources of the Department of Elderly Affairs.

(2) Implementation of the memory-impairment screening grant program created under s. 430.5025, Florida Statutes, is contingent upon appropriation of state funds or the availability of private resources.

Section 3. Subsection (6) of section 400.1755, Florida

Statutes, is amended to read:

400.1755 Care for persons with Alzheimer's disease or related disorders.—

(6) Upon completing any training listed in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility or to an assisted living facility, home health agency, adult day care center, or hospice ~~adult family care home~~. The direct caregiver must comply with other applicable continuing education requirements.

Section 4. Paragraph (h) of subsection (1) of section 400.6045, Florida Statutes, is amended to read:

400.6045 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.—

(1) A hospice licensed under this part must provide the following staff training:

(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different hospice or to

a home health agency, assisted living facility, nursing home, or adult day care center. The direct caregiver must comply with other applicable continuing education requirements.

Section 5. Subsection (4) of section 429.178, Florida Statutes, is amended to read:

429.178 Special care for persons with Alzheimer's disease or other related disorders.—

(4) Upon completing any training listed in subsection (2), the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different assisted living facility or nursing home, hospice, adult day care center, or home health agency ~~facility~~. The employee or direct caregiver must comply with other applicable continuing education requirements.

Section 6. This act shall take effect July 1, 2012.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/3/11
Meeting Date

Topic Alzheimer's Legislation
Bill Number SB 316 *(if applicable)*

Name Charles T. Corley
Amendment Barcode *(if applicable)*

Job Title Secretary

Address 4040 Esplanade Way
Street
Tallahassee FL 32399-7000
City *State* *Zip*

Phone 850-414-2000

E-mail corleyct@elderaffairs.org

Speaking: ☐ For ☐ Against ☒ Information

Representing Dept. of Elder Affairs

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11-3-11
Meeting Date

Topic Alzheimer's Disease
Bill Number SB 316 *(if applicable)*

Name FELY CURVA (CURVA)
Amendment Barcode *(if applicable)*

Job Title Partner, Curva & Associates

Address 1212 Piedmont Dr.
Street
Tallahassee FL 32312
City *State* *Zip*

Phone (850) 508-2257

E-mail curva@mindspring.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Alzheimer's Foundation of America

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/3/11
Meeting Date

Topic Alzheimer's Disease
Bill Number SB 316 *(if applicable)*

Name Laura Cantwell
Amendment Barcode _____ *(if applicable)*

Job Title Sr. Program Specialist

Address 200 W College Avenue, Suite 304
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850-577-5163

E-mail lcantwell@aarp.org

Speaking: ☑ For ☐ Against ☐ Information

Representing AARP

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11-2
Meeting Date

Topic A/Z Disease
Bill Number 316 *(if applicable)*

Name Lee Ann Griffin
Amendment Barcode _____ *(if applicable)*

Job Title Dir. of Quality + Reg. Serv.

Address 307 W. Park
Street
TLH FL 32301
City *State* *Zip*

Phone 224 3907

E-mail lgriffin@fhca.org

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Health Care Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/3/11
Meeting Date

Topic Alzheimer's Disease
Bill Number SB 316 *(if applicable)*

Name Wendy Hedrick
Amendment Barcode *(if applicable)*

Job Title

Address 215 S. Monroe Street
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 850 205-9000

E-mail wendy.hedrick@metrlaw.com

Speaking: [X] For [ ] Against [ ] Information

Representing FL Academy of Family Physicians

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Nov. 3, 2011
Meeting Date

Topic Alzeheimer's
Bill Number SB 316 *(if applicable)*

Name Dixie Sansom
Amendment Barcode ~ *(if applicable)*

Job Title The Sansom Group

Address PO Box 98
Street
Cocoa FL 32923
City *State* *Zip*

Phone 321-777-8130

E-mail DixieSansom@aol.com

Speaking: [X] For [ ] Against [ ] Information

Representing The ARC of Florida

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/20/11)

The Florida Senate

Committee Agenda Request

To: Senator Ronda Storms, Chair
Committee on Children, Families, and Elder Affairs

Subject: Committee Agenda Request

Date: October 6, 2011

I respectfully request that **Senate Bill # 316**, relating to Alzheimer's Disease, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Stephen R. Wise
Florida Senate, District 5

File signed original with committee office

agency for persons with disabilities
State of Florida

iBudget Florida

Senate Committee on Children, Families, and Elder Affairs
November 3, 2011

Rick Scott
Governor

Michael P. Hansen
Director

iBudget Overall Goals

- **Customer self-direction and choice**
- **Equitable distribution of appropriated Medicaid waiver funds**
- **Business process efficiencies using technology**

iBudget Background

- 2009 GAA required plan by February 2010
  - APD researched other states' systems and best practices
  - APD worked with iBudget Florida Stakeholders' Group to design plan
- iBudget implementation authorized in s. 393.0662, F.S., in 2010

iBudget Allocation Formula

AGE	QSI ASSESSMENT 1) Functional Score 2) Behavioral Score 3) Ability to: Transfer, Self-Protect, and Maintain Hygiene	LIVING SETTING

Determines Individual Budgets

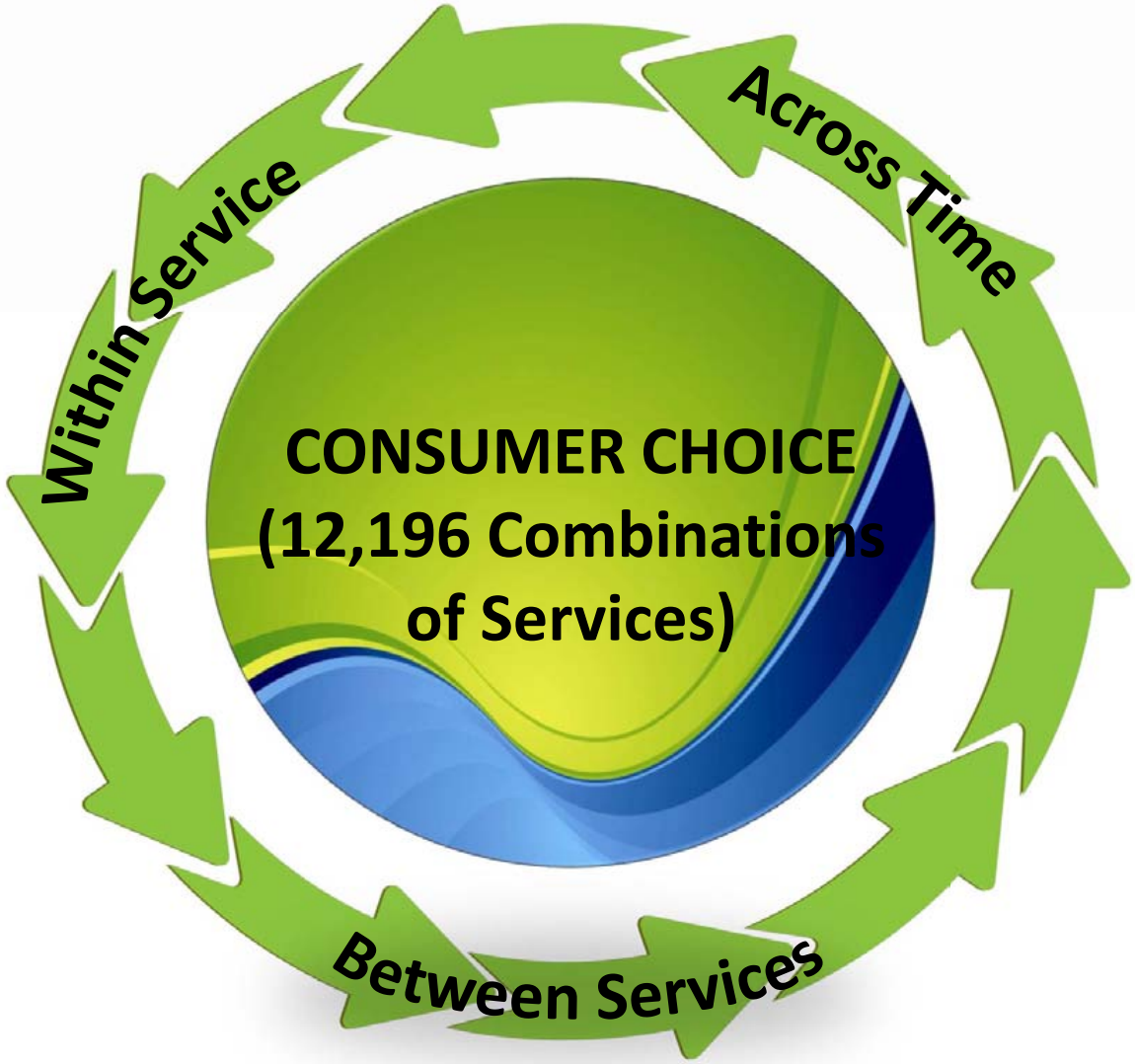
Consumer Flexibility in Spending

LEAST FLEXIBLE:

- Residential Services
- Therapeutic Supports & Wellness

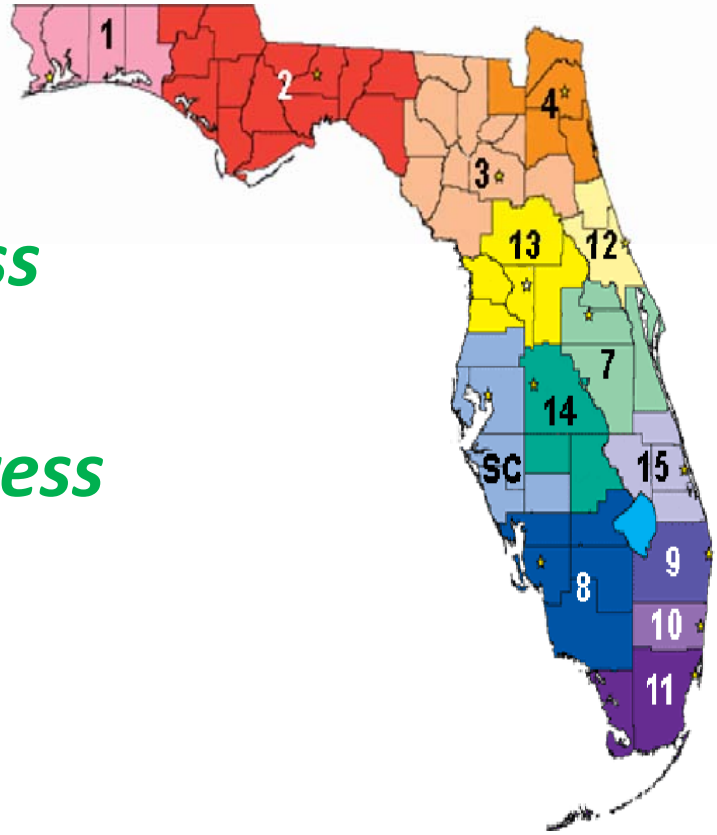
MOST FLEXIBLE:

- Life Skills Development
- Supplies & Equipment
- Personal Supports
- Support Coordination
- Transportation
- Dental Services



iBudget Phase-In Plan

1. Create Overall Plan ✓
2. Technical/Process *In Progress*
3. Transition Areas 1 & 2 *In Progress*
4. Finalize Deployment Strategy
5. Implement in Phases Statewide



HARD CHOICES

	Description	Impact
Original	**Methodology based on original iBudget Plan distribution through algorithm for all services including extraordinary needs for those who qualify.**	• **Based on current appropriation ($810M)** • **Consumers have flexibility to choose services within limits of their individual allocation** • **Reductions will be significant for some consumers**

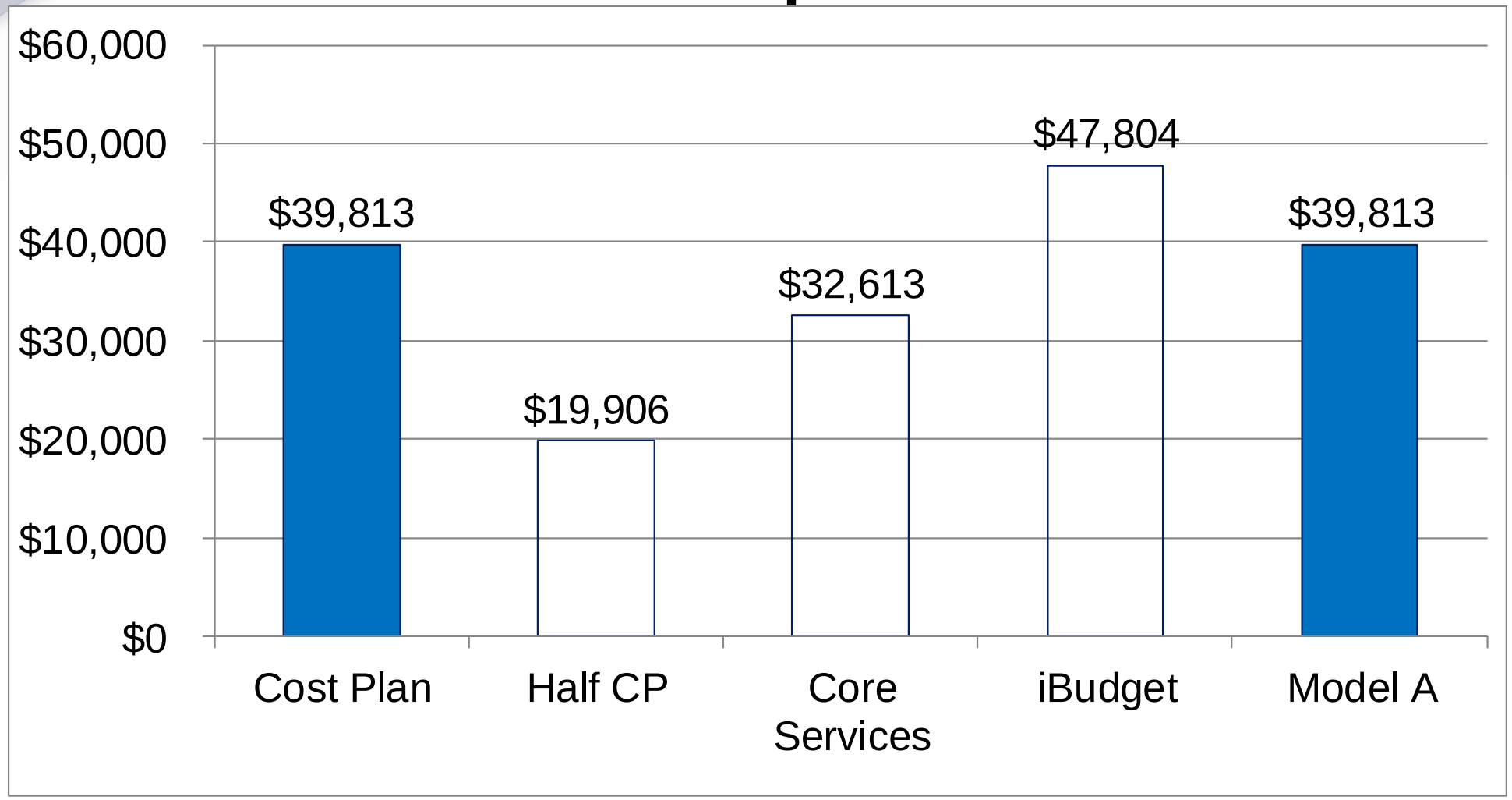
HARD CHOICES

	Description	Impact
Base Model	This model compares the iBudget with the current cost plan and selects the result according to the following decision rules: 1.If Cost Plan less than iBudget, select Cost Plan. 2.If iBudget less than Cost Plan, select iBudget except when iBudget less than half Cost Plan. Then select half Cost Plan.	• Retains current cost plan for consumers whose needs are less than the iBudget • Total cost ($725 M) is within appropriation with funds remaining for extraordinary needs and crisis situations • Many consumers would not have sufficient allocation to meet their core services needs

HARD CHOICES

	Description	Impact
Model A *Including core services*	**This option would provide funding for core services for consumers whose allocation was insufficient to meet their core services.**	• **Adds $143 M in cost** • **About 9,600 people are affected** • **Total allocation would exceed appropriation by about $57 M** • **Adult Day Training (ADT) would not be funded for all current people who use ADT**

Example 1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$40,000
$30,000
$20,000
$10,000
$0
$39,813
$19,906
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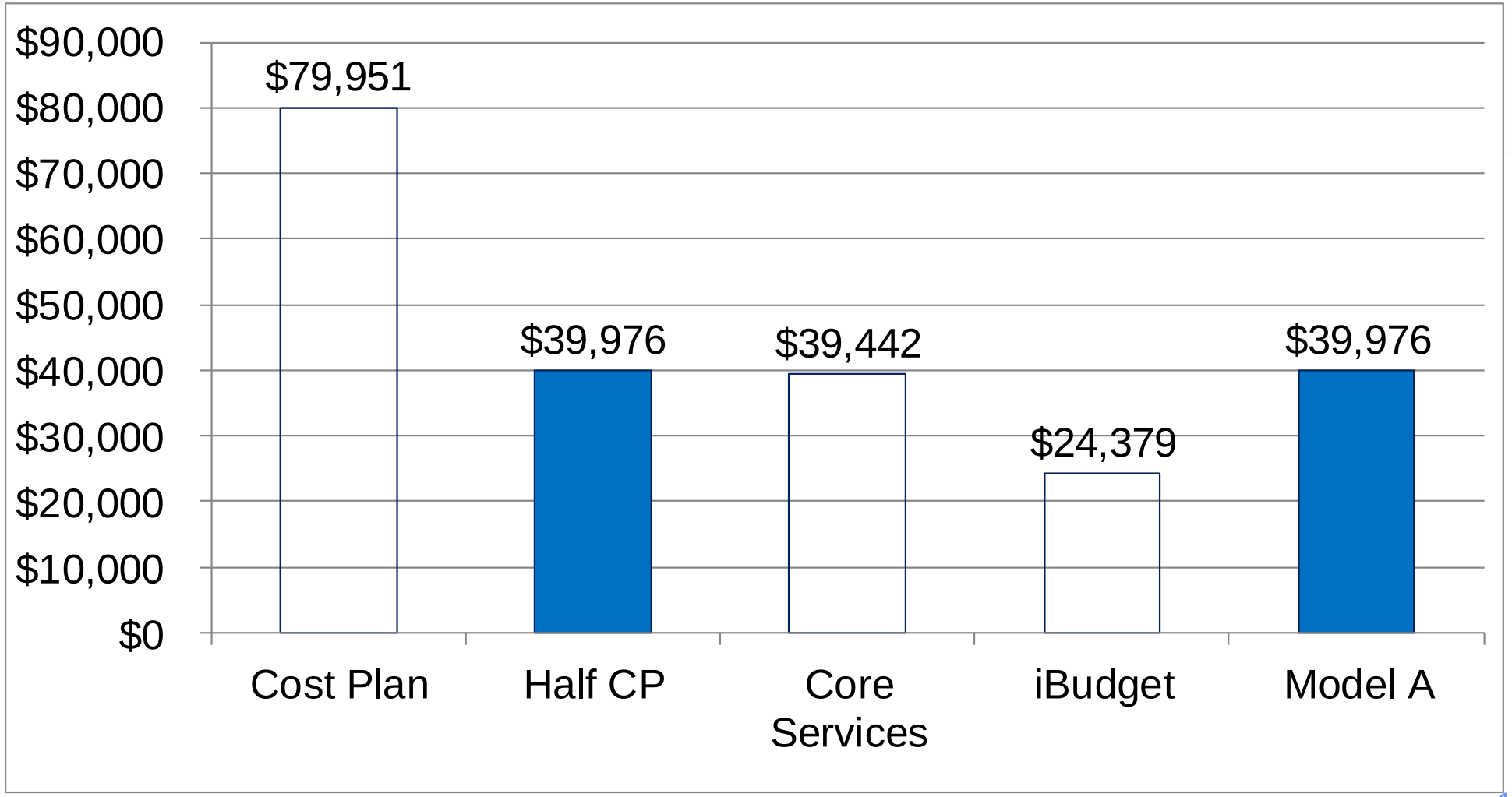
$39,813
Cost Plan
Half CP
Core Services
iBudget
Model A

Example 2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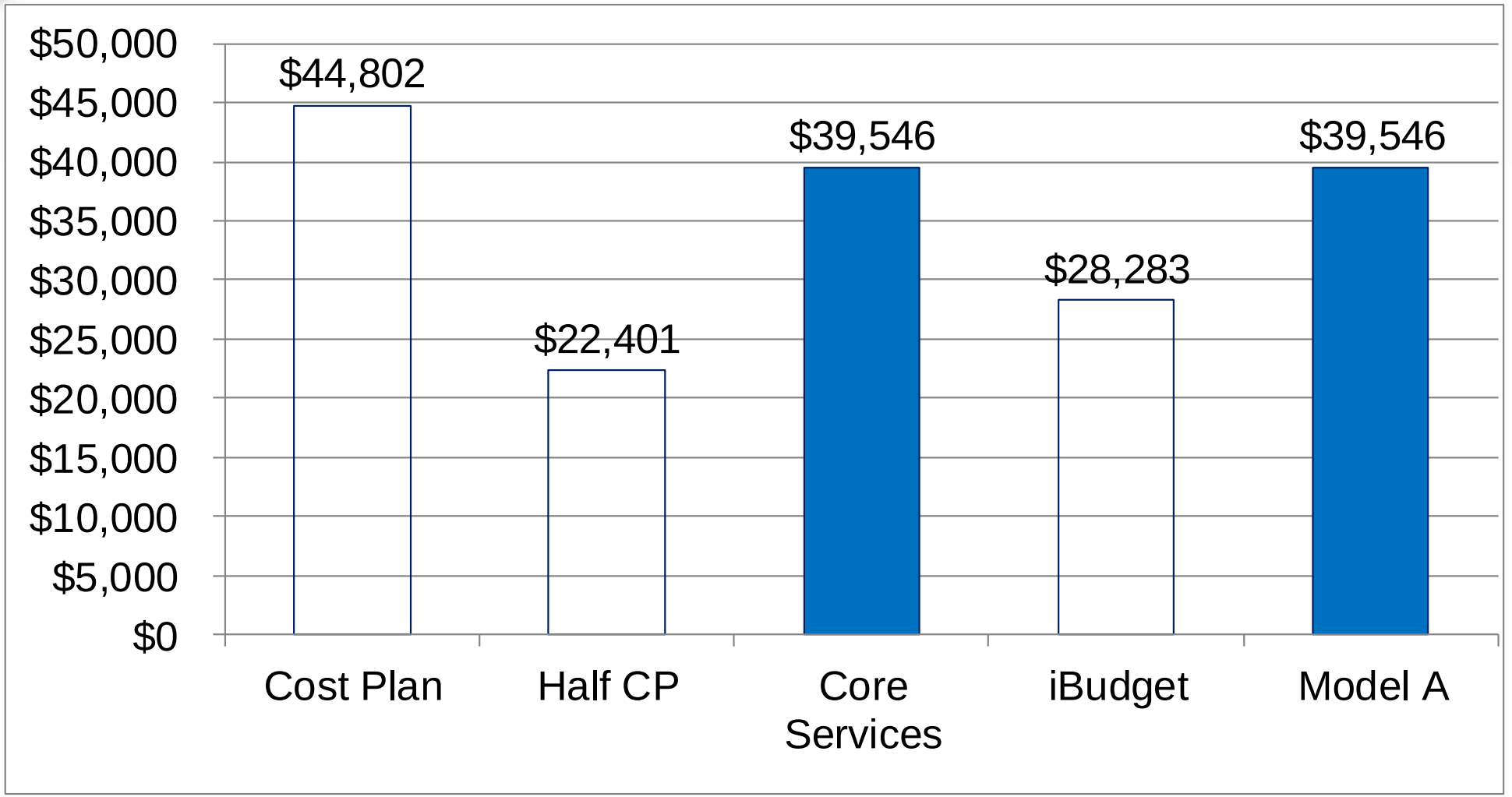
Cost Plan
Half CP
Core Services
iBudget
Model A

Example 3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$0
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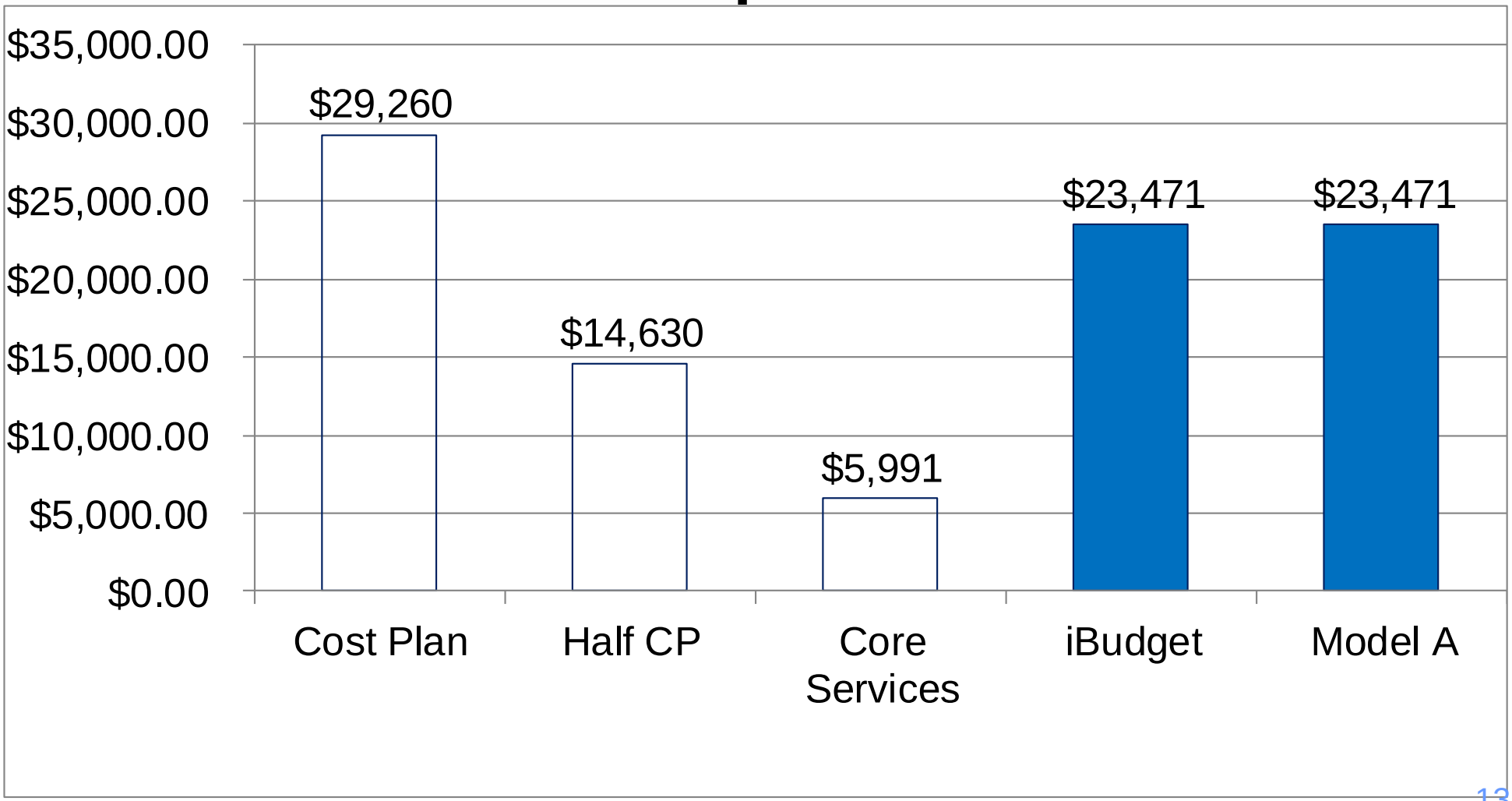
$39,546
$28,283
$39,546
Cost Plan
Half CP
Core Services
iBudget
Model A

Example 4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$29,260
$14,630
$5,991
$23,471
$23,471
Cost Plan
Half CP
Core Services
iBudget
Model A

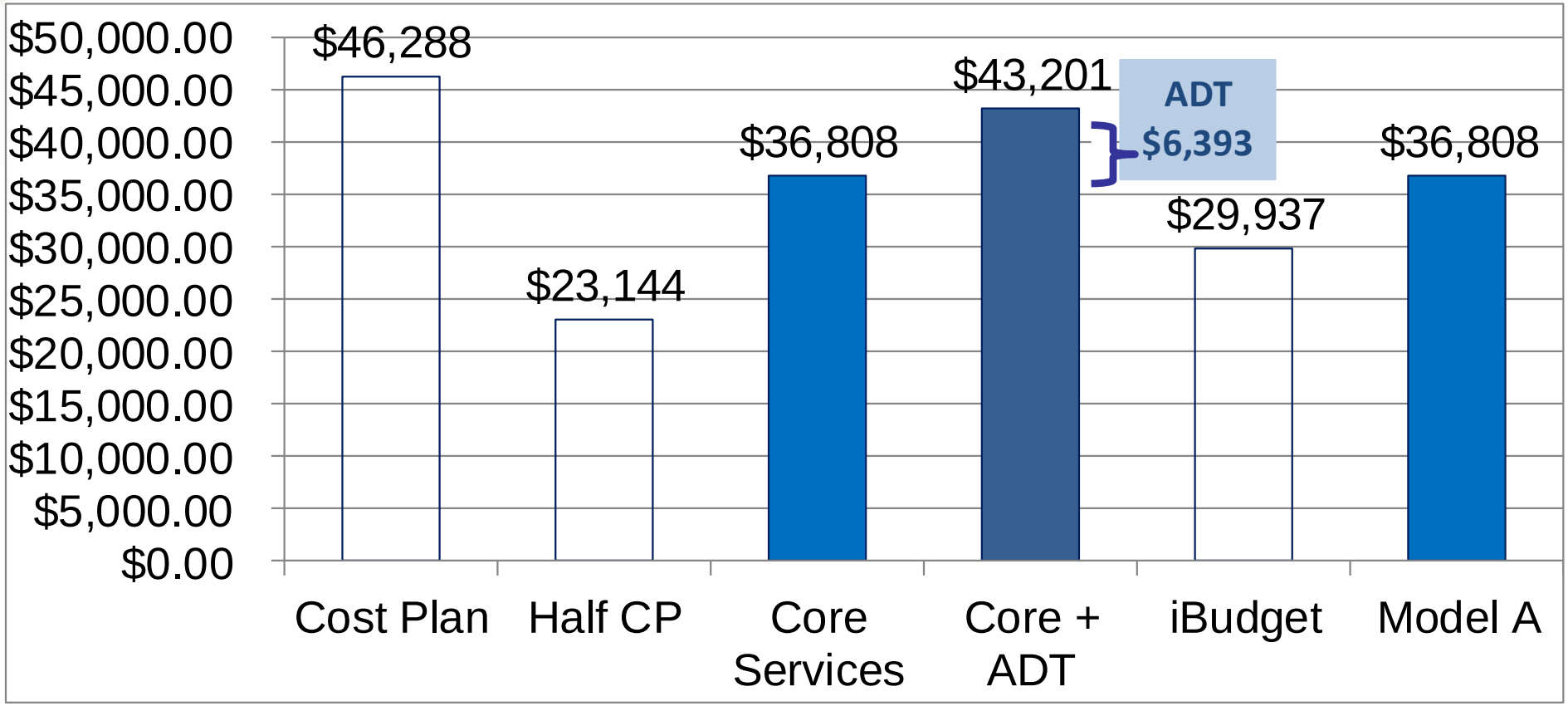
Thank You!

Supplemental Slides if Time Allows

HARD CHOICES

	Description	Impact
Model A ***with Adult Day Training (ADT) Added***	This option would provide funding for ADT for consumers whose base allocation was insufficient to include ADT.	• Adds $34.6 M in additional cost • About 5,200 people are affected • Total allocation including core and ADT services would total $902 M

ADT Example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$29,937
$36,808
ADT
$6,393
Cost Plan
Half CP
Core Services
Core + ADT
iBudget
Model A

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Nov. 3, 2011.
Meeting Date

Topic iBudget Progress Report.

Bill Number _____ *(if applicable)*

Name Michael P. Hansen

Amendment Barcode _____ *(if applicable)*

Job Title Director

Address 4030 Esplanade Way, Suite 380. *Street*

Phone (850) 488-1558

Tallahassee *City* FL *State* 32399 *Zip*

E-mail michael_hansen@apd.state.fl.us

Speaking: ☐ For ☐ Against ☑ Information

Representing Agency for Persons with Disabilities

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/20/11)

Assisted Living Facility Regulation

Agency for Health Care Administration

Molly McKinstry

Deputy Secretary Health Quality Assurance

November 3, 2011

Assisted Living
State & Local Government
Roles & Responsibilities

- Agency for Health Care Administration
  - Licensure and Regulation
  - Medicaid – Assisted Care Services, Various Waiver
- Department of Children and Families
  - Adult Protective Services
  - Mental Health Clients in ALFs
  - Specific Medicaid Waiver
- Agency for Persons with Disabilities
  - Developmentally Disabled Clients in ALFs
- Attorney General
  - Medicaid Fraud Control
  - Patient Abuse, Neglect and Exploitation (PANE)
  - Operation Spot Check
- Health Department
  - Health & Sanitation Inspections

Assisted Living
State & Local Government
Roles & Responsibilities

- Department of Elder Affairs
  - Rule Development for Assisted Living, Adult Family Care Home, Adult Day Care, Hospice
  - Comprehensive Assessment and Review of Long-Term Care Services (CARES)
  - Long-Term Care Ombudsman Program
  - Statewide Public Guardianship Office
  - Assisted Living Trainer Certification
  - Specific Medicaid Waivers
- Local Authorities (ALF)
  - Fire Authority – Fire & Life Safety Approval
  - Zoning / Building Code Approval and Enforcement

Assisted Living Demographics

- State Licensure Only - No Federal “Certification”
- No Limitation on Licensure (No Needs Assessment)
- Limited Medicaid Funding
  - Home and Community Based Waivers
  - Medicaid Assisted Care Services (State Plan)
  - Nursing Home Diversion
  - Frail Elder Program
- Residents Served
  - Aged & Disabled
  - Mental Health
  - Developmentally Disabled

Assisted Living Bed Growth

	# of ALFs	# of Beds	# ALFs w LMH Beds	# LMH Beds	# ALFs w ECC Beds	# ECC Beds	# ALFs w OSS Beds	# OSS Beds
2003	2,272	76,714	612	12,956	398	18,853	1,176	14,171
2004	2,275	74,788	747	13,988	346	17,967	1,179	14,100
2005	2,291	74,282	779	14,109	327	16,144	1,205	13,992
2006	2,340	74,317	818	14,076	312	15,316	1,206	13,881
2007	2,442	75,958	871	14,309	306	15,064	1,249	14,161
2008	2,643	77,338	994	15,177	302	16,124	1,367	14,665
2009	2,783	79,302	1,052	15,463	306	16,882	1,454	15,436
2010	2,850	81,027	1,083	15,804	308	16,976	1,505	15,709
2011	2,960	82,951	1,103	15,639	277	14,480	1,521	15,686

Assisted Living Bed Demographics

	# of ALFs	# of Beds	# ALFs w LMH Beds	# LMH Beds	# ALFs w ECC Beds	# ECC Beds	# ALFs w OSS Beds	# OSS Beds
2003	2,272	76,714	612	12,956	398	18,853	1,176	14,171
2004	2,275	74,788	747	13,988	346	17,967	1,179	14,100
2005	2,291	74,282	779	14,109	327	16,144	1,205	13,992
2006	2,340	74,317	818	14,076	312	15,316	1,206	13,881
2007	2,442	75,958	871	14,309	306	15,064	1,249	14,161
2008	2,643	77,338	994	15,177	302	16,124	1,367	14,665
2009	2,783	79,302	1,052	15,463	306	16,882	1,454	15,436
2010	2,850	81,027	1,083	15,804	308	16,976	1,505	15,709
2011	2,960	82,951	1,103	15,639	277	14,480	1,521	15,686

Basic Assisted Living Services

- Housing, nutritional meals, and special diets
- Help with the activities of daily living (bathing, dressing, eating, walking)
- Giving 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 (providing temporary supervision to relieve caregiver)
- Social and leisure activities

Limited Nursing Services Specialty License

- ALF may provide directly or through contract:
  - 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
  - Application of cold or heat treatments, passive range of motion exercises, ear and eye irrigations
  - Monthly nursing assessment must describe general health status, type, amount, duration, scope and outcomes of services

Extended Congregate Care Specialty License

- 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
- Monthly nursing assessment must describe general health status, type, amount, duration, scope and outcomes of services
- Residents may be retained and age in place under certain conditions

Limited Mental Health Specialty License

- Three or more mentally ill or disabled residents
- LMH resident defined as person who receives:
  - Social Security Disability Income (SSID) for mental disorder or Social Security Income (SSI) due to a mental disorder and
  - Optional State Supplementation (OSS)
- Basic staff training in mental health
- Ensure that the resident has a community living support plan
- Provide assistance to the resident in carrying out the plan
- Maintain a cooperative agreement for handling emergency resident matters
- DCF oversight regarding assessment, case management and community supported living plans
- DCF Circuit develops 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

AHCA Inspections

- Re-Licensure Surveys - Every Two Years
- Monitor Visits
  - Limited Nursing Services License - Twice/Year
  - Extended Congregate Care License – Quarterly
- Complaint Investigations
  - Prioritize Allegations
  - Investigate Based on Severity
  - Priority One – Investigate in Two Days
  - All Investigated on Average in 27 Days
  - 40% Find Deficiencies
  - Fee for Complaint Investigations with Deficiencies

Assisted Living Complaints & Visits

Complaint Investigations

- Prioritize based on risk to residents
- Serious and immediate threats are investigated within one day
- All complaints investigated on average within 22 days
- Complaint increase over 25% since May 2011

ALF visits (licensure and complaints)

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

Regulatory Oversight Revisions

- Statewide Complaint Training of Survey Staff
- Revised Assisted Living Facility Inspection Process
- Development of Assisted Living Enforcement Team

Revised Assisted Living Survey

- Enhanced Focus on Residents
- Concentration on Interviews, Observations, and Record Review
- Improve Consistency/Revised Regulation (Tags)
- Abbreviated Review as Authorized by Law
    - Two Survey Periods (Four Years)
    - Consistent Ownership
    - Survey History
    - Licensure Complaint History
    - Ombudsman Complaint History
- Largely Based on Wisconsin Model

Abbreviated Survey

- Focus on Resident and Family Feedback
- Observations by the Surveyor
- Record Reviews Based on Observations and Interviews
- Concerns Identified Result in Expanded Sample Selection up to Standard Survey

Regulatory Violations / Deficiencies

Class I – Immediate danger or substantial probability that death or serious physician or emotional harm would result.

- Examples: Facility culpability for resident death or risk of death or serious injury such as development of severe pressure sores, unlicensed staff, administering and managing resident feeding tubes.
- Fine $5,000 to $10,000

Class II – Directly threaten the physical or emotional health, safety, or security of clients.

- Example: Unsanitary conditions including insect infestation, environmental safety hazards and unsanitary conditions, unsafe medication practices.
- Fine $1,000 to $5,000

Regulatory Violations / Deficiencies

Class III – Indirectly or potentially threaten physical or emotional health, safety or security of clients.

- Example: Failure to provide staff training* or meet other training or employment standards, failure to have required resident health assessments or approved emergency plan.
- Fine $500 to $1,000 if uncorrected

Class IV – Related to maintenance of provider or required reports, forms, or documents that do not negatively affect clients.

- Example: Failure to maintain appropriate documentation of staff qualifications and other requirements.
- Fine $100 to $200 if uncorrected

* Classification can escalate depending on associated outcomes.

Assisted Living Citations

	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	Total
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

Regulatory Sanctions

- Emergency Actions – Limited to Serious Ongoing Issues

  (Imposed Before Due Process)

  - Moratorium
  - Suspension
- Sanctions for Violations
  - Fines / Conditional Licenses
  - Denial of License Renewal or Initial Application
  - Revocation of License
    - Closure During Litigation
- Due Process for Sanctions
  - Opportunity to Challenge
  - Agency Has Clear and Convincing Burden of Proof
  - Actions Pend During Litigation
  - Imposed by Final Order
    - May Also Be Challenged
    - Court Can Enjoin Agency Imposition

Assisted Living Fines Imposed

Fiscal Year	ALF Fines Imposed by Final Order
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

Assisted Living Enforcement Actions and Affiliated Closures

	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	Total
Moratoria	7	7	5	4	7	30
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 pending legal cases or history of legal actions	38	34	37	40	46	195

Consumer Information and Outreach

- Florida Health Finder
  - Demographic Information
  - Inspection Reports
  - Emergency Actions and Legal Actions once Final
- Consumer Awareness Brochures
- Outreach to Partners and Providers – Developed Online Partner Observation Tool
  - Regulators and Advocates
  - Managed Care Plans
  - Health Care Providers

Outreach Activities

- Interagency facility staffing's
- Joint training activities include other Departments
  - Provider training
  - Staff training
- Access to systems and data used by partners
- Joint visits with partner agencies
- Ongoing collaboration with partner agencies at the state and local levels

Rick Scott, Governor
David E. Wilkins, Secretary

Adult Protective Services Program Overview

Senate Children, Families & Elder Affairs
November 3, 2011

Robert Anderson
Department of Children and Families
Director of Adult Services

Mission: Protect the Vulnerable, Promote Strong and Economically Self- Sufficient Families, and Advance Personal and Family Recovery and Resiliency.

Who is a Vulnerable Adult?

Vulnerable Adult means a person age 18 or older whose ability to perform the normal activities of daily living, and/or to provide for his or her own care or protection, is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or due to the infirmities of aging.

What is Abuse?

- **“Abuse”** means any willful act or threatened act by a relative, caregiver or household member which causes, or is likely to cause, significant impairment to a vulnerable adult’s physical, mental, or emotional health. Abuse includes acts and omissions.

  Per 415.102, Florida Statutes

What is Neglect?

- **“Neglect”** means the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult. It also means the failure of the caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. It is a repeated conduct or a single incident of carelessness.

  Per 415.102, Florida Statutes

What is a Caregiver?

- "Caregiver" means a person who has been entrusted with or has assumed the responsibility for frequent and regular care of or services to a vulnerable adult on a temporary or permanent basis and who has a commitment, agreement, or understanding with that person or that person's guardian that a caregiver role exists.

  Per 415.102(4), Florida Statutes

Protecting Vulnerable Adults

- Chapter 415, F.S. – DCF to investigate reports alleging abuse, neglect or exploitation of vulnerable adults
- **Purpose of Investigation**
  - Determine if alleged victim has been abused, neglected or exploited
  - Determine if assistance is necessary to protect the victim's health and safety

Abuse, Neglect and Exploitation

Partnerships to assist Florida's vulnerable adult population:

- Department of Elder Affairs
- Agency for Persons with Disabilities
- Disability Rights Florida
- Agency for Health Care Administration
- Long Term Care Ombudsman Program
- Office of the Attorney General / Medicaid Fraud Control Unit
- Department of Health

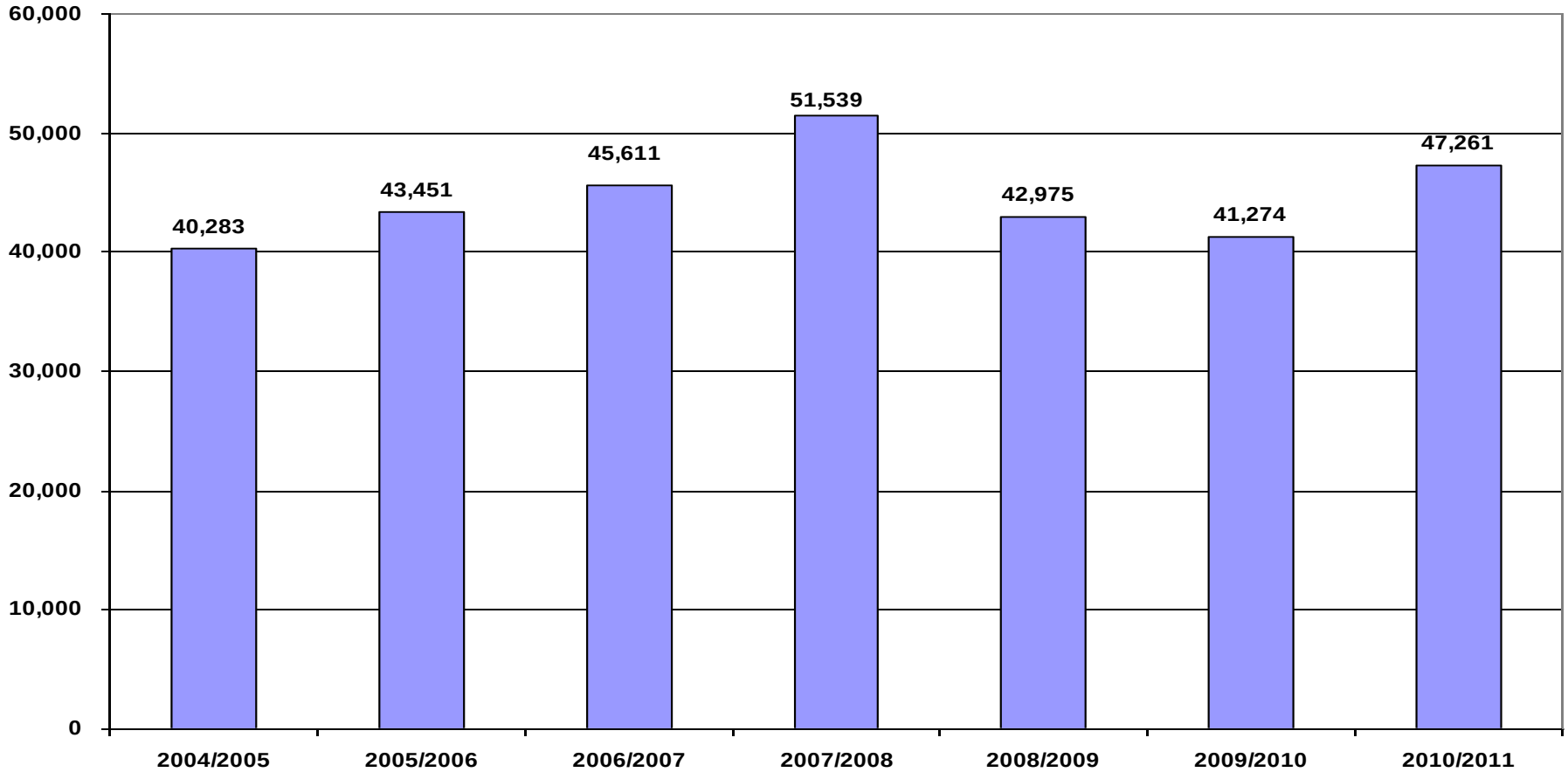
Reporting Abuse, Neglect, and Exploitation

- **Mandatory Reporting**
- Required by law (415.1034, F.S.)
  - Any person who has reasonable cause to believe that a vulnerable adult is being abused, neglected or exploited
- **Florida Abuse Hotline (1-800-96-ABUSE)**
  - 24-hour, toll-free statewide hotline
  - Accepted 47,261 reports alleging adult abuse in FY 2010-11

The Protective Investigation Process

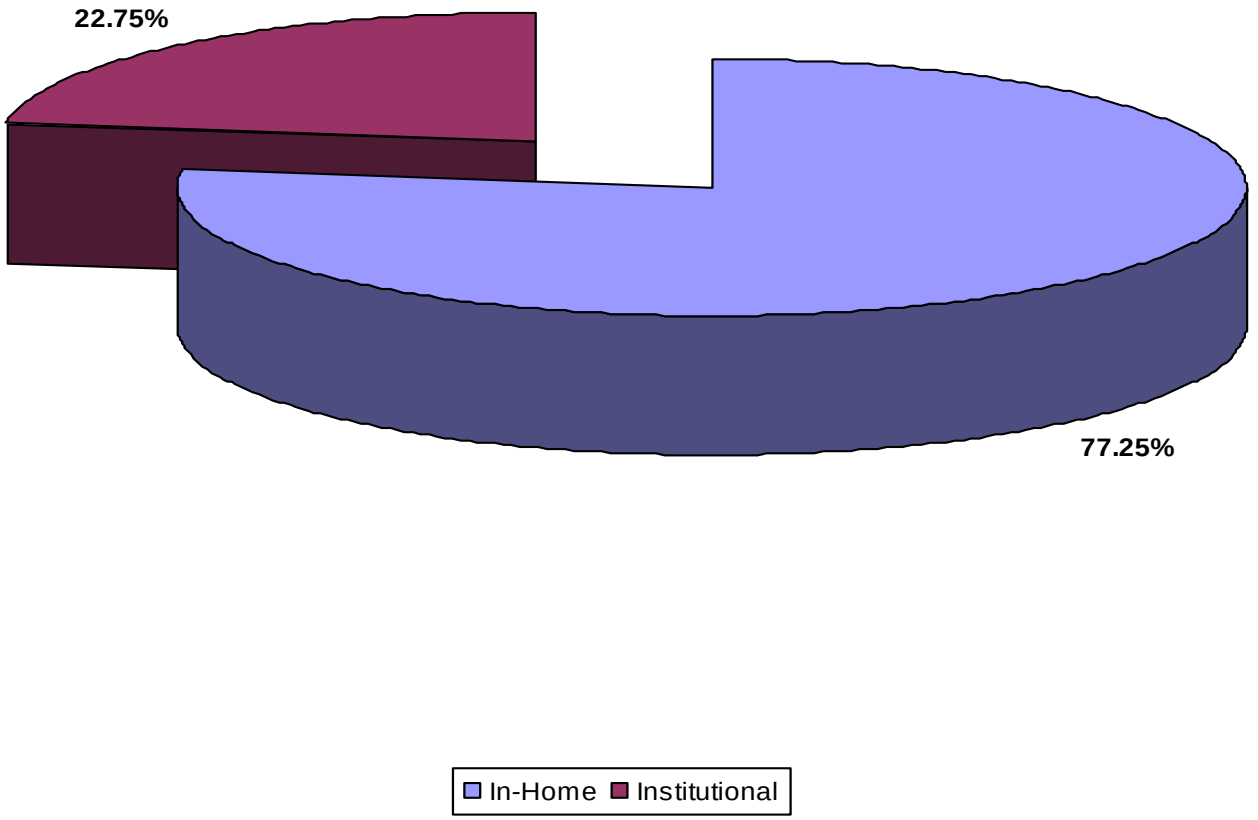
- Commence investigation within 24 hours of receiving report
- Determine any indicators of abuse, neglect or exploitation
- Assess safety and risk of further harm
- Determine need for services
- Complete investigation within 60 days

Adult Investigations
Reports Received
2004-2011

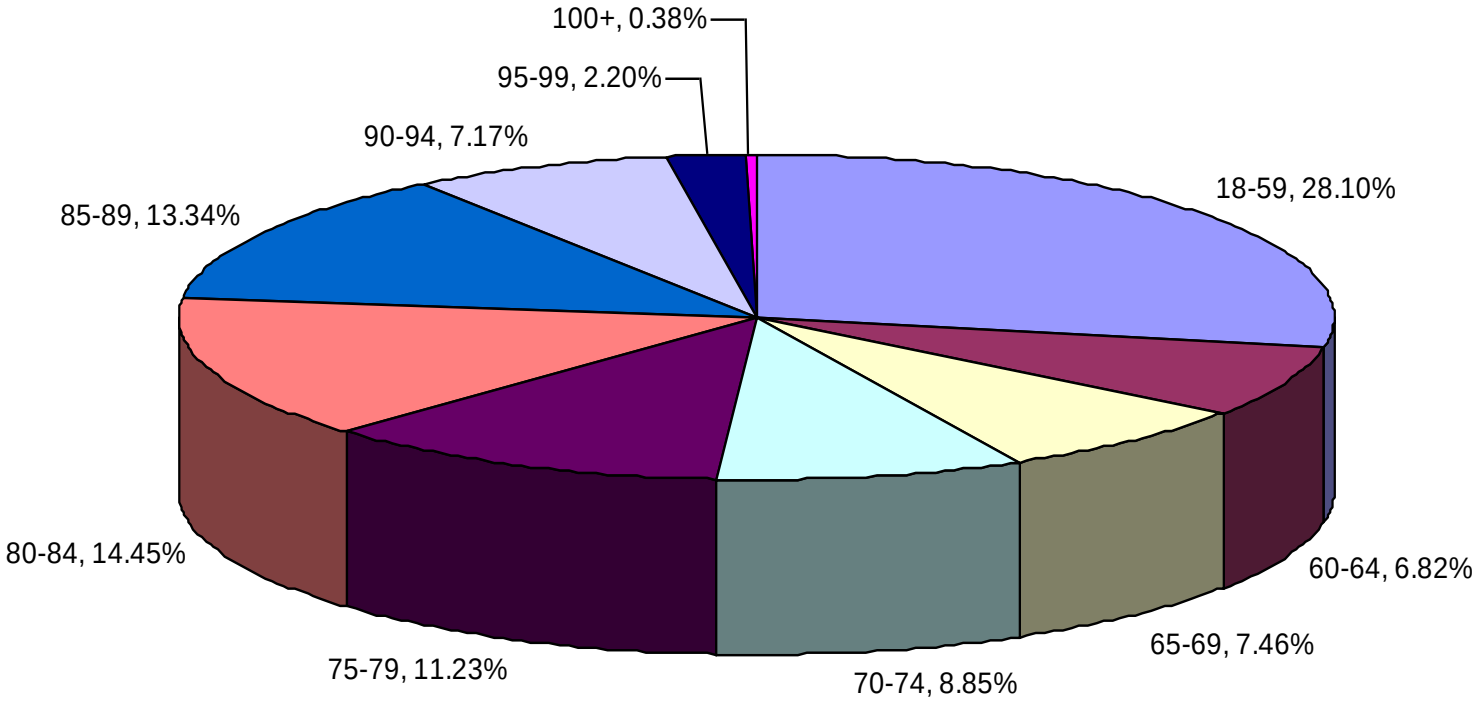


Statewide Totals

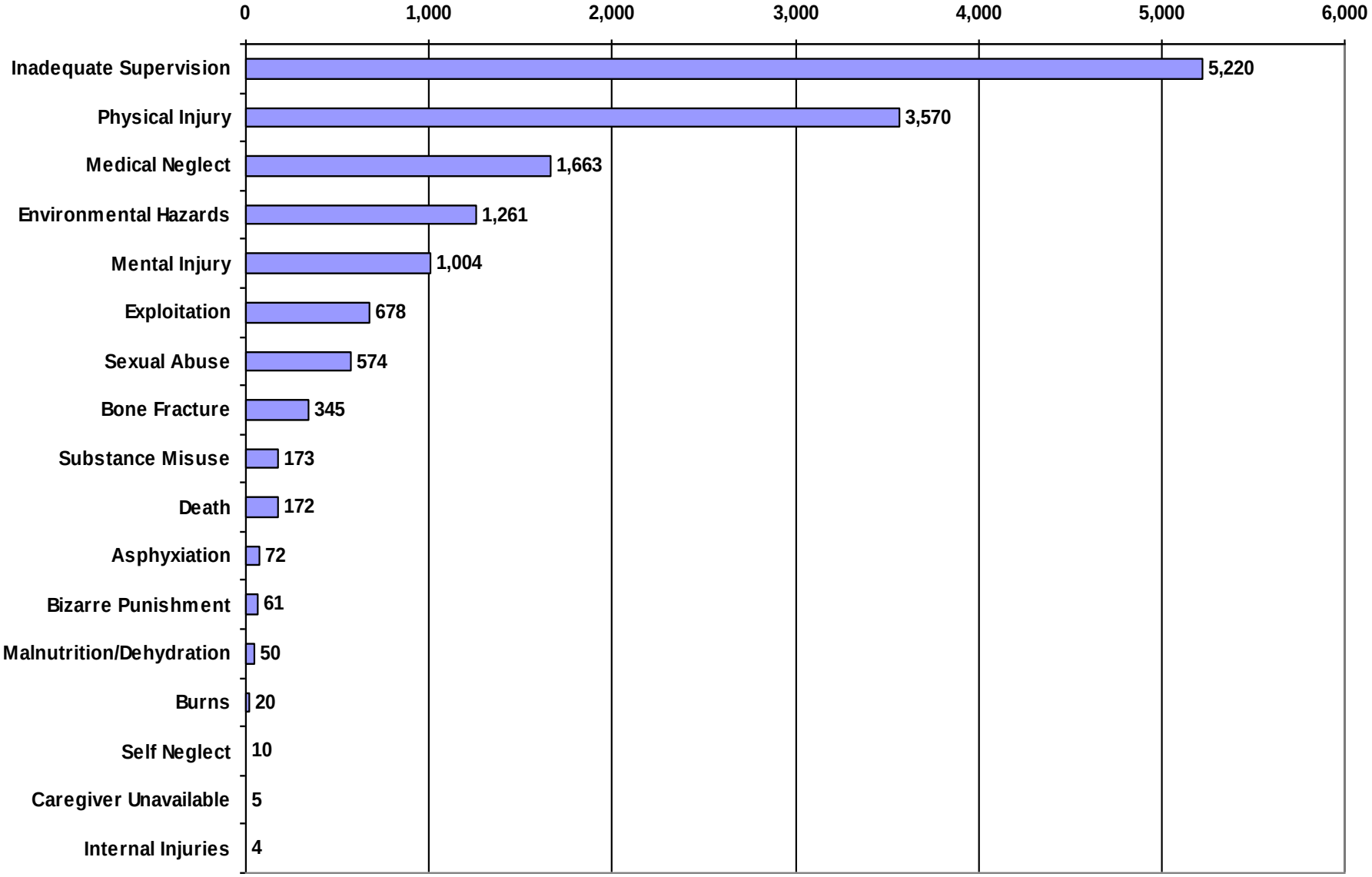
Institutional vs. In-Home Reports, FY 2010-2011



Victim Age in APS Reports, FY 2010-2011



Institutional Maltreatments Distribution at Intake, FY 2010-2011



Institutional Investigations

- Verified

- For FY 2010/2011, 741 reported maltreatments were verified for abuse, neglect, or exploitation (4.98%)

- Not Substantiated

- For FY 2010/2011, 2,623 reported maltreatments were found to have “some indication” of abuse, neglect, or exploitation (17.63%)

- No Indicators

- For FY 2010/2011, 11,518 reported maltreatments were found to have no indicators of abuse, neglect, or exploitation (77.40%)

Definition of Findings

- **Verified** – This finding is used when there is a preponderance of credible evidence that supports the allegations occurred.

- **Not Substantiated** – This finding is used when there is credible evidence, which does not meet the standard of being a preponderance, to support the allegations.

- **No Indicators** – This finding is used when there is NO credible evidence to support the allegations in the report.

Notifications

For institutional reports, the following agencies are notified at onset and closure of the investigation

- **Long Term Care Ombudsman (LTCOC)**
- **Agency for Health Care Administration (AHCA)**
- **Medicaid Fraud Control Unit (MFCU)**
- **Agency for Persons with Disabilities (APD)**
- **Law Enforcement/State Attorney's Office**
- **Department of Health – Professional Licensure**

Rick Scott, Governor
David Wilkins, Secretary

DCF Mental Health and Assisted Living Facilities

with Limited Mental Health Licenses

Senate Children, Families & Elder Affairs
November 3, 2011

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

Mission: Protect the Vulnerable, Promote Strong and Economically Self- Sufficient Families, and Advance Personal and Family Recovery and Resiliency.

Definitions

- Assisted Living Facility (ALF) with a Limited Mental Health (LMH) License is:
  - An ALF licensed and monitored by AHCA that serves **3** or more mental health residents

- Mental Health Resident is an individual who:
  - Receives social security disability income due to a mental disorder as determined by the Social Security Administration or
  - Receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation

Quick Facts

- 1,110 Assisted Living Facilities (ALF)-Limited Mental Health (LMH) facilities
- Total of 15,548 beds statewide
- 11,702 are Optional State Supplementation (OSS) beds
- Remainder are Private

DCF's Role Is To Assure That:

- A mental health resident has been **assessed** to be appropriate to reside in an assisted living facility;
- A **cooperative agreement** to provide 24/7 emergency access information 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** to identify needs and services has been prepared by a mental health resident and a case manager in consultation with the administrator of the facility;

DCF's Role Is To Assure That: (con't.)

- The ALF is provided with documentation that the **individual meets the definition** of a mental health resident; and

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

How DCF Assures

- AHCA has responsibility to monitor all ALFs
- However, as of July 2011, Contract Language added for contracted Mental Health providers to ensure statute was implemented
  - Monitored by DCF via Managing Entities
- Developing Templates for Community Living Support Plan and Cooperative Agreement

Training

- Requirement
  - LMH staff whom have **direct contact** with residents must take a DCF approved or DCF provided **6 hour training course** about "working with individuals with mental health diagnosis" **within 6 months** of receiving LMH license **or within 6 months of employment**
- How Training is Provided Currently
  - Regional SAMH or Managing Entity staff or through contracts with community mental health providers at least every 6 months or more
- Future Direction
  - Updating curriculum after surveying ALF-LMHs to determine specific needs
  - Provide training with new competency-based curriculum which can be used via face to face or on-line

Consideration for Future Direction

- Should pre-service training be required instead of current training requirement that allows person to work in ALF for up to 6 months before getting trained?
- Determine how to enforce non-DCF mental health provider compliance.
- Consider individual choice and refusal of case management and other services.

The Miami Herald
Posted on Sat, Apr. 30, 2011

NEGLECTED TO DEATH | Part 1: Once pride of Florida; now scenes of neglect

By Rob Barry, Michael Sallah and Carol Marbin Miller
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Phil Sears / For The Miami Herald

Sunshine Acres is an Assisted Living Facility in the small Panhandle town of Caryville, Fla. When AHCA agents were forced out of Sunshine Acres Loving Care in 2008 due to threats by the owner, they didn't go back for eight months. They returned to find filthy conditions and residents drugged without doctors' orders.

This is part one in a three-part series. Read part two here. For more than a decade, Bruce Hall ran his assisted-living facility in Florida's Panhandle like a prison camp.

He punished his disabled residents by refusing to give them food and drugs. He threatened them with a stick. He doped them with powerful tranquilizers, and when they broke his rules, he beat them — sending at least one to the hospital.

"The conditions in the facility are not fit even for a dog," one caller told state agents.

When Florida regulators confronted Hall in 2004 over a litany of abuses at his facility in the rolling hills of Washington County, they said he chased them from the premises while railing against government intrusion.

Under state law, regulators could have shut down Sunshine Acres Loving Care or suspended the home's license, but they did neither. Instead, they ordered the 50-year-old Hall to see a therapist for his anger and to promise not to use "any weapon or object" on his residents — allowing him to keep his doors open for five more years.

In that time, Hall went on to break nearly every provision of Florida's assisted-living law: He threw a woman to the ground, and forced her to sleep on a box spring for six

days after she urinated on her covers. Though the temperature outside reached 100 degrees, he forced his residents to live without air conditioning. And during a critical overnight shift, he fell asleep on the job while a 71-year-old woman with mental illness wandered from her bed, walked out the door and drowned in a nearby pond.

In a state where tens of thousands reside in assisted-living facilities, the case of Hall's Sunshine Acres represents everything that has gone wrong with homes once considered the pride of Florida.

Created more than a quarter-century ago, ALFs were established in landmark legislation to provide shelter and sweeping protections to some of the state's most vulnerable citizens: the elderly and mentally ill.

Tragedies revealed

But a Miami Herald investigation found that the safeguards once hailed as the most progressive in the nation have been ignored in a string of tragedies never before revealed to the public.

In Kendall, a 74-year-old woman was bound for more than six hours, the restraints pulled so tightly they ripped into her skin and killed her.

In Hialeah, a 71-year-old man with mental illness died from burns after he was left in a bathtub filled with scalding water.

In Clearwater, a 75-year-old Alzheimer's patient was torn apart by an alligator after he wandered from his assisted-living facility for the fourth time.

The deaths highlight critical breakdowns in a state enforcement system that has left thousands of people to fend for themselves in dangerous and decrepit conditions.

The Miami Herald found that the Agency for Health Care Administration, which oversees the state's 2,850 assisted-living facilities, has failed to monitor shoddy operators, investigate dangerous practices or shut down the worst offenders.

Time and again, the agency was alerted by police and its own inspectors to caretakers depriving residents of the most basic needs — food, water and protection — but didn't take action.

When AHCA agents were forced to end their inspection of Sunshine Acres in 2008 because of threats by the owner — the second time in four years — the agency didn't return for eight months.

By the time agents went back, they found a resident eating from a filthy food bin, four inches of dirt on the floor of a dorm room and six residents drugged on tranquilizers

without doctors' orders.

"Lord help us all if he gets mad," one resident told state regulators about the owner.

Frustrated over the state's inability to close Sunshine Acres, neighbors began gathering at the local fire station to launch a plan to prompt regulators to act.

"It took the whole damn neighborhood," said Dewayne Anderson, 55, who lives next door to the home.

A representative of the group fired off several e-mails to AHCA, demanding the state enforce its laws and pointing out a litany of problems created by the facility.

After 14 years of running the home and racking up more than 100 violations, Hall was finally told by AHCA to sell Sunshine Acres. But once again, regulators struck another deal: Hall was given a year to find a buyer.

Failure to protect

The Miami Herald spent a year examining thousands of state inspections, police reports, court cases, autopsy files, e-mails, death certificates and conducting dozens of interviews with operators and residents across the state.

Reporters found that as the ranks of assisted-living facilities grew to make room for Florida's booming elderly population, the state failed to protect the people it was meant to serve.

For example:

• Nearly once a month, residents die from abuse and neglect — with some caretakers even altering and forging records to conceal evidence — but law enforcement agencies almost never make arrests.

• Homes are routinely caught using illegal restraints — including powerful tranquilizers, locked closets and ropes — but the state rarely if ever punishes them.

• State regulators could have shut down 70 homes in the past two years for a host of severe violations — including neglect and abuse by caretakers — but in the end, closed just seven.

• While the number of new homes has exploded across the state — 550 in the past five years — the state has dropped critical inspections by 33 percent, allowing some of the worst facilities to stay open.

• Though the state has the power to impose fines on homes that break the law, the

penalties are routinely decreased, delayed or dropped altogether.

• The state's lack of enforcement has prompted other government agencies to cut off funding and in some cases refuse to send clients to live in homes AHCA won't close.

For example, the Miami-Dade Court's mental health project won't send clients to All America ACLF, where Angel Joglar, a 71-year-old man with schizophrenia, was scalded in a bathtub after his caretaker left him alone in 2006, dying from the burns weeks later.

Since his death, AHCA has cited the home for at least 100 violations — including untrained staff failing to stop residents from beating each other with two-by-fours.

After Hillandale ALF was caught locking residents with mental illness in a closet to punish them — along with a host of other violations — the state Agency for Persons with Disabilities cut off hundreds of thousands of dollars it was sending to the home in Pasco County.

Both facilities are still licensed by AHCA.

AHCA, which is empowered with tough tools to enforce the law, said its goal is to get facilities to obey the rules — and imposing fines or other penalties are secondary measures.

Reluctant to punish

The agency, which would only respond to questions in writing, said pushing to revoke a home's license is a "very harsh penalty" used as a last resort. Before doing so, it considers several issues, including the immediate danger to residents and the ability to relocate them to a new home.

Each penalty is considered based on "unique circumstances," and other actions are explored "prior to the most serious sanction of revocation," the agency wrote.

However, The Miami Herald found that AHCA repeatedly catches homes breaking the law but fails to act, at times with dire consequences.

At Hampton Court in Haines City, regulators caught caretakers 11 times in the past five years failing to give out medication, not keeping records of drugs given to residents and falsifying records to show drugs had been given when they hadn't. The state could have imposed emergency measures, including a ban on new residents until the home cleaned up its practices, but never did.

Eventually, someone died.

Norman Dube, a 74-year-old retired postal worker suffering from diabetes and

depression, went 13 days last March without crucial antibiotics — and several days without food or water. As he slipped into unconsciousness, he began telling people “things were crawling on his skin,” a state report said.

At the same time, the home failed to tell his doctor he wasn’t getting his drugs, which included blood pressure medications and anti-psychotics.

The next month, Dube died. A state Department of Children & Families investigation concluded the home committed medical neglect.

But the problems didn’t end. On June 25, two months later, state agents returned to the home and found two more residents languishing without their medication, despite doctor’s orders.

The home promised to correct the problems, but in August it happened again — this time, three more residents were not getting their drugs. Two months ago, the facility was taken over by a new owner.

When it comes to imposing fines, AHCA said it doesn’t routinely drop or reduce them, saying it only lowered fines by 7 percent this fiscal year.

But an analysis shows the agency rarely asks for what’s allowed by law. Consider: In 2009 — the same year lawmakers expanded AHCA’s power to levy fines — the agency could have imposed more than $6 million, but took in just $650,000.

Homes of horror

The law that empowered the state to discipline homes was passed three decades ago in response to a growing crisis: Elderly people moving to Florida were ending up in group homes run by abusive caretakers.

The state passed a celebrated Residents Bill of Rights in 1980 — championed by veteran Miami congressman Claude Pepper — pledging that people in those homes would be protected and treated with dignity.

The homes would shelter two of the state’s fastest-growing groups — the elderly and mentally ill — and at the same time offer an alternative to nursing homes.

Now, people who needed help with everyday chores but didn’t require 24-hour nursing care could live independently.

But as the industry boomed, the state began a series of crucial moves that would change the way it regulated homes.

Instead of inspecting ALFs once a year like most large states — including Arizona, Texas, Pennsylvania, North Carolina and Illinois — Florida cut inspections to just

once every two years.

The same trend took place with investigations of serious incidents like deaths and injuries — known as adverse incidents — which were slashed by 90 percent between 2002 and 2008.

Regulators never investigated Isabel Adult Care III after the owner reported that Aurora Navas, an 85-year-old grandmother with dementia, had quietly wandered from the Miami-Dade home and drowned in a pond in the backyard in 2008.

“Her lack of ability to find her way back caused her accidental death,” wrote the home’s administrator, Isabel Lopez, in a report to AHCA. “We found that all procedures were followed. The facility has door alarms, proper door locks, and a fenced backyard.”

But records show that if regulators had carried out what was once a routine exercise, they would have found just the opposite: The door alarm and video cameras weren’t working, the back gate was unlocked and an attendant had fallen asleep, Miami-Dade police records show.

Navas, who had a history of wandering, was found floating in 18 inches of water, clad only in her lavender sleeping gown, a blue slipper on the ground nearby.

To this day, Alfredo Navas says he’s enraged the state never investigated his mother’s death at the quiet suburban home just north of Kendall.

“You don’t follow up when it comes to human beings who are supposed to be watching other human beings. They get nothing,” said Navas, 59, adding that his mother was afraid of water most of her life. “The safeguards you thought in place weren’t in place.”

In an interview, Lopez said she was ordered by fire inspectors to remove the locks from the rear door. But county records show that was not the case: Inspectors simply told her to get new locks.

Cases skyrocket

While inspections of homes were dropping across the state, another troubling trend was under way that would set new records.

The state Department of Elder Affairs ombudsman program was uncovering more cases of abuse and neglect than it had seen in the last three decades, with numbers doubling in the past five years.

Though the program sends its findings to AHCA, regulators failed to investigate the vast majority of the cases, records show. In fact, a state audit in 2008 found that

AHCA couldn't locate two-thirds of the complaints sent to the agency.

"It's baffling to me," said Brian Lee, the ombudsman program's past director. "We find things, and it's like, how did they not see the same things?"

Even when AHCA does find problems — including people dying from abuse and medical neglect — it rarely moves to close homes, allowing the same dangerous violations to turn up again.

Though Briarwood Manor has been the target of more than 1,200 police and rescue calls in the past five years — with residents stabbing, fighting and suffering psychiatric breakdowns — the Broward County facility has been allowed to stay open.

The drab, stuccoed home in the heart of Lauderhill has been slapped with scores of violations by AHCA — 100 in the past five years — including an episode in which a man slashed his roommate with a knife during a crack binge while the night caretaker was nowhere to be found. Twice in the past five years, the state could have revoked or suspended the home's license, but did neither.

Instead, AHCA allowed Briarwood to operate for four years while it owed massive fines that peaked at more than $370,000, with AHCA eventually agreeing to reduce the amount by 74 percent in 2008.

Briarwood is among the hundreds of ALFs that opened their doors in the past decade, driven by the closing of state mental health institutions.

But as the industry boomed, AHCA failed to keep up with the growth, with state agents taking longer to respond to dangerous breakdowns. A Miami Herald analysis shows it took inspectors an average of 37 days to complete complaint investigations in 2009, 10 days longer than five years earlier.

At least five times, other agencies were forced to take the lead in shutting down homes when AHCA didn't act.

One Hardee County sheriff's detective said he was unable to prod AHCA to shut down Southern Oaks Retirement Center last year after he found residents sleeping on torn, urine-soaked mattresses surrounded by moldy, cracked walls and boarded-up windows.

Though AHCA had turned up the same hazards at the Central Florida home for eight years — including just a month earlier — the facility stayed open until fire officials ordered the evacuation of all 49 residents on June 22, 2010.

Not until the home made critical repairs five weeks later was the order lifted.

For Rosalie Manor, it was a longer battle.

For years, Pinellas County sheriff's deputies had been forced to round up dozens of residents with mental illnesses found wandering the small town of Dunedin, breaking into a school and homes, and shoplifting from businesses.

When deputies finally investigated, they found Rosalie Manor owner Erik Anderson had placed a 53-year-old man just released from a psychiatric ward in charge of dispensing powerful psychotropic drugs to others in the home.

When two residents suffered breakdowns after not getting their crucial medications, detectives sent a warning to AHCA: Shut the place down.

But regulators dropped the case a month later, citing a lack of evidence — prompting an angry response from Sgt. J. Michael Daily, who slammed AHCA for its "inability to take action on this and other valid complaints at Rosalie Manor," records show.

During the next two months, deputies joined prosecutors in a rare effort to close the 34-bed facility.

Detectives brought forward reams of paperwork in 2006 detailing abuse and neglect inside the cluster of cottages near downtown Dunedin — including violations turned up by AHCA year after year.

They found Anderson had covered up crucial evidence in death investigations of the home's residents.

In one case in 2003, he threatened to fire any employee who called police after finding blood splattered on the walls of a 72-year-old man's bedroom and a suicide note on the dresser.

In 2005, he drove a male resident with a criminal history to a pharmacy to fill a prescription for powerful narcotics, but failed to collect the drugs from the man, who then fed them to a 20-year-old female resident with mental illness. She was then raped by the man and died in her bedroom from an overdose.

Administrator charged

In the end, prosecutors charged Anderson, 60, with neglect, witness tampering and falsifying medical records. He pleaded guilty and surrendered his ALF license. His sentence: probation.

Caretaker Mary Pressley, 47, who worked at Rosalie for nearly a decade, said she couldn't understand why AHCA never moved to close the home. "I don't know how he got away with what he did," she said.

Since 2005, Rosalie was among more than 40 homes found to be placing residents in immediate danger — the most serious breach of Florida's ALF law — with a quarter of the homes going on to do it again.

Even after AHCA inspectors warned their own agency that Bruce Hall was running a dangerous facility in 2004, he was allowed to renew his license and expand the home to make room for eight more beds.

It was the third time the troubled facility was granted a renewal by AHCA, despite breaking the state's ALF law 51 times.

The next year, Hall fell asleep on night watch duty just long enough for 71-year-old Elnora Shuler to wander out the door with her baby doll and slip into a pond on the premises.

When AHCA investigators asked Hall why the fence around the pond was only half finished, an inspection report states he responded: "My complacency is the reason… I knew I'd find [Shuler] down there in that pond someday."

When agents visited the ramshackle 52-bed home in North Florida to investigate a tip that Hall threatened residents with a gun, he flew into a rage, referring to the residents as "deranged, mental retarded sons of bitches," while lashing out at state agents, reports showed.

In the end, inspectors Patty McIntire and Kara Cowart, along with a Washington County sheriff's deputy, left the property without completing their investigation, citing "safety concerns."

For his tirade, Hall was fined $1,756 and ordered to visit a therapist because of his anger. But just 17 days later, he shoved a woman diagnosed with mental retardation to the ground, sending her to the hospital with a sprained ankle and cuts on her arm, elbow, knee and shin.

Hall told regulators he was protecting his wife after the resident grabbed her arm, but state agents cited him for abuse.

In an interview with The Miami Herald, Hall said regulators were "bureaucrats" who didn't understand the challenges of dealing with people with mental disabilities — and that he had a right to impose force on residents when they got unruly.

"If one of them jumps on you and you got to beat the hell out of them to get them off you, then you get held responsible," he said. "I'm the damn culprit that's the bad guy in all this?"

He blamed residents and his neighbors for bringing unwarranted scrutiny to the

facility.

“These mentally handicapped residents, they know the game,” he said. “They will play you. They are of the system, they know the system — just like a prisoner. They know what they can get away with.”

He said if he hadn’t imposed discipline on his residents, they would have taken control of the facility. “They’re going to realize they can continue to treat you like a dog,” he said.

During a state inspection in 2006, 14 residents at Sunshine Acres refused to give their names to AHCA agents, saying they feared retaliation.

Between 2007 and 2008, five employees quit their jobs, saying they were tired of the abuse at the home, state reports show.

During that same period, sheriff’s deputies and rescue workers were called to the home more than 400 times for, among other things, fights between residents and people suffering psychiatric breakdowns.

“It was like a damn nightmare,” said Dewayne Anderson, a next-door neighbor who joined the community coalition to close the home.

In 2008, Hall ran AHCA agents off the premises a second time after berating an elderly female resident who was trying to talk privately to them.

Hall “dropped to his knees in front of the resident” and with “flushed face, clenched jaw, rapid, loud speech, flaying [flying] arms,” he said he was throwing her out for complaining about him.

“The survey was discontinued at this point due to a fear for the safety of the surveyors,” inspectors wrote.

After the event, the state threatened to kick Hall out of the business.

In April, agents sent a letter saying Sunshine Acres’ license would not be renewed. But it was. In October, regulators told Hall to get out — but once again, bargained the punishment down, giving him a year to sell the troubled home.

Through it all, agents continued to find more problems: Six residents were illegally given powerful drugs known as “chemical restraints,” designed to keep them under control — without a doctor’s consent, agents wrote.

Finally, after more than 115 citations from AHCA, Hall sold the home in September 2009 — still holding the mortgage in a deal that will earn him $1.1 million during the next 10 years.

The Miami Herald
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NEGLECTED TO DEATH | Part 2: Assisted-living facility caretakers unpunished: ‘There’s a lack of justice’

By MICHAEL SALLAH, CAROL MARBIN MILLER and ROB BARRY
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Chuck Fadely / Miami Herald Staff
Karen Pagano, granddaughter of Francis Tremblay, is shown with her daughter Gabrielle. Frances Tremblay fell a total of 11 times while left unattended at Living Legends home in Deerfield Beach. She died in 2008 after suffering blunt head trauma.

While his caretakers watched him die, William Hughes shivered under the covers in a cramped and dirty bedroom.

They didn’t give him food. They didn’t give him water. Despite doctor’s orders, they never gave him the very medicine that would have saved his life.

Instead, they let him languish for days at the Tampa assisted-living facility where he lived in 2006 — vomiting and defecating in his bed — refusing to clean him because the stench was too strong.

Despite pleas from residents that he desperately needed help, caretakers never called paramedics to try to save the severely diabetic man.

“They let this man just die,” said resident Kevin Conway. “It just boggles my mind to this day.”

His body was sent to the Hillsborough County morgue and cremated at state

expense — his ashes sent to his mother in Ohio, the state investigation closed.

The 55-year-old musician was among dozens who died at the hands of their caretakers in assisted-living facilities across Florida.

One starved to death; another burned in a tub of scalding water. Two were fed lethal doses of drugs. Three died from the ravages of gangrene when their wounds were ignored for weeks.

The state Agency for Health Care Administration — the entity entrusted with overseeing ALFs — refuses to release the records of more than 300 questionable deaths during the past decade, citing state law.

But The Miami Herald obtained confidential records of 70 people who died in the past eight years from the actions of their caregivers.

The records from the Department of Children & Families, another agency tasked with investigating deaths, show people are routinely abused and neglected to death in assisted-living facilities — but in the end, few are ever held accountable.

“There comes a point when you need to say people’s lives are in danger and we need to do more,” said Nick Cox, a former DCF regional administrator who is now Florida’s statewide prosecutor.

Though Florida boasts one of the toughest elder-abuse laws in the country, The Miami Herald found few caretakers are ever charged in the deaths of the people they are supposed to protect.

In an analysis of each of the deaths, including a review of police and autopsy reports, medical records, and interviews with relatives, residents and employees, The Miami Herald found:

• An average of nearly once a month, law enforcement agents were called to investigate cases of residents who died from abuse or neglect — with caretakers even admitting to breaking the law — but almost never made arrests. In at least five cases, caregivers were fired from homes after people directly under their care died from neglect, but none were charged.

• In the two cases in which arrests were made, caregivers were granted plea agreements, never spending a day in prison. One owner was given probation in the death of a 74-year-old woman who was strapped so tightly to her bed that she suffered blood clots and died. The charges were later expunged from the caretaker’s record.

• Four caretakers were caught forging and shredding medical records during death

investigations — concealing key evidence. None was charged.

• Records of deaths at the homes are kept secret by the state — hidden even from family members — allowing facilities to conceal the critical mistakes that took the lives of their residents.

• In three cases, family members were told relatives died of natural causes, but records show their caretakers had abused and neglected them.

The wrong drugs

When the Marrones gathered to bury the 82-year-old matriarch of the family two years ago, they believed Magdalena Marrone had succumbed to old age.

What they didn't know: Caretakers at Emeritus at Crossing Pointe had violated a doctor's orders and failed to give her critical heart medication for four days — and then gave her the wrong drugs on the day she died.

The elderly grandmother was found blue and frothing at the mouth in the Orlando home's activities room. Home administrators later admitted they never read her chart.

"What happened to my grandmother is just devastating," said Kevin Marrone. "We assumed as a family that it was natural."

When Suzanne Hughes got the call from the Hillsborough County medical examiner's office in 2006, she was told her younger brother William died at Escondido Palms from complications of diabetes.

What she wasn't told: He didn't get his insulin for 27 days, and caretakers refused to call an ambulance as he slipped into the throes of diabetic shock.

It would be five years before she would learn from a Miami Herald reporter the fate of William Hughes and the medical neglect that killed him.

The case is among dozens buried in the archives of state regulators — the names blacked out and the details sparse — revealing the blunders and mistakes that cost people their lives in ALFs.

As William Hughes shook in the darkness of his room in the aging facility, two caretakers refused to clean him while his body was shutting down — one complaining the odor was too strong and the other saying she was pregnant.

"No one is helping this man," recalled resident Larry Thrall, 41. "He's still laying there in his own feces."

In the end, Thrall was forced to call paramedics from a cellphone using an alias after

the caretakers refused to dial 911, records state.

By the time rescue workers arrived, it was too late: Hughes was dead from a lack of diabetes medication. “One shot of insulin would have revived him immediately,” said Hillsborough County associate medical examiner Leszek Chrostowsk, who performed the autopsy.

Though a state attorney general’s agent called for prosecutors to charge chief caretaker Charlotte Allen with neglect after she admitted to never reading his charts, the case took a familiar turn. Instead of pursuing charges, the Hillsborough County state attorney’s office dropped the case, saying there wasn’t enough evidence to prove culpable negligence.

Though a witness told police Hughes had gone four times to the office asking for his drugs, assistant state attorney Jay Pruner said he couldn’t prove the requests were made to Allen.

“We were looking to make a case against her,” Pruner said. “This was a horrific situation.”

But under Florida law, prosecutors have charged entire facilities with criminal neglect — and have won convictions.

“I don’t have a response to that,” Pruner said.

Two years after Hughes’ death, Allen, 60, pleaded guilty to stealing $9,000 in disability checks from another resident at the home after being charged by the state attorney’s office. The facility has since been sold.

Fatal mistakes

The lack of prosecutions come as the number of assisted-living facilities rises in Florida — 408 new ones in the past three years.

During the past decade, the DCF death cases reveal a stunning sequence of fatal mistakes made by caretakers who are supposed to protect their vulnerable wards.

In more than 40 percent of the death cases reviewed by The Miami Herald — 29 in all — the people who died of neglect or abuse were suffering from dementia.

At one West Melbourne home, caretakers were supposed to follow a simple rule when the home’s exit alarm was triggered: do a head count and call 911.

But when 74-year-old Waymon Cross slipped out the door of Alterra Clare Bridge in the early hours in 2003, his caretaker shut off the alarm and went back to work.

It was hours before another employee spotted his cap floating in a pond near the home, his body drifting nearby.

“Her job is to protect and take care of [Cross], and she didn’t do that,” recalled West Melbourne police Detective Barbara Smith, adding the caretaker twice changed her story before admitting to what happened.

The home’s administrator did not return repeated phone calls.

For a month in 2008, workers at Living Legends Retirement Center were finding Frances Tremblay sprawled on the floor, her body covered in cuts and bruises.

Instead of taking steps to protect her, administrators at the Deerfield Beach home ignored warnings from a staff nurse that the woman was constantly falling.

The end came after the 11th fall.

When a Broward County sheriff’s deputy showed up, the 98-year-old grandmother was lying in a puddle of blood in a locked room, screaming for help.

At the hospital, doctors found she had two black eyes, a gash over her nose and a fractured neck. She died months later without ever recovering from her injuries.

“What they did to her was criminal,” said William Dean, an attorney who represents Tremblay’s family.

Though charges were never filed in the case, the details of her death emerged for the first time this year, when a Broward County jury found sweeping negligence in Tremblay’s death, awarding her estate $2.39 million in one of the county’s largest jury awards ever rendered against an ALF.

As people were dying in homes across the state — 40 in the past five years — another agency joined regulators in probing deaths: the state attorney general’s office.

In the past eight years, the office reviewed more than half the death cases turned up by DCF — including drownings, medical neglect and drug overdoses — but made just one arrest.

The DCF files show that even when caretakers were caught destroying evidence in death cases — shredding and in some cases falsifying key medical records — the attorney general’s office didn’t act.

Baseball-size sore

When Dorothy Archer arrived at a Pasco County hospital two years ago, rescue

workers discovered a blackened hole the size of a baseball festering on her back.

“Egregious neglect” was how the wound was described by DCF agents investigating her treatment at Edwinola ALF.

But when agents tried to find out how the 90-year-old developed the septic sore, they hit a barrier: Key records describing her final two months at Edwinola had disappeared. Worse, nurses’ notes detailing the wound appeared fabricated.

“For such a serious wound to develop undetected in the ALF … was inexplicable,” DCF agents wrote after she died.

The home’s only punishment: a $1,000 fine levied by the Agency for Healthcare Administration for failing to seek medical care or keep proper records.

Archer’s husband of 37 years, Theodore Robert Archer, said he’s still angry over the home’s treatment of his wife. “They never told me a thing about her condition,” he said. “Oh God, she was suffering.” Janice Merrill, an attorney representing the home, declined to comment.

Beyond problems at the homes, the DCF records reveal another troubling breakdown in the death cases: dozens of bodies found at the homes were sent to the grave without any forensic scrutiny.

The Miami Herald found 33 cases in which bodies were already embalmed or cremated by the time state agents found sweeping evidence of neglect.

Take the case of Muriel Christine Staab, a blind woman in a wheelchair, whose body was cremated before state agents found she had been a victim of neglect.

Clay County sheriff’s deputies responded three years ago to a call to the state’s abuse hotline: The 101-year-old woman developed a severe infection that went untreated and weeks later was found sprawled on the bathroom floor at Park of the Palms.

Under state law, sheriff’s deputies could have asked for an autopsy, but instead allowed a doctor to sign the death certificate saying the death was due to natural causes.

Dr. Daniel B. Cox told police he would simply declare she died from natural causes, even though he was told she had fallen and injured herself. “Dr. Cox said that he would not list the bump on the back of the victim’s head as a contributing factor to death because she probably had a heart attack and then fell to the floor,” a Clay County sheriff’s report states.

Two days later, her body was cremated at Watts Funeral Home in Keystone Heights

with no autopsy.

In the end, DCF agents concluded Cox had “signed the death certificate with limited information.”

Agents later found the home had failed to call a doctor when Staab came down with a serious stomach virus, and then waited 15 minutes to call 911 after finding her on the bathroom floor the night she died.

“There is a strong possibility had medical attention been sought earlier in the day or evening, or 911 called immediately, [the victim] may have survived,” investigators wrote.

No red flags

Cox said the call from sheriff’s deputies the night she died “didn’t raise any red flags,” and he decided to declare her cause of death — without examining her. Home administrator Larry Henderson declined to comment, citing privacy restrictions.

Bentley Lipscomb, a former secretary of Elder Affairs, said the DCF files show for the first time the extent of neglect in homes, and the lack of criminal prosecutions that follow. “They just don’t value old people’s lives,” he said.

He and others spearheaded the changes 15 years ago that toughened state law to allow prosecutors to charge caretakers with neglect when people die under their care. “I was tired of seeing people die unnecessarily and no one doing anything about it,” he said.

George Sheldon, the former DCF secretary, said prosecutors are still failing to look for ways to hold caretakers accountable. He said his former agency — which investigates abuse of the elderly and children — has been frustrated by the number of cases turned over to law enforcement that don’t get prosecuted.

“A lot of attention is paid to children,” he said. “Somehow, we don’t have the same kind of outrage when a person is 70 or 80. There’s clearly a lack of justice.”

One of two cases that prosecutors took to court began on Mother’s Day in 2004 when Gladys Horta’s family got a call from caretakers: the 74-year-old had fallen in the shower, but she wasn’t hurt.

When one of her relatives arrived at The Gardens of Kendall that night to take Horta to dinner, however, she found the elderly woman in bed, curled up in pain.

By the time Horta arrived at the hospital, she was soaked in urine and unconscious, with blackened feet and deep bruises inexplicably circling her legs.

Though doctors performed emergency surgery, Horta died two days later.

In the ensuing weeks, investigators found there was more to the story than what the family was told on Mother's Day.

Instead of a fall in the shower, Horta's injuries were caused by a caretaker who had gone to extremes to keep the elderly woman from wandering: Horta was strapped down for at least six hours — so tightly she lost circulation in her legs, forming the blood clot that killed her, DCF reports state.

After an investigation by the attorney general's office, facility owner Mayra Del Olmo was charged with aggravated neglect and later sentenced to one year of house arrest and five years' probation in 2006, a state attorney general report said.

But to this day, there is no record of her conviction. The reason: Her case was later expunged.

Miami Herald staff writer Jared Goyette contributed to this report.

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Part III | At homes for the mentally ill, a sweeping breakdown in care

By CAROL MARBIN MILLER, ROB BARRY and MICHAEL SALLAH
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Chuck Fadely / Miami Herald Staff

Karen Westfall, a former resident at the Hillandale ALF in Port Richey, Florida, talks about the conditions in the home. She was interviewed October 13, 2010, in the group home where she now lives.

For the residents of Hillandale, punishment was swift and painful: violent takedowns, powerful tranquilizers that made them stumble and drool, and staffers who would scream and tackle them when they misbehaved.

The worst was the closet — a cramped room at the end of a hallway where the residents who were deemed unruly were locked, sometimes for hours.

“It’s like you’re in jail,” said Karen Westfall, who lived at Hillandale for five years.

And like a jail, the Pasco County assisted-living facility sometimes prevented residents from leaving, records show.

Last April, the staff protested the removal of a 47-year-old man — frail and mentally retarded — who said he wanted to move, while residents shouted and blocked the path of state workers trying to safely escort him from the home.

In the end, regulators were forced to bring in sheriff’s deputies to clear a path and break up the crowd gathered behind the gates of the facility.

The dramatic rescue highlights the problems that have turned a special subset of assisted-living facilities into Florida’s most dangerous.

While most ALFs are designed to care for the elderly — providing help with everyday

tasks — Florida licenses facilities like Hillandale to also care for people with severe mental illness.

Created a generation ago, the special homes were the state's answer to providing housing for thousands left in the streets after the historic closings of Florida's psychiatric institutions.

But The Miami Herald found dozens of the homes are so poorly run that residents are forced to languish without crucial needs — including medication and psychiatric help — leaving their care to police and rescue workers.

Ranging from small cottages in suburban neighborhoods to 350-bed complexes, the homes represent a third of ALFs in the state, but account for some of the most egregious cases of abuse.

"It's a cheap, easy, unregulated system of care," said Miami-Dade Mental Health Court Judge Steve Leifman, who refuses to send people in his program to some of the homes because of dangerous and decrepit conditions.

While The Herald found sweeping breakdowns in the state's oversight of standard ALFs, the lack of controls in ALFs for mentally ill residents have created even more problems for some of the state's most vulnerable residents.

Complaints to the Agency for Health Care Administration — the state entity entrusted with overseeing the facilities — are routinely ignored, leaving residents at the mercy of shoddy operators.

Even when the agency found enough violations to close facilities, which frequently mix elderly and mentally ill residents, regulators rarely act under state law.

The Herald's examination of Florida's 1,083 homes for people with mental illness, including a review of state inspection reports, police investigations, court records and interviews with mental health experts, found:

• Regulators find nearly twice the rate of abuse and neglect at the special homes, including caretakers beating and sexually molesting residents.

• State agents have caught nearly 100 homes using illegal restraints since 2002 — including doping residents with tranquilizers without doctor's approval, tying them with ropes and locking them in isolation rooms — only to catch them doing it again.

• Florida's requirements to run a home for people with mental illnesses are among the lowest in the nation: a high school diploma and 26 hours of training — less than the state requirements for barbers, cosmetologists and auctioneers.

• Caretakers are routinely caught intoxicated, asleep and even abandoning their

posts entirely — often with severe consequences to residents, but rarely to the operators.

Twice, residents at Tampa's Escondido Palms were forced to call police when fellow residents were dying — one from a drug overdose, after the lone caretaker had locked the office door and fallen asleep.

It wasn't until a third resident died in 2007 after caretakers failed to perform CPR — leaving the task to another resident — that AHCA asked the facility's owner to sell the home.

A criminal moves in

When Darryl McGee moved into the Munne Center in 2007, he was supposed to get psychiatric care and medication at the sprawling facility in Miami-Dade.

Instead, caretakers gave him a bed in the home's locked Alzheimer's ward with people twice his age and never arranged for care, state reports show.

During the next four months, the burly man with a criminal past became a 214-pound nightmare, beating the elderly residents at least four times before he brutally raped a 71-year-old woman in her bedroom.

The 33-year-old man, diagnosed with bipolar disorder and schizophrenia, was like thousands who flooded into ALFs during the past decade — a younger generation that would now be housed with older people with dementia.

Though residents who move into the specially licensed facilities are supposed to receive psychiatric intervention and care — paid for by state dollars — The Herald found that hundreds of homes are failing to provide those critical services.

In at least 555 cases during the past decade, state agents caught homes failing to make sure residents got medications, psychological care and the supervision needed to spot drastic changes in behavior.

One of those was the Munne Center. The facility had been warned in 2006 it was not delivering the services to its residents, but the following year, it was still not complying with the law.

For four months in 2007, McGee terrorized the home's elderly residents during drunken rages, beating elderly men and women.

After citing the home for a host of violations in the aftermath of the rape, inspectors returned months later — only to find the Munne Center was still not providing care and treatment.

State agents concluded the home was an “unsafe environment to live” and eventually slapped it with a $19,000 fine — later reducing it to $2,000. Then in 2010, it happened again: AHCA found the home had placed another resident with severe mental illness in the Alzheimer’s ward, leading to an assault on an elderly resident.

“They give them chance after chance after chance,” said Brian Lee, former head of the state Department of Elder Affairs ombudsman program. “Their residents were being abused.’’

Home administrator Olga Munoz referred questions to Sean Ellsworth, an attorney for the home, who said the facility is now “under a microscope” and “has been inspected frequently.”

McGee, who had been arrested 11 times before the rape on charges ranging from simple assault and vandalism to cocaine possession, was found incompetent to stand trial.

The incidents at the Munne Center underscore a wider problem in Florida ALFs that care for people with mental illnesses: Homes are allowed to stay open despite histories of violence that jeopardize the safety of residents.

Twice the rate of abuse

Year after year, regulators found people inside the homes suffering twice the rate of abuse — including beatings, sexual abuse and intimidation — than at standard facilities, a Herald analysis shows.

A manager at Arlington House in Palatka was found sexually abusing at least three different men with severe mental illnesses in 2008, but it wasn’t until the local fire inspector found a broken sprinkler system the next year that the facility was closed.

At Nueva Vida, a cluster of cottages in Miami-Dade, police were called 38 times in 2008, and investigated six assaults and a brutal murder in which a 29-year-old man with a violent criminal past smashed a brick into the head of his 52-year-old roommate, nearly severing his ear. The next year, the violence continued, with residents routinely beating one another, police reports show. Though the home was required to report the incidents to AHCA, inspectors found it hadn’t — and the agency never imposed sanctions allowed by state law.

In an analysis of facilities in Miami-Dade, where the majority of the special homes are located, The Herald found the homes cited for inadequate supervision are also far more likely to draw police and emergency calls.

The violence does more than disrupt residents’ treatment: It leaves them in serious danger.

“Even a person without a mental illness would have a difficult time,” said Alan Lipton, Florida’s former chief of psychiatric services. “It’s unacceptable.”

In Lauderhill, a special enclave set aside for a group of ALFs catering to people with mental illness draws police or rescue calls an average of every four hours — 10,703 in the past five years. Police have gone on so many calls to the area known as “Cannon Point” that Lauderhill officers now receive special training in crisis intervention.

The rise in violence comes as advocates and Florida’s Department of Elder Affairs are pressing for increasing the minimum qualifications of people running the facilities and ramping up training for their employees.

Lee, former chief of the Elder Affairs ombudsman program, said as the homes become the primary residences for people with mental disorders, they are failing to provide the professional care to take on that role.

To open a home for people with mental illness, administrators need only a high school diploma and four days of training — far less than other major states, including Ohio, Pennsylvania, California and Texas.

“You’re talking about people with mental challenges — complex — and you got a cook in there supervising,” Lee said. “Talk about warehousing.”

In fact, The Herald found that more than two-thirds of the homes have been caught by state agents with untrained workers or dangerously low staff levels since 2002 — and in some cases, no employees at all.

At Tampa’s Escondido Palms, staff never helped as two residents died in separate incidents — one from a drug overdose, the other from neglect.

For an entire day, Jason Thomas Wright, a 28-year-old recovering addict, was stumbling, slurring his words and falling asleep outside the home. Though caretakers were alerted to his drastic change in behavior and struggles with drug abuse, they never called a doctor.

That night, as Wright gasped for breath, his roommate pounded on the office door to get the lone caretaker to call 911. But no one answered, forcing the roommate to run to a payphone at a nearby Food Town store.

When paramedics arrived, Wright was dead — killed by an overdose of painkillers. Regulators later discovered the caretaker hadn’t come to the door because he, too, had taken painkillers and fallen asleep.

When state agents cited the home for the death in 2005, it was the fifth time in two years the facility was slapped with staffing violations. Former owner Avelino Garcia

did not return repeated phone calls seeking comment.

While many homes were allowed to stay open by paying fines, another problem was emerging that would have a direct impact on the safety of residents.

In home after home, regulators were catching caretakers resorting to a wide range of illegal restraints to control disturbed residents — clear violations of state law and residents' rights.

Since 2002, AHCA has cited homes 508 times for actions ranging from feeding tranquilizers to residents without doctor's orders to strapping disabled people to wheelchairs and beds.

In fact, The Herald found at least 96 homes were repeatedly cited for the same violations — actions that could have drawn sanctions ranging from suspensions to bans on new residents.

Caretakers were caught 14 times in one month tackling residents and forcing them into a locked "isolation" closet at Pasco County's Hillandale.

Known as the time-out room, it became a symbol of the home's excesses: a cramped chamber with a metal door magnetically locked from the outside.

'They split her head'

Residents suffering from mental retardation, hearing impairment and other disabilities were left in the room for "sometimes hours," said Karen Westfall, a resident who recalled one incident in which a friend was thrown in the closet. "They split her head open," she said. "All I could hear was a big, loud thud."

Former resident Tommy Drinnenberg, 45, described the room through a sign-language interpreter. "Dark. Can't see," said the deaf man. "Hated that… Bad."

A former office manager who phoned in a complaint to AHCA about the room told The Herald she kept a log of what she saw, including scratch marks around the door frame — where residents tried to claw their way out — and footprints on the walls.

Ellen Rothermel said her notes from February 2005 also say she heard screams, and remembers one incident in which a female resident was ordered to remove her clothes before being dragged into the room by the home's administrator.

Though ordered by AHCA to stop using the room — which was linked to a spate of injuries — Hillandale administrator John Ross was defiant: "I don't care how many times they cite me for this," state agents quoted him in a report.

In an interview, Ross said he no longer uses the room, but feels it was the best

solution for dealing with people with severe mental illness who were acting out.

“I defend it to this day,” he said. “You just put them in a room and let them chill down.”

At the same time, regulators found the home was also overdosing its residents on tranquilizers.

In 2007, a psychiatrist working for the state found people at the home were so overmedicated — one resident was on at least 18 mind-altering drugs — that they drooled and slept most of the day. The doctor said the drugs placed residents at “significant risk,” and appeared to be “an attempt to chemically restrain” them.

“I knew I didn’t need all that medication,” said Westfall, who said she spent a year detoxifying after she left the facility.

No end to problems

Though AHCA slapped sanctions on Hillandale — including a temporary ban on new admissions — the problems continued: In just 18 months, sheriff’s deputies were called to the home 174 times to investigate assaults, thefts and missing persons, records show.

When a 50-year-old man living at the home tripped the exit alarm before dawn in 2007, the lone caretaker shut off the device and did nothing until police called an hour later asking if anyone was missing.

It took two more hours before staff members learned Co Dang — who suffered from paranoid schizophrenia — was dead, struck by a car as he walked along the road nearly two miles away, his spine severed.

Again, AHCA cited the home for failing to safeguard its residents — Co had been found wandering by police more than a dozen times — but in the end, never imposed a penalty.

During the next three years, state agents turned up more problems, including residents abusing other residents.

In April 2010, a disabilities advocate visiting the home found a 47-year-old man — clad in a woman’s blouse and mismatched shoes — so overmedicated he was drooling and couldn’t hold up his head.

State workers agreed to remove him after he asked to leave, but their efforts sparked a near riot at the facility. It had been the fourth time in 18 months that agents had encountered trouble while trying to move residents, state records show.

Shortly after two AHCA agents came to whisk him away, angry residents began to circle the agents when they were told by a Hillandale staff worker to “stall” the removal of their fellow resident, a state report said.

The men and women formed an unruly “mob” that “cursed” at the two AHCA workers, blocking their path to a state van.

Finally, sheriff’s deputies were called to protect the two inspectors and put an end to the disturbance.

After the incident, one agency criticized the home’s oversight of its residents, saying “clients were visibly overmedicated” and the home lacked proper supervision, noted Ken Winn, a behavior specialist for the Agency for Persons with Disabilities. “This represents an escalating pattern.”

But AHCA — the lone state agency with regulatory authority — took no action, saying it “did not find rules or laws were being violated.”

The Florida Senate

Interim Report 2012-128 *September 2011*

Committee on Health Regulation

REVIEW REGULATORY OVERSIGHT OF ASSISTED LIVING FACILITIES IN FLORIDA

Issue Description

There are 2,956 assisted living facilities (ALFs) in Florida that are licensed by the Agency for Health Care Administration (AHCA) and subject to regulation under administrative rules adopted by the Department of Elder Affairs (DOEA), in consultation with the AHCA, the Department of Children and Family Services (DCF), and the Department of Health (DOH).

Recently, the Miami Herald completed a three part investigative series relating to ALFs in the state. This series highlighted concerns with the management and administration of facilities and the deficiencies in the state regulation of such facilities, which has garnered the attention of many state lawmakers, stakeholders, related agencies, and residents and their family members.

Senate professional staff examined the claims made in the Miami Herald investigative series, pertinent state laws, and agency regulatory processes for ALFs. Senate professional staff recommends a more comprehensive and multifaceted approach to resolving regulatory deficiencies in order to better protect vulnerable residents in ALFs.

Background

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, 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.[1, 2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[4]

The ALFs are licensed by the AHCA, pursuant to part I of ch. 429, F.S., relating to assisted living facilities, and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. The ALFs are also subject to regulation under Chapter 58A-5, Florida Administrative Code (F.A.C.). These rules are adopted by the DOEA in consultation with the AHCA, the DCF, and the DOH.[5] An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Chapter 69A-40, F.A.C., and standards enforced by the DOH concerning food hygiene; physical plant sanitation; biomedical waste; and well, pool, or septic systems.[6]

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[1] Section 429.02(5), F.S.

[2] An ALF does not include an adult family-care home or a non-transient public lodging establishment. An adult family-care home is regulated under ss. 429.60–429.87, F.S., and is defined as a full-time, family-type living arrangement, in a private home where the person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives. A non-transient establishment (a.k.a. boarding house) is regulated under part I of ch. 509, F.S., and is defined as any public lodging establishment that is rented or leased to guests by an operator whose intention is that the dwelling unit occupied will be the sole residence of the guest.

[3] Section 429.02(16), F.S.

[4] Section 429.02(1), F.S.

[5] Section 429.41(1), F.S.

[6] *See* chs. 64E-12, 64E-11, and 64E-16, F.A.C.

As of June 1, 2011, there were 2,956 licensed ALFs in Florida.[7] In addition to a standard license, an ALF may have specialty licenses that authorize an ALF to provide limited nursing services (LNS),[8] limited mental health (LMH) services,[9] and extended congregate care (ECC) services.[10] Out of the 2,956 licensed ALFs, 1,062 have LNS licenses, 1,100 have LMH licenses, and 278 have ECC licenses.[11]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. Generally, the care and services include at a minimum:[12]

- Supervising the resident in order to monitor the resident's diet; being aware of the general health, safety, and physical and emotional well-being of the resident; and recording significant changes, illnesses, incidents, and other changes which resulted in the provision of additional services;
- Contacting appropriate persons upon a significant change in the resident or if the resident is discharged or moves out;
- Providing and coordinating social and leisure activities in keeping with each resident's needs, abilities, and interests;
- Arranging for health care by assisting in making appointments, reminding residents about scheduled appointments, and providing or arranging for transportation as needed; and
- Providing to the resident a copy of, and adhering to, the Resident Bill of Rights.

An unlicensed person who has received the appropriate training may assist a resident in an ALF with the self-administration of medication. Persons under contract to the ALF, employees, or volunteers, who are licensed under the nurse practice act[13] and uncompensated family members or friends may:[14]

- Administer medications to residents;
- Take a resident's vital signs;
- Manage individual weekly pill organizers for residents who self-administer medication;
- Give prepackaged enemas ordered by a physician; and
- Observe residents, document observations on the appropriate resident's record, and report observations to the resident's physician.

Additionally, in an emergency situation, persons licensed under the nurse practice act may carry out their professional duties until emergency medical personnel assume responsibility for care.[15] A resident may independently arrange, contract, and pay for additional services provided by a third-party of the resident's choice.

The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on an assessment of the strengths, needs, and preferences of the individual; the health assessment; the preliminary service plan; the facility's residency criteria; services offered or arranged for by the facility to meet resident needs; and the ability of the facility to meet the uniform fire-safety standards.[16]

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[7] Agency for Health Care Administration, *Assisted Living Directory*, available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/pdf/Directory_ALF.pdf (Last visited on July 15, 2011).
[8] Section 429.07(3)(c), F.S.
[9] An ALF that serves three or more mental health residents must obtain a limited mental health specialty license. A mental health resident is 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). *See* ss. 429.075 and 429.02(15), F.S.
[10] Section 429.07(3)(b), F.S.
[11] Agency for Health Care Administration, *Directories*, available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml (Last visited on July 15, 2011).
[12] Rule 58A-5.0182, F.A.C.
[13] Part I of ch. 464, F.S.
[14] Section 429.255, F.S.
[15] *Id.*
[16] Section 429.26, F.S., and Rule 58A-5.030, F.A.C.

A resident who requires 24-hour nursing supervision[17] may not reside in an ALF, unless the resident is enrolled as a hospice patient.[18] Continued residency of a hospice patient is conditioned upon a mutual agreement between the resident and the facility, additional care being rendered through a licensed hospice, and the resident being under the care of a physician who agrees that the physical needs of the resident are being met.[19]

If a 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 must be discharged in accordance with the Resident Bill of Rights.[20]

Limited Nursing Services Specialty License

An LNS specialty license enables an ALF to provide, directly or through contract, a select number of nursing services in addition to the personal services that are authorized under the standard license.

The nursing services authorized to be provided with this license are limited to acts specified in administrative rules,[21] may only be provided as authorized by a health care provider's order, and must be conducted and supervised in accordance with ch. 464, F.S., relating to nursing, and the prevailing standard of practice in the nursing community. A nursing assessment, that describes the type, amount, duration, scope, and outcomes or services that are rendered 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.[22]

Extended Congregate Care Specialty License

An ECC specialty license enables an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services[23] to persons who otherwise would be disqualified from continued residence in an ALF.[24]

The primary purpose of ECC services is to allow residents, as they become more impaired with physical or mental limitations, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined

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[17] "Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services must be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or disease state or stage. Definition found at s. 429.02(26), F.S.

[18] Section 429.26(11), F.S.

[19] Section 429.26(9), F.S.

[20] Section 429.28, F.S.

[21] Rule 58A-5.031, F.A.C. The additional nursing services that might be performed pursuant to the LNS license include: conducting passive range of motion exercises; applying ice caps or collars; applying heat, including dry heat, hot water bottle, heating pad, aquathermia, moist heat, hot compresses, sitz bath and hot soaks; cutting the toenails of diabetic residents or residents with a documented circulatory problem if the written approval of the resident's health care provider has been obtained; performing ear and eye irrigations; conducting a urine dipstick test; replacing an established self-maintained indwelling urinary catheter, or performing an intermittent urinary catheterization; performing digital stool removal therapies; applying and changing routine dressings that do not require packing or irrigation, but are for abrasions, skin tears and closed surgical wounds; caring for stage 2 pressure sores, (care for stage 3 or 4 pressure sores are not permitted); caring for casts, braces and splints (care for head braces, such as a halo, is not permitted); assisting, applying, caring for, and monitoring the application of anti-embolism stockings or hosiery; administering and regulating portable oxygen; applying, caring for, and monitoring a transcutaneous electric nerve stimulator (TENS); performing catheter, colostomy, and ileostomy care and maintenance; conducting nursing assessments; and, for hospice patients, providing any nursing service permitted within the scope of the nurse's license, including 24-hour nursing supervision.

[22] Section 429.26, F.S., and Rule 58A-5.031(3)(c), F.A.C.

[23] Supportive services include 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. *See* Rule 58A-5.030(8)(a), F.A.C.

[24] Section 429.07(3)(b), F.S., and Rule 58A-5.030, F.A.C.

appropriate for admission to the ECC facility. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour nursing supervision.[25]

An ECC program may provide additional services, such as:[26]

- Total help with bathing, dressing, grooming, and toileting;
- Nursing assessments conducted more frequently than monthly;
- Measuring and recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- Assisting with self-administered medications or administering medications and treatments pursuant to a health care provider's order;
- Supervising residents with dementia and cognitive impairments;
- Health education, counseling, and implementing health-promoting programs;
- Rehabilitative services; and
- Escort services to health-related appointments.

An individual must undergo a medical examination before admission to an ALF with the intention of receiving ECC services or upon transfer within the same facility to that portion of the facility licensed to provide ECC services. The ALF must develop a service plan[27] that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

A supervisor, who may also be the administrator, must be designated to be responsible for the day-to-day management of the ECC program and ECC resident service planning.[28] A nurse, provided as staff or by contract, must be available to provide nursing services as needed by ECC residents, participate in the development of resident service plans, and perform the monthly nursing assessment for each resident receiving ECC services. The ECC-licensed ALF must provide awake staff to meet resident scheduled and unscheduled night needs.[29]

Persons under contract to the ECC, employees, or volunteers, who are licensed under the nurse practice act,[30] including certified nursing assistants, may perform all duties within the scope of their license or certification, as approved by the facility administrator.[31] These nursing services must be authorized by a health care provider's order and pursuant to a plan of care; medically necessary and appropriate treatment for the condition; in accordance with the prevailing standard of practice in the nursing community and the resident's service plan; a service that can be safely, effectively, and efficiently provided in the facility; and recorded in nursing progress notes.[32]

Facilities holding an ECC license must also:

- Ensure that the administrator of the facility and the ECC supervisor, if separate from the administrator, has a minimum of 2 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 1 year of the required experience and a nursing home administrator is considered to be qualified for the position.
- Provide enough qualified staff to meet the needs of ECC residents considering the amount and type of services established in each resident's service plan.

[25] Section 429.07(3)(b), F.S.
[26] Rule 58A-5.030, F.A.C.
[27] Section 429.02(21), F.S.
[28] If the administrator supervises more than one facility, then he or she must appoint a separate ECC supervisor for each facility holding an ECC license. *See* Rule 58A-5.030, F.A.C.
[29] Rule 58A-5.030, F.A.C.
[30] Part I of ch. 464, F.S.
[31] Section 429.255(2), F.S.
[32] Rule 58A-5.030(8)(c), F.A.C.

- Immediately provide additional or more qualified staff, when the AHCA 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.
- Ensure and document that staff receive required ECC training.

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.[33] A mental health resident is 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).[34,35] The DCF is responsible for ensuring that a mental health resident is assessed and determined able to live in the community in an ALF with an LMH license.[36]

An ALF licensed to provide LMH services must assist the mental health resident in carrying out the activities in the resident's community living support plan. The mental health resident's community living support plan, which is updated annually, includes:[37]

- The specific needs of the resident which must be met for the resident to live in the ALF and community;
- The clinical mental health services to be provided by the mental health care provider to help meet the resident's needs, and the frequency and duration of such services;
- Any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident's needs, and the frequency and duration of such services and activities;
- Obligations of the ALF to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities identified in the plan;
- A description of other services to be provided or arranged by the ALF; and
- A list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms particular to the resident that indicates the immediate need for professional mental health services.

The LMH licensee must execute a cooperative agreement between the ALF and the mental health care services provider. The cooperative agreement specifies, among other things, directions for the ALF accessing emergency and after-hours care for the mental health resident.

Additionally, according to Rule 58A-5.029, F.A.C., facilities holding an LMH license must:

- Provide an opportunity for private face-to-face contact between the mental health resident and the resident's mental health case manager or other treatment personnel of the resident's mental health care provider.
- Observe resident behavior and functioning in the facility, and record and communicate observations to the resident's mental health case manager or mental health care provider regarding any significant behavioral or situational changes which may signify the need for a change in the resident's professional mental health services, supports and services described in the community living support plan, or that the resident is no longer appropriate for residency in the facility.
- Ensure that designated staff have completed the required LMH training.
- Maintain facility, staff, and resident records in accordance with the requirements of the law.

[33] Section 429.075, F.S.
[34] Section 429.02(15), F.S.
[35] Optional State Supplementation is a cash assistance program. Its purpose is to supplement a person's income to help pay for costs in an assisted living facility, mental health residential treatment facility, or adult family care home, but it is not a Medicaid program. Department of Elder Affairs, *Florida Affordable Assisted Living: Optional State Supplementation (OSS)*, available at: http://elderaffairs.state.fl.us/faal/operator/statesupp.html (Last visited on August 17, 2011).
[36] Section 394.4574, F.S., requires a mental health resident to be assessed by a psychiatrist, clinical psychologist, clinical social worker, psychiatric nurse, or an individual who is supervised by one of these professionals to determine whether it is appropriate for the person to reside in an ALF.
[37] Rule 58A-5.029(2)(c)3., F.A.C.

ALF Staffing Requirements

Every ALF must be under the supervision of an administrator, who is responsible for the operation and maintenance of the facility, including the management of all staff and the provision of adequate care to all residents. An ALF administrator must be at least 21 years of age and, if employed on or after August 15, 1990, must have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed ALF in Florida for at least 1 of the past 3 years in which the facility has met minimum standards. However, all administrators employed on or after October 30, 1995, must have a high school diploma or G.E.D. An administrator must be in compliance with level 2 background screening standards and complete a core training requirement.[38]

Administrators may supervise a maximum of either three ALFs or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility must appoint in writing a separate "manager" for each facility who must be at least 21 years old and complete a core training requirement.[39]

All staff are required to be assigned duties consistent with the level of his or her education, training, preparation, and experience and staff providing services requiring licensing or certification must be appropriately licensed or certified. Facilities with a licensed capacity of 17 or more residents are required to develop a written job description for each staff position, must provide a copy of the job description to each staff member, and must maintain time sheets for all staff.[40]

All staff, who are employed by or contracted with the ALF to provide personal services to residents, must receive a level 2 background screening.[41]

ALFs are required to offer personal supervision, as appropriate for each resident, and must:

- Monitor the quantity and quality of resident diets;
- Make daily observations 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;
- Keep a general awareness of the resident's whereabouts, although the resident may travel independently in the community;
- Contact 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;
- Contact the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out; and
- Make a written record, updated as needed, of any significant changes such as 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.[42]

[38] Section 429.174, F.S., and Rule 58A-5.019, F.A.C.
[39] *Id.*
[40] *Id.*
[41] Section 408.809(1)(e), F.S. and s. 429.174, F.S.
[42] Rule 58A-5.0182(1), F.A.C.

ALFs must maintain the following minimum staff hours per week:[43]

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

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

Other staffing precautions include:

- At least one staff member, who has access to facility and resident records in case of an emergency, must be within the facility at all times when residents are in the facility.
- Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager, or other staff are absent from the facility.
- In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
- At least one staff member who is trained in First Aid and CPR must be within the facility at all times when residents are in the facility.
- During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least 18 years of age must be designated in writing to be in charge of the facility.
- Staff whose duties are exclusively building maintenance, clerical, or food preparation cannot be counted toward meeting the minimum staffing hours requirement.
- The administrator or manager's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule.
- Only on-the-job staff may be counted in meeting the minimum staffing hours; vacant positions or absent staff may not be counted.[44]

Each ALF must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident's care. An ALF may be required by the AHCA to immediately increase staff above the minimum staffing levels if the AHCA determines that adequate supervision and care are not being provided to residents, resident care standards are not being met, or that the facility is failing to meet the terms of residents' contracts. When additional staff is required above the minimum, the AHCA requires the submission of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met.[45]

The AHCA may also require, based on the recommendations of the local fire safety authority, additional staff when the facility fails to meet the fire safety standards described in s. 429.41, F.S., and ch. 69A-40, F.A.C., until such time as the local fire safety authority informs the AHCA that fire safety requirements are being met.[46]

[43] Rule 58A-5.019(4), F.A.C.
[44] Rule 58A-5.019, F.A.C.
[45] *Id.*
[46] *Id.*

Resident Elopement

All facilities must assess residents at risk for elopement or must identify those residents having any history of elopement in order for staff to be alerted to their needs for support and supervision. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at-risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff's attention must be directed toward residents assessed at high risk for elopement, with special attention given to those with Alzheimer's disease and related disorders assessed at high risk. At a minimum, the facility must have a photo identification of at-risk residents on file within 10 calendar days of admission that is accessible to all facility staff and law enforcement, as necessary. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification must be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident's family or caregiver.[47]

The facility is required to develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must include:

- An immediate staff search of the facility and premises;
- The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;
- The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to an immediate search of the facility and premises; and
- The continued care of all residents within the facility in the event of an elopement.[48]

Use of Restraints

Florida law limits the use of restraints on residents of ALFs. The use of physical restraints[49] is limited to half-bed rails as prescribed and documented by the resident's physician with the consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The physician is to review the order for physical restraints biannually.[50] The use of chemical restraints[51] is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess the continued need for the medication, the level of the medication in the resident's blood, and the need for adjustments in the prescription.

ALF Staff Training

Administrators and other ALF staff must meet minimum training and education requirements established by the DOEA by rule.[52] This training and education is intended to assist facilities appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.[53]

The ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and a competency test. Administrators and managers are required to successfully complete the ALF core training

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[47] Rule 58A-5.0182(8), F.A.C.
[48] *Id.*
[49] "Physical restraint" means a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. The term shall not include bandage material used for the purpose of binding a wound or injury. Section 429.02(17), F.S.
[50] Rule 58A-5.0182(6)(h), F.S.
[51] "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms. Section 429.02(6), F.S.
[52] Rule 58A-5.0191, F.A.C.
[53] Section 429.52(1), F.S.

requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test.[54] The minimum passing score for the competency test is 75 percent.[55]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every 2 years. A newly hired administrator or manager, who has successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager, who has successfully completed the core training but has not maintained the continuing education requirements, is considered a new administrator or manager for the purposes of the core training requirements. He or she must retake the ALF core training and retake and pass the competency test.[56]

Facility administrators or managers are required to provide or arrange for the following in-service training to facility staff:

- Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides must receive a minimum of 1-hour in-service training in infection control, including universal precautions, and facility sanitation procedures before providing personal care to residents.[57]
- 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 reporting of major incidents, reporting of adverse incidents, and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
- Staff who provide direct care to residents, who have not taken the core training program, must receive a minimum of 1-hour in-service training within 30 days of employment that covers resident rights in an ALF and recognizing and reporting resident abuse, neglect, and exploitation.
- Staff who provide direct care to residents, other than nurses, CNAs, or home health aides must receive 3 hours of in-service training within 30 days of employment that covers resident behavior and needs and providing assistance with the activities of daily living.
- Staff who prepare or serve food and who have not taken the ALF core training, must receive a minimum of 1-hour in-service training within 30 days of employment in safe food handling practices.
- All facility staff are required to receive in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment, must be provided with a copy of the facility's resident elopement response policies and procedures, and must demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.[58]

Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which must include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.[59]

Assistance with Self-Administered Medications

Unlicensed persons who are to provide assistance with self-administered medications must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff.[60] Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in ALFs; procedures and techniques for assisting the resident with self-administration of medication, including how to read a prescription label; providing the right medications to the

[54] Rule 58A-5.0191, F.A.C.

[55] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.

[56] Rule 58A-5.0191, F.A.C.

[57] Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. Rule 58A-5.0191(2)(a), F.A.C.

[58] Rule 58A-5.0191, F.A.C.

[59] Section 429.41(1)(a)3., F.S.

[60] Section 429.52(5), F.S.

right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training must include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises.[61]

To receive a training certificate, a trainee must demonstrate an ability to read and understand a prescription label and provide assistance with self-administration including:

- Assist with oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms;
- Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
- Recognize the need to obtain clarification of an "as needed" prescription order;
- Recognize a medication order, which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders;
- Complete a medication observation record;
- Retrieve and store medication; and
- Recognize the general signs of adverse reactions to medications and report such reactions.[62]

Those unlicensed persons, who provide assistance with self-administered medications and have successfully completed the initial 4-hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an ALF.[63]

ECC Specific

The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility's receiving its ECC license or within 3 months of beginning employment in the facility as an administrator or ECC supervisor.[64] The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every 2 years in topics relating to the physical, psychological, or social needs of frail elderly and disabled persons, or persons with Alzheimer's disease or related disorders.[65]

All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an ECC facility.[66]

LMH Specific

The administrator, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility, must receive the following training:[67]

- A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.
- A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with mental health diagnoses or mental health treatment.

[61] Rule 58A-5.0191(5)(a), F.A.C.
[62] Rule 58A-5.0191(5)(b), F.A.C.
[63] Rule 58A-5.0191(5)(c), F.A.C.
[64] ECC supervisors who attended the ALF core training prior to April 20, 1998, are not required to take the ALF core training competency test. Rule 58A-5.0191(7), F.A.C.
[65] Rule 58A-5.0191(7)(b), F.A.C.
[66] Rule 58A-5.0191(7)(c), F.A.C.
[67] Section 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.

Special Care for Persons with Alzheimer's Disease

Facilities which advertise that they provide special care for persons with Alzheimer's disease and related disorders must ensure that facility staff who have regular contact with or provide direct care to residents with Alzheimer's disease and related disorders, obtain 4 hours of initial training within 3 months of employment.[68] Initial training, entitled "Alzheimer's Disease and Related Disorders Level I Training," must address the following subject areas:

- Understanding Alzheimer's disease and related disorders;
- Characteristics of Alzheimer's disease;
- Communicating with residents with Alzheimer's disease;
- Family issues;
- Resident environment; and
- Ethical issues.

Facility staff who provide direct care to residents with Alzheimer's disease and related disorders must obtain an additional 4 hours of training, entitled "Alzheimer's Disease and Related Disorders Level II Training," within 9 months of employment. Alzheimer's Disease and Related Disorders Level II Training must address the following subject areas as they apply to these disorders:

- Behavior management;
- Assistance with activities of daily living;
- Activities for residents;
- Stress management for the care giver; and
- Medical information.[69]

Direct care staff is required to participate in 4 hours of continuing education annually.[70] Facility staff who, have only incidental contact[71] with residents with Alzheimer's disease and related disorders, must receive general written information provided by the facility on interacting with such residents within 3 months of employment.[72]

Do Not Resuscitate Orders

Facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least 1 hour of training in the facility's policies and procedures regarding Do Not Resuscitate Orders within 30 days after employment.[73]

Trainers

Training for administrators must be performed by trainers registered with the DOEA. The trainer must provide the DOEA with proof that he or she has completed the minimum core training education requirements, successfully passed the competency test, and complied with continuing education requirements (12 contact hours of continuing education in topics related to assisted living every 2 years), and meet one of the following requirements:

- Provide proof of completion of a 4-year degree from an accredited college or university and have worked in a management position in an ALF for 3 years after being core certified;
- Have worked in a management position in an ALF for 5 years after being core certified and have 1 year of teaching experience as an educator or staff trainer for persons who work in ALFs or other long-term care settings;
- Have been previously employed as a core trainer for the DOEA;

[68] Those that have completed the core training program between April 20, 1998, and July 1, 2003, are deemed to have satisfied this requirement. Those qualified to provide such training are not required to complete this requirement or the requirement for Alzheimer's Disease and Related Disorders Level II Training. *See* Rule 58A-5.0191, F.A.C.
[69] Rule 58A-5.0191, F.A.C.
[70] Section 429.178, F.S.
[71] "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. Rule 58A-5.0191(9)(f), F.A.C.
[72] Section 429.178, F.S.
[73] Rule 58A-5.0191(11), F.A.C.

- Have a minimum of 5 years of employment with the AHCA, or formerly the Department of Health and Rehabilitative Services, as a surveyor of ALFs;
- Have a minimum of 5 years of employment in a professional position in the AHCA Assisted Living Unit;
- Have a minimum of 5 years employment as an educator or staff trainer for persons working in an ALF or other long-term care settings;
- Have a minimum of 5 years of employment as an ALF core trainer, which was not directly associated with the DOEA; or
- Have a minimum of a 4-year degree from an accredited college or university in the areas of healthcare, gerontology, social work, education or human services, and a minimum of 4 years experience as an educator or staff trainer for persons working in an ALF or other long-term care settings after core certification.[74]

Inspections and Surveys

The AHCA is required to conduct a survey, investigation, or appraisal of an ALF:

- Prior to the issuance of a license.
- Prior to biennial renewal of a license.
- When there is a change of ownership.
- To monitor facilities licensed to provide LNS or ECC services, or facilities cited in the previous year for a class I or class II, or four or more uncorrected class III, violations.[75]
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If the AHCA has reason to believe a facility is violating a provision of part III of ch. 429, F.S., relating to adult day care centers, or an administrative rule.
- To determine if cited deficiencies have been corrected.
- To determine if a facility is operating without a license.[76]

An applicant for licensure renewal is eligible for an abbreviated biennial survey by the AHCA if the applicant does not have any:

- Class I or class II violations or uncorrected class III violations.
- Confirmed long-term care ombudsman council complaints reported to the AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[77]

The AHCA must expand an abbreviated survey or conduct a full survey if violations, which threaten or potentially threaten the health, safety, or security of residents are identified during an abbreviated survey.[78]

An LNS licensee is subject to monitoring inspections by the AHCA or its agents at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.[79]

An ECC licensee is subject to quarterly monitoring inspections by the AHCA or its agents. At least one registered nurse must be included in the inspection team. The AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately, and there are no serious violations or substantiated complaints about the quality of service or care.[80]

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[74] Section 429.52(9)-(10), F.S. and Rule 58T-1.203, F.A.C.
[75] *See below* information under subheading "Violations and Penalties" for a description of each class of violation.
[76] *See* s. 429.34, F.S., and Rule 58A-5.033, F.A.C.
[77] Rule 58A-5.033(2), F.A.C.
[78] *Id.*
[79] Section 429.07(3)(c), F.S.
[80] Section 429.07(3)(b), F.S.

Violations and Penalties

Under s. 408.813, F.S., which provides the general licensure standards for all facilities regulated by the AHCA, ALFs may be subject to administrative fines imposed by the AHCA for certain types of violations. Each of the following violations is classified according to the nature of the violation and the gravity of its probable effect on facility residents:

- 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 AHCA 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 must be abated or eliminated within 24 hours, unless a fixed period, as determined by the AHCA, is required for correction. The AHCA must impose an administrative fine for a cited class I violation, notwithstanding the correction of the violation.
- 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 AHCA determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The AHCA must impose an administrative fine, notwithstanding the correction of the violation.
- 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 AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The AHCA must impose an administrative fine and a citation for a class III violation, which 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.
- 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 AHCA determines do not threaten the health, safety, or security of clients. The AHCA must impose an administrative fine and a citation for a class IV violation, which 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 AHCA must provide written notice of a violation and must impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation; impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation; impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation; and impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation.[81]

When determining if a penalty is to be imposed and in fixing the amount of the fine, the AHCA must consider the following factors:

- The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.
- Actions taken by the owner or administrator to correct violations.
- Any previous violations.
- The financial benefit to the facility of committing or continuing the violation.
- The licensed capacity of the facility.[82]

Each day of continuing violation after the date fixed for termination of the violation, as ordered by the AHCA, constitutes an additional, separate, and distinct violation.[83]

The AHCA may deny, revoke, and suspend any license and impose an administrative fine against a licensee for a violation of any provision of part I of ch. 429, F.S., part II of ch. 408, F.S., or applicable rules; for the actions of

[81] Section 429.19(2), F.S.
[82] Section 429.19(3), F.S.
[83] Section 429.19(4), F.S.

any person subject to level 2 background screening under s. 408.809, F.S.; for the actions of any facility employee; or for any of the following actions by a licensee:

- An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.
- A determination by the AHCA that the owner lacks the financial ability to provide continuing adequate care to residents.
- Misappropriation or conversion of the property of a resident of the facility.
- Failure to follow the criteria and procedures provided under part I of ch. 394, F.S., relating to the transportation, voluntary admission, and involuntary examination of a facility resident.
- A citation for one or more cited class I deficiencies, three or more cited class II deficiencies, or five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified.
- Failure to comply with background screening standards.
- Violation of a moratorium.
- Failure of the license applicant, the licensee during re-licensure, or a licensee that holds a provisional license to meet the minimum license requirements at the time of license application or renewal.
- An intentional or negligent life-threatening act in violation of the uniform fire-safety standards for ALFs or other fire-safety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the AHCA by the local authority having jurisdiction or the State Fire Marshal.
- Knowingly operating any unlicensed facility or providing without a license any service that must be licensed.
- Any act constituting a ground upon which application for a license may be denied.[84]

Upon notification by the local authority having jurisdiction or by the State Fire Marshal, the AHCA may deny or revoke the license of an ALF that fails to correct cited fire code violations that affect or threaten the health, safety, or welfare of a resident of a facility.[85]

Additionally, the AHCA may deny a license to any applicant or controlling interest[86] which has or had a 25 percent or greater financial or ownership interest in any other licensed facility, or in any entity licensed in Florida or another state to provide health or residential care, which facility or entity during the 5 years prior to the application for a license closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it.[87]

The AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar or identical to violations identified by the AHCA during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[88]

The AHCA may also impose an immediate moratorium[89] or emergency suspension on any provider if the AHCA determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client.[90] The AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[91]

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[84] Section 429.14, F.S.
[85] Section 429.14(2), F.S.
[86] "Controlling interest" means the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5 percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5 percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member. Section 408.803(7), F.S.
[87] Section 429.14(3), F.S.
[88] Section 429.14(4), F.S.
[89] "Moratorium" means a prohibition on the acceptance of new clients. Section 408.803(10), F.S.
[90] Section 408.814, F.S.
[91] Section 429.14(7), F.S.

Licensure Fees

The biennial licensure fees for the ALF standard license and specialty licenses are found in s. 429.07(4), F.S. This section refers to the general health care licensure provisions in part II of ch. 408, F.S. Section 408.805, F.S., provides for licensure fees to be adjusted annually by not more than the change in the Consumer Price Index (CPI) based on the 12 months immediately preceding the increase. The following chart reflects the licensure fees contained in s. 429.07(4), F.S., and the adjusted licensure fees based on the CPI that are currently in effect.[92]

Fee Description	Per s. 429.07(4), F.S.	CPI Adjusted
Standard ALF Application Fee	$300	$371
Standard ALF Per-Bed Fee (non-OSS)	$50	$62
Total Licensure fee for Standard ALF	$10,000	$13,644
ECC Application Fee	$400	$523
ECC Per-Bed Fee (licensed capacity)	$10	$10
LNS Application Fee	$250	$309
LNS Per-Bed Fee (licensed capacity)	$10	$10

Income from fees and fines collected by the AHCA must be used by the AHCA for the following purposes:

- Up to 50 percent of the trust funds accrued each fiscal year may be used to offset the expenses of receivership,[93] if the court determines that the income and assets of the facility are insufficient to provide for adequate management and operation.
- An amount of $5,000 of the trust funds accrued each year must be allocated to pay for inspection-related physical and mental health examinations requested by the AHCA for residents who are either recipients of SSI or have monthly incomes not in excess of the maximum combined federal and state cash subsidies available to SSI recipients, but such funds are only to be used where the resident is ineligible for Medicaid.
- Any trust funds accrued each year and not used for the purposes of receivership or inspection-related physical and mental health examinations must be used to offset the costs of the licensure program, verifying information submitted, defraying the costs of processing the names of ALF applicants, and conducting inspections and monitoring visits.[94]

Criminal Penalties

Under Florida's Criminal Code, ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[95] and disabled adults.[96] Section 825.102, F.S., provides that a person who knowingly or

[92] Agency for Health Care Administration, Bureau of Long Term Care, Form Letter to ALF Providers, available at: http://ahca.myflorida.com/MCHQ/LONG_TERM_CARE/Assisted_living/alf/ALF_fee_increase.pdf, (Last visited on August 17, 2011).
[93] *See* s. 429.22, F.S., for instances as to when a court may appoint a receiver for an ALF.
[94] Section 429.18, F.S.
[95] "Elderly person" means a person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. Section 825.101(5), F.S. It does not constitute a defense to a prosecution for any violation of this chapter that the accused did not know the age of the victim. Section 825.104, F.S.
[96] "Disabled adult" means a person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. Section 825.101(4), F.S.

willfully abuses[97] an elderly person or disabled adult without causing great bodily harm, permanent disability, or permanent disfigurement to the elderly person or disabled adult commits a felony of the third degree.[98]

Additionally, s. 825.102, F.S., provides that a person who commits aggravated abuse of an elderly person or disabled adult[99] commits a felony of the first degree.[100] A person who willfully or by culpable negligence neglects an elderly person or disabled adult[101] and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the elderly person or disabled adult commits a felony of the second degree.[102] A person who willfully or by culpable negligence neglects an elderly person or disabled adult without causing great bodily harm, permanent disability, or permanent disfigurement to the elderly person or disabled adult commits a felony of the third degree.

Neglect of an elderly person or disabled adult may be based on repeated conduct or on a single incident or omission that results in, or could reasonably be expected to result in, serious physical or psychological injury, or a substantial risk of death, to an elderly person or disabled adult.[103]

If a person commits lewd or lascivious battery upon an elderly person or disabled person, [104] he or she commits a felony of the second degree. It is a felony of the third degree to commit lewd or lascivious molestation[105] of an elderly person or disabled person or commit a lewd or lascivious exhibition[106] in the presence of an elderly person or disabled person.

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[97] "Abuse of an elderly person or disabled adult" means intentional infliction of physical or psychological injury upon an elderly person or disabled adult; an intentional act that could reasonably be expected to result in physical or psychological injury to an elderly person or disabled adult; or active encouragement of any person to commit an act that results or could reasonably be expected to result in physical or psychological injury to an elderly person or disabled adult. Section 825.102(1), F.S.

[98] Punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S., (maximum imprisonment of 5 years, maximum fine of $5,000, or penalties applicable for a habitual offender).

[99] "Aggravated abuse of an elderly person or disabled adult" occurs when a person commits aggravated battery on an elderly person or disabled adult; willfully tortures, maliciously punishes, or willfully and unlawfully cages, an elderly person or disabled adult; or knowingly or willfully abuses an elderly person or disabled adult and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the elderly person or disabled adult. Section 825.102(2), F.S.

[100] Punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S., (maximum imprisonment of 30 years, maximum fine of $10,000, or penalties applicable for a habitual offender).

[101] "Neglect of an elderly person or disabled adult" means a caregiver's failure or omission to provide an elderly person or disabled adult with the care, supervision, and services necessary to maintain the elderly person's or disabled adult's physical and mental health, including, but not limited to, food, nutrition, clothing, shelter, supervision, medicine, and medical services that a prudent person would consider essential for the well-being of the elderly person or disabled adult; or a caregiver's failure to make a reasonable effort to protect an elderly person or disabled adult from abuse, neglect, or exploitation by another person. Section 825.102(3)(a), F.S.

[102] Punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S., (maximum imprisonment of 15 years, maximum fine of $10,000, or penalties applicable for a habitual offender).

[103] Section 825.102(3)(a), F.S.

[104] "Lewd or lascivious battery upon an elderly person or disabled person" occurs when a person encourages, forces, or entices an elderly person or disabled person to engage in sadomasochistic abuse, sexual bestiality, prostitution, or any other act involving sexual activity, when the person knows or reasonably should know that the elderly person or disabled person either lacks the capacity to consent or fails to give consent. Section 825.1025(2)(a), F.S.

[105] "Lewd or lascivious molestation of an elderly person or disabled person" occurs when a person intentionally touches in a lewd or lascivious manner the breasts, genitals, genital area, or buttocks, or the clothing covering them, of an elderly person or disabled person when the person knows or reasonably should know that the elderly person or disabled person either lacks the capacity to consent or fails to give consent. Section 825.1025(3)(a), F.S.

[106] "Lewd or lascivious exhibition in the presence of an elderly person or disabled person" occurs when a person, in the presence of an elderly person or disabled person, intentionally masturbates; intentionally exposes his or her genitals in a lewd or lascivious manner; or intentionally commits any other lewd or lascivious act that does not involve actual physical or sexual contact with the elderly person or disabled person, including but not limited to, sadomasochistic abuse, sexual bestiality, or the simulation of any act involving sexual activity, when the person knows or reasonably should know that the elderly person or disabled person either lacks the capacity to consent or fails to give consent to having such act committed in his or her presence. Section 825.1025(4)(a), F.S.

A person may also be subject to criminal penalties for exploiting an elderly person or disabled adult.[107] If the funds, assets, or property involved in the exploitation of the elderly person or disabled adult is valued at $100,000 or more, the offender commits a felony of the first degree; $20,000 or more, but less than $100,000, the offender commits a felony of the second degree; or less than $20,000, the offender commits a felony of the third degree.[108]

Adult Protective Services

The DCF is required under s. 415.103, F.S., to establish and maintain a central abuse hotline to receive reports, in writing or through a single statewide toll-free telephone number, of known or suspected abuse, neglect, or exploitation of a vulnerable adult[109] at any hour of the day or night, any day of the week. The central abuse hotline must be operated in such a manner as to enable the DCF to:

- Accept reports for investigation when there is a reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited.
- Determine whether the allegations require an immediate, 24-hour, or next-working-day response priority.
- When appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns.
- Immediately identify and locate prior reports of abuse, neglect, or exploitation through the central abuse hotline.
- Track critical steps in the investigative process to ensure compliance with all requirements for all reports.
- Maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation.
- Serve as a resource for the evaluation, management, and planning of preventive and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation.[110]

Upon receiving an oral or written report of known or suspected abuse, neglect, or exploitation of a vulnerable adult, the central abuse hotline must determine if the report requires an immediate onsite protective investigation. For reports requiring an immediate onsite protective investigation, the central abuse hotline must immediately notify the DCF's designated district staff responsible for protective investigations to ensure prompt initiation of an onsite investigation. For reports not requiring an immediate onsite protective investigation, the central abuse hotline must notify the DCF's designated district staff responsible for protective investigations in sufficient time to allow for an investigation to be commenced within 24 hours. If the report is of known or suspected abuse of a vulnerable adult by someone other than a relative, caregiver, or household member, the report shall be immediately transferred to the appropriate county sheriff's office.[111]

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[107] "Exploitation of an elderly person or disabled adult" means:

- Knowingly, by deception or intimidation, obtaining or using, or endeavoring to obtain or use, an elderly person's or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the elderly person or disabled adult of the use, benefit, or possession of the funds, assets, or property, or to benefit someone other than the elderly person or disabled adult, by a person who stands in a position of trust and confidence with the elderly person or disabled adult or has a business relationship with the elderly person or disabled adult;
- Obtaining or using, endeavoring to obtain or use, or conspiring with another to obtain or use an elderly person's or disabled adult's funds, assets, or property with the intent to temporarily or permanently deprive the elderly person or disabled adult of the use, benefit, or possession of the funds, assets, or property, or to benefit someone other than the elderly person or disabled adult, by a person who knows or reasonably should know that the elderly person or disabled adult lacks the capacity to consent; or
- Breach of a fiduciary duty to an elderly person or disabled adult by the person's guardian or agent under a power of attorney which results in an unauthorized appropriation, sale, or transfer of property. *See* Section 825.103, F.S.

[108] *Id.*

[109] "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. Section 415.102(27), F.S.

[110] Section 415.103(1), F.S.

[111] Section 415.103, F.S.

The following persons, who know, or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited are required to immediately report such knowledge or suspicion to the central abuse hotline:

- A physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;
- A health professional or mental health professional;
- A practitioner who relies solely on spiritual means for healing;
- Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;
- A state, county, or municipal criminal justice employee or law enforcement officer;
- An employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments;
- A Florida advocacy council member or long-term care ombudsman council member; or
- An officer, trustee, or employee of a bank, savings and loan, or credit union.[112]

Any person who is required to investigate reports of abuse, neglect, or exploitation and who has reasonable cause to suspect that a vulnerable adult died as a result of abuse, neglect, or exploitation must immediately report the suspicion to the appropriate medical examiner, to the appropriate criminal justice agency, and to the DCF. The medical examiner is required to accept the report for investigation and must report the findings of the investigation, in writing, to the appropriate local criminal justice agency, the appropriate state attorney, and the DCF. Autopsy reports maintained by the medical examiner are not subject to the confidentiality requirements under s. 415.107, F.S.[113]

If at any time during a protective investigation the DCF has reasonable cause to believe that an employee of a facility that provides day or residential care or treatment for vulnerable adults is the alleged perpetrator of abuse, neglect, or exploitation of a vulnerable adult, the DCF must notify the AHCA, Division of Health Quality Assurance, in writing. If at any time during a protective investigation the DCF has reasonable cause to believe that professional licensure violations have occurred, the DCF must notify the Division of Medical Quality Assurance within the DOH in writing. The DCF must provide a copy of its investigation to the AHCA when the DCF has reason to believe that a vulnerable adult resident of a facility licensed by the AHCA or to the DOH when the investigation determines that a health professional licensed or certified under the DOH may have abused, neglected, or exploited a vulnerable adult.[114]

The DCF must also provide written notification to the state attorney having jurisdiction in the county in which the abuse, neglect, or exploitation occurred if evidence indicates that further criminal investigation is warranted. At the conclusion of a protective investigation at a facility, the DCF must notify, in writing, either the Florida local advocacy council or long-term care ombudsman council of the results of the investigation.[115]

All criminal justice agencies have a duty and responsibility to cooperate fully with the DCF to provide protective services. Such duties include, but are not limited to, forced entry, emergency removal, emergency transportation, and the enforcement of court orders.[116]

To ensure coordination, communication, and cooperation with the investigation of abuse, neglect, or exploitation of vulnerable adults, the DCF is required to develop and maintain inter-program agreements or operational procedures among appropriate departmental programs and the State Long-Term Care Ombudsman Council, the Florida Statewide Advocacy Council, and other agencies that provide services to vulnerable adults. These agreements or procedures must cover such subjects as the appropriate roles and responsibilities of the DCF in

[112] Section 415.1034, F.S.
[113] *Id.*
[114] Section 415.1055, F.S.
[115] *Id.*
[116] Section 415.106(1), F.S.

identifying and responding to reports of abuse, neglect, or exploitation of vulnerable adults; the provision of services; and related coordinated activities. In addition, the DCF must cooperate with and seek cooperation from all appropriate public and private agencies, including health agencies, educational agencies, social service agencies, courts, organizations, or programs providing or concerned with human services related to the prevention, identification, or treatment of abuse, neglect, or exploitation of vulnerable adults.[117]

Florida's Long-Term Care Ombudsman Program

The federal Older Americans Act (OAA) requires each state to create a Long-Term Care Ombudsman Program to be eligible to receive funding associated with programs under the OAA.[118] In Florida, the program is a statewide, volunteer-based system of district councils that protect, defend, and advocate on behalf of long-term care facility residents, including residents of nursing homes, ALFs, and adult family-care homes. The Office of State Long-Term Care Ombudsman (Office) is administratively housed in the DOEA and is headed by the State Long-Term Care Ombudsman, who is appointed by and serves at the pleasure of the Secretary of Elderly Affairs.[119] The program is supported with both federal and state funding.[120]

Florida's Long-Term Care Ombudsman Program (State Program) is made up of nearly 400 volunteers, who are organized into councils in 17 districts[121] around the state. During fiscal year 2009-2010 (October 1, 2009 to September 30, 2010), ombudsmen:

- Completed 4,015 administrative assessments statewide, visiting 100 percent of the licensed long-term care facilities in Florida;
- Completed 9,098 complaint investigations;[122]
- Donated 20,221 hours of volunteer service to the residents; and
- Provided 5,829 free in-service trainings in nursing homes, ALFs, and adult family care homes throughout the state to encourage facility staff members to adopt best practices to improve the residents' quality of life.[123]

The Office is required to establish a statewide toll-free telephone number for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents of nursing homes, ALFs and adult family care homes. Every resident or representative of a resident must receive, upon admission to a long-term care facility, information regarding the purpose of the State Program, the statewide toll-free telephone number for receiving complaints, and other relevant information regarding how to contact the State Program. Residents or their representatives must be furnished additional copies of this information upon request.[124]

The names or identities of the complainants or residents involved in a complaint, including any problem identified by an ombudsman council as a result of an investigation, are confidential and exempt from Florida's public records laws, unless the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure in writing; the complainant or resident consents orally and the consent is documented

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[117] Section 415.106(2), F.S.
[118] 42 U.S.C. 3058. *See also* s. 400.0061(1), F.S.
[119] Section 400.0063, F.S.
[120] According to *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, in fiscal year 2009-2010, the program received a total of $3,242,586 in funding; the state contribution totaled $1,452,977. *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, available at: http://ombudsman.myflorida.com/publications/ar/2009-2010%20Annual%20Report.pdf (Last visited on August 17, 2011).
[121] A list of the district offices is available at: http://ombudsman.myflorida.com/DistrictsList.php (Last visited on August 17, 2011).
[122] Section 400.0073, F.S., requires a local council to investigate any complaint of a resident, a representative of a resident, or any other credible source based on the action or inaction of an administrator, employee, or representative of a long-term care facility, which might be contrary to law; unreasonable, unfair, oppressive, or unnecessarily discriminatory, even though in accordance with law; based on a mistake of fact; based on improper or irrelevant grounds; unaccompanied by an adequate statement of reasons; performed in an inefficient manner; or otherwise adversely affecting the health, safety, welfare, or rights of a resident.
[123] *Florida's Long-Term Care Ombudsman Program 2009-2010 Annual Report*, available at: http://ombudsman.myflorida.com/publications/ar/2009-2010%20Annual%20Report.pdf (Last visited on August 17, 2011).
[124] Section 400.0078, F.S.

contemporaneously in writing by the ombudsman council requesting such consent; or the disclosure is required by court order.[125]

The Miami Herald Investigative Series on Assisted Living Facilities

Beginning on April 30, 2011, the Miami Herald published a three-part series, titled "Neglected to Death," which exposed several examples of abuses occurring in ALFs and the state regulatory responses to such cases. According to the publication, the Miami Herald spent a year examining thousands of state inspections, police reports, court cases, autopsy files, e-mails, and death certificates and conducting dozens of interviews with operators and residents throughout Florida.

The three-part investigative series gives several examples of abuses or neglect that took place at facilities in Florida, including:[126]

- The administrator of an ALF in Caryville punished his disabled residents by refusing to give them food and drugs, threatened the residents with a stick, doped the residents with powerful tranquilizers, beat residents who broke the facilities rules, forced residents to live without air conditioning even when temperatures reached 100 degrees Fahrenheit, and fell asleep on the job while a 71-year-old woman with mental illness wandered outside the facility and drowned in a nearby pond.
- In an ALF in Kendall, a 74-year-old woman was bound for more than 6 hours, the restraints pulled so tightly that they ripped into her skin and killed her.
- In an ALF in Hialeah, a 71-year-old man with mental illness died from burns after he was left in a bathtub filled with scalding water.
- In an ALF in Clearwater, a 75-year-old Alzheimer's patient was torn apart by an alligator after he wandered from his ALF for the fourth time.
- In an ALF in Haines City, a 74-year-old suffering from diabetes and depression died after going 13 days without crucial antibiotics and several days without food or water.
- An ALF in Miami-Dade County had a door alarm and video cameras in disrepair, an unlocked back gate on the premises, and an attendant who had fallen asleep, which enabled an 85-year-old to wander from the facility and drown in a pond.
- The administrator of an ALF in Dunedin drove a male resident with a criminal history to a pharmacy to fill a prescription for powerful narcotics but failed to collect the drugs from the resident. The resident fed the drugs to a 20-year-old female resident with mental illness, raped her, and caused her to die of an overdose.
- In an ALF in Tampa, a 55-year-old man died after his caretakers failed to give him food, water, or medicine.
- An ALF in Orlando failed to give an 82-year-old woman critical heart medication for 4 days, failed to read her medical chart, and gave her the wrong drugs on the day she died.
- An ALF in West Melbourne shut off the facility's exit alarm when it was triggered without doing a head count or calling 911 as a 74-year-old man slipped out the door and drowned in a nearby pond.
- An ALF in Deerfield Beach did not provide protections to a 98-year-old woman who fell 11 times and died of resulting injuries, including a fractured neck.
- A caretaker in an ALF in Miami-Dade County strapped down a 74-year-old woman for at least 6 hours so tightly that she lost circulation in her legs and as a result a blood clot formed which killed her.

The investigative series decried the state's regulatory and law enforcement agencies responses to the alleged egregious acts claiming:[127]

- Nearly once a month residents die from abuse and neglect, with some caretakers altering and forging records to conceal evidence, but law enforcement agencies almost never make arrests.

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[125] Section 400.0077(1)(b), F.S.
[126] The Miami Herald, *Neglected to Death, Parts 1-3*, available at: http://www.miamiherald.com/2011/04/30/2194842/once-pride-of-florida-now-scenes.html and http://www.miamiherald.com/2011/05/03/2199747/key-medical-logs-doctored-missing.html (Last visited on August 17, 2011) (see left side of article to access weblinks to the three-part series).
[127] *Id.*

- Facilities are routinely caught using illegal restraints, including powerful tranquilizers, locked closets, and ropes, but the state rarely punishes them.
- State regulators could have shut down 70 facilities in the past 2 years for a host of severe violations, but only seven facilities were closed.
- Although the number of ALFs has increased substantially over the last 5 years, the state has dropped critical inspections by 33 percent.
- Although the state has the authority to fine ALFs that break the law, the penalties are routinely decreased, delayed, or dropped altogether.
- The state's lack of enforcement has prompted other government agencies to cut off funding and in some cases the agencies refuse to send clients to live in certain ALFs.
- In at least one case, an investigation was never performed by the AHCA, although a woman drowned after wandering off the premises.
- It took the AHCA inspectors an average of 37 days to complete a complaint investigation in 2009, which was 10 days longer than 5 years earlier.
- At least five times, other state agencies were forced to take the lead in shutting down homes when the AHCA did not act.

Governor Rick Scott's ALF Task Force

In response to the Miami Herald Investigative Series on ALFs, Governor Rick Scott announced in his veto message of HB 4045 (2011),[128] which pertains to ALFs, that he was going to form an ALF task force for the purpose of examining current assisted living regulations and oversight. Governor Scott directed the task force to develop recommendations to improve the state's ability to monitor quality and safety in ALFs and ensure the well-being of their residents.[129]

The task force, which has also been referred to as the "Assisted Living Workgroup," consists of 14 members. These members represent the following entities:

- Florida Association of Homes and Services for the Aging.
- Eastside Care, Inc.
- Palm Breeze Assisted Living Facility.
- Long Term Care Ombudsman.
- Florida House of Representatives.
- Lenderman and Associates.
- The Florida Bar, Elder Law Section.
- Florida State University, the Pepper Center.
- The Villa at Carpenters.
- Florida Council for Community Mental Health.
- Florida Assisted Living Association.
- Villa Serena I-V.
- Florida Senate.
- Florida Health Care Association.[130]

The task force held its first meeting on August 8, 2011, to hear recommendations from industry representatives and interested parties. The task force also planned for the future prioritization of recommendations for legislative

[128] HB 4045 (2011) repealed a requirement for the annual dissemination of a list of ALFs that had been sanction or fined, a requirement for an ALF to report monthly any liability claims filed against it, a requirement to disseminate the results of the inspection of each ALF, provisions concerning rule promulgation for ALFs by the DOEA, provisions concerning the collection of information regarding the cost of care in ALFs, and the authority for local governments or organizations to contribute to the cost of care of local facility residents.

[129] Governor Rick Scott's veto message for HB 4045 (2011) is available at: http://www.flgov.com/wp-content/uploads/2011/06/hb4045.pdf (Last visited on August 17, 2011).

[130] Agency for Health Care Administration, *Assisted Living Workgroup Members*, available at: http://ahca.myflorida.com/SCHS/ALWG2011/wgmembers.shtml (Last visited on August 17, 2011).

action. There are currently two more meetings planned; one to be held on September 23, 2011, and another in October. The tentative date for release of the task force's first report is November 2011.

Findings and/or Conclusions

Inadequate Reporting

The older population in the U.S. will burgeon between the years 2010 and 2030 when the "baby boom" generation[131] reaches age 65. The population of those age 65 and over is expected to increase from 40 million in 2010 to 55 million in 2020. By 2030, there will be about 72.1 million older persons, almost twice their number in 2008. People age 65 and over represented 12.8 percent of the population in the year 2008 but are expected to grow to be 19.3 percent of the population by 2030.[132] Most of the growth, especially over the next 10 to 15 years, will be among the young old (age 65-74) because of the aging of the baby boomers.[133] Within Florida, the population of those age 65 and over will increase from 3.3 million in 2010 to 4.5 million in 2020, and to 6.2 million in 2030.[134] According to the U.S. Census Bureau (2010), Florida's 3.2 million residents age 65 or older make up more than 17 percent of its population, the highest percentage in all fifty states. [135]

Although the increase in the older population will increase the demand for long-term care services, the demand depends mainly on the growth in the 85 and over population (referred to as the "oldest-old"), not only because they have much higher rates of disability, but they also are much more likely to be widowed and without someone to provide assistance with daily activities.[136] Nationally, the population of the oldest old is projected to increase from 5.8 million in 2010, to 6.6 million in 2020, and to 8.7 million in 2030.[137] In Florida, the population of the oldest-old is projected to increase from 536,926 in 2010, to 739,069 in 2020, and to just over 1 million in 2030.[138] The baby boomers will begin to turn age 85 in 2031.[139]

Not only do the elderly need long-term care services, but many people with developmental or severe physical disabilities, mental illness and cognitive impairment need such services. Although long-term care is typically associated with old age, more than 42 percent of long-term care service beneficiaries are under age 65.[140]

With the expected increase in need for long-term care services, it is important that an adequate number of ALFs or ALF beds are available to meet this need. Although the AHCA tracks the number of ALFs in Florida and the number of beds per licensed ALF, there is no reporting requirement for the AHCA to track the occupancy rate of each ALF. Therefore, there is no current data to suggest whether there are a sufficient number of beds to meet the current need for long-term care services in ALF or whether Florida is prepared for the expected increase for such needs.

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[131] The baby boomer generation consists of people born between 1946 and 1964. U.S. Department of Labor, Bureau of Labor Statistics, *Comparing the Retirement Savings of the Baby Boomers and Other Cohorts*, available at: http://www.bls.gov/opub/cwc/cm20050114ar01p1.htm (Last visited on August 17, 2011).

[132] U.S. Department of Health and Human Services, Administration on Aging, *A Profile of Older Americans: 2009*, pg. 5, available at: http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2009/docs/2009profile_508.pdf, (Last visited on August 17, 2011).

[133] AARP, *Across the States, Profiles of Long-Term Care and Independent Living, Eighth Edition, 2009*, available at: http://assets.aarp.org/rgcenter/il/d19105_2008_ats.pdf, (Last visited on August 17, 2011).

[134]The Office of Economic and Demographic Research, The Florida Legislature, available at: http://edr.state.fl.us/Content/population-demographics/data/Pop_0401_b.pdf, (Last visited on August 17, 2011).

[135] U.S. Census Bureau, *Annual Estimates of the Resident Population by Sex and Age for States and for Puerto Rico: April 1, 2000 to July 1, 2009*, June 2010, available at: http://www.census.gov/compendia/statab/2011/tables/11s0016.pdf (Last visited on August 17, 2011).

[136] *Supra* note 133.

[137] *Supra* note 132, and U.S. Census Bureau, *The Next Four Decades: The Older Population in the United States: 2010 to 2050*, Issued May 2010, pg. 3, available at: http://www.census.gov/prod/2010pubs/p25-1138.pdf, (Last visited on August 17, 2011).

[138] *Supra* note 134.

[139] *Supra* note 133.

[140] Kaiser Commission on Medicaid Facts, *Medicaid and Long-Term Care Services and Supports*, December 2007, available at: http://www.kff.org/medicaid/upload/2186_05.pdf (Last visited on August 17, 2011).

A major shift has been occurring in the nation's long-term care system away from institutional care and toward home- and community-based care (HCBC). Historically, people who needed publicly funded long-term care services could look to only two basic sources: the nursing home or intermediate care facilities for the mentally retarded (ICF/MRs). State Medicaid programs are required to pay for nursing home care and home health care for those who qualify under federal and state criteria. However, states may choose the populations and the services they will provide for HCBC services funded by Medicaid and/or state general revenues.[141] In addition, in 1999, the U.S. Supreme Court in *Olmstead v. L.C. ex rel. Zimring*, increased state responsibility to provide HCBC options to people with disabilities who could be served in the community rather than in institutions.[142] Basing its decision on the Americans with Disabilities Act, the Court suggested that states demonstrate that they have a comprehensive, effective working plan for placing qualified people in less restrictive settings, and that they are making efforts to move people on waiting lists to community programs at a reasonable pace.

With consumers overwhelmingly indicating their preference for HCBC and with evidence that such care is less costly in most cases, state policymakers have been "rebalancing" or redefining their long-term care systems. Today, every state has federal waiver programs that allow them to provide a wide range of HCBC services. As a result, Medicaid spending on institutional care as a proportion of total Medicaid long-term care services spending had dropped from 90.2 percent in 1987 to 75.8 percent in 1997, and then to 63 percent by 2005. In 2008, that number decreased to 58 percent. By contrast, home care spending nearly doubled from 10.8 percent in 1987 to 24.0 percent in 1997. By 2005, the proportion of Medicaid spending for home care had risen to 37 percent, and in 2008 it had increased to 42 percent.[143]

In 2011, the Florida Legislature enacted HB 7107 and HB 7109, to establish statewide Medicaid managed care reform. This reform includes a long-term care managed care program, which seeks to provide HCBC, including care in ALFs, to those who qualify as an alternative to nursing home care.[144]

Because the current trend is for consumers to choose, and states to promote, HCBC services, a frailer and more disabled population may be entering the ALF population. ALFs should be prepared to meet the greater needs of residents and provide sufficient quality of care. Because there is no current reporting requirement for ALFs to report to AHCA the number of residents in their facilities that require mental health, limited nursing, or extended care, the AHCA has been unable to determine the current population demographics of ALFs in Florida or whether those demographics have been changing over time. Consequently, it is difficult for state policy-makers to plan for adequate residential options.

AHCA Survey and Inspection Process Needs Improvement

The AHCA inspects all licensed ALFs, regardless of licensure type and past compliance, at least once every 2 years. However, the AHCA does perform additional limited inspections in response to certain violations and complaints. Furthermore, an LNS licensee is subject to monitoring inspections by the AHCA or its agents at least twice a year, while an ECC licensee is subject to quarterly monitoring inspections by the AHCA or its agents, regardless of past complaints. An LMH licensee is not subject to additional monitoring inspections.

Although authorized under s. 429.929, F.S., currently the AHCA does not perform abbreviated inspections. On June 28, 2011, the AHCA participated in an ALF roundtable discussion with industry representatives, legislators, and other interested parties to reveal its plans to initiate abbreviated inspections.[145] The AHCA plans to initiate abbreviated inspections on October 1, 2011.[146]

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[141] National Conference of State Legislatures, *Long-Term Care Frequently Asked Questions*, February 2011, available at: http://www.ncsl.org/default.aspx?tabid=14053 (Last visited on July 14, 2011).
[142] *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S.Ct. 2176 (1999).
[143] *Supra* note 141.
[144] Chapters 2011-134 and 2011-135, L.O.F.
[145] The AHCA's slideshow presentation from the June 28, 2011, roundtable discussion, revealing the AHCA's plans for abbreviated inspections is available at: http://www.falausa.com/portals/46/ALF%20Survey%20Process%20Revised.pdf (Last visited on August 17, 2011).
[146] Senate professional staff received this information via e-mail from AHCA staff on August 15, 2011.

The following chart provides the average number of visits by the AHCA for the last five fiscal years. Visits include responses to complaints, monitoring, and all initial, biennial, and change of ownership inspections.[147]

Fiscal Year	ALFs	Visits	Average Visits per ALF
2006-07	2389	6274	2.63
2007-08	2521	6892	2.73
2008-09	2743	6060	2.21
2009-10	2842	6455	2.27
2010-11	2918	6327	2.17

There are 274 full-time equivalent (FTE) surveyors. While there are some surveyors who have particular expertise with ALF surveys, generally, the AHCA does not have surveyors designated or assigned to inspect only ALFs.[148] As a result, surveys may not be consistent across the state.

Since the 2006-07 FY, the AHCA has not generated enough revenue from fees and fines to fund the number of inspections that are required.[149] Below is a chart demonstrating an increasing deficit experienced by the AHCA from performing the required inspections.[150]

Fiscal Year	Fees/Licenses	Fines/ Penalties	Refunds/ Cancelled Warrants	Total Revenues	Expenditures	GR Service Charge	Surplus / (Deficit)
06/07	$3,217,965	$678,641	$7,642	$3,904,248	$5,904,855	$290,937	($2,291,544)
07/08	$3,225,366	$866,377	$12,993	$4,104,735	$6,408,389	$285,181	($2,588,835)
08/09	$3,377,421	$609,040	$2,099	$3,988,560	$5,811,926	$286,982	($2,110,347)
09/10	$3,422,707	$530,637	$4,598	$3,957,942	$7,960,372	$331,588	($4,334,017)

The Legislature may want to consider different options to fund the required inspections.

The current survey and inspection process appears to contain inefficiencies by not focusing inspection and monitoring resources on facilities that most need it. In addition, because LMH licensees contain a population of residents that need additional care measures, additional monitoring akin to the LNS and ECC licensed facilities might be warranted.

Additionally, in light of some of the findings reported by the Miami Herald, the inspection or survey forms used by the AHCA may not sufficiently gauge whether ALFs are compliant with the law or meeting the needs and adequately protecting ALF residents. It may be beneficial to have an independent workgroup assess the inspection or survey forms to determine if the forms sufficiently address critical factors to ensure ALFs are being adequately monitored.

Inadequate Training and Qualifications

Core Training Providers

Prior to 2003, the DOEA provided core trainers throughout the state. However, in 2003, the Legislature privatized the core training providers and the DOEA's role changed to registering and monitoring such providers.[151] Although there are several qualifications a person must meet in order to register with the DOEA to be a core training provider and train potential administrators of ALFs, there is limited oversight or accountability of such

[147] Senate professional staff received this information via e-mail from AHCA staff on August 15, 2011.
[148] *Id.*
[149] Notwithstanding the additional survey fees authorized under s. 429.19(7), F.S.
[150] *Supra* note 147.
[151] During Special Session 2003-A, the Legislature privatized the Department of Elderly Affairs' ALF core training program and the eleven FTE training positions associated with the program were eliminated. Section 3, ch. 2003-405, L.O.F.

providers once they have become registered. According to Rule 58T-1.205, F.A.C., the DOEA may attend and monitor core training courses; review the core training provider's records and course materials; and conduct on-site monitoring, follow-up monitoring, and require implementation of a corrective action plan if the provider does not adhere to the approved curriculum.

The statutory authority provided to the DOEA in s. 429.52, F.S., is silent regarding disciplinary action or revoking a core training provider's registration and their ability to continue providing training if the provider commits certain acts, such as using outdated curriculums, providing false information to become registered as a core trainer, or violating accepted trainer practices. Additionally, because the DOEA does not have sufficient oversight authority, there may be a lack of consistency in the way the 39[152] registered core trainers provide training.

The DOEA has reported that more monitoring of core training providers might be warranted, but are hindered by a lack of resources.[153] Currently, the registration and monitoring of core training providers is not funded by fee. Instead, money from the General Revenue Fund is used to fund these activities. A dedicated source of income and more explicit authority may enhance the DOEA's ability to provide more oversight of core training providers.

Core Training Curriculum and Competency Test

The ALF minimum core training curriculum is organized into 10 prescribed mandatory modules and one mandatory module of the provider's choice that must relate to ALFs and aging issues. Under each module, specific objectives are included, which trainees are expected to achieve. Successful completion of the core training is intended to prepare the trainee for passage of the competency test required under s. 429.52, F.S., and provide the basic tools for administering an ALF. The following is a list of the modules covered under the minimum core training curriculum:[154]

- Module 1: General License Activity
- Module 2: Administration of an Assisted Living Facility
- Module 3: Records
- Module 4: Residency Cycle
- Module 5: Food Service
- Module 6: Medication Management
- Module 7: Personal Care and Services
- Module 8: Special Needs Population (Alzheimer's Disease, Mental Health, Hospice)
- Module 9: Resident Rights
- Module 10: Enforcement Activities
- Module 11: Individualized Topic of Trainer's Choice

Currently, Florida's core training curriculum is based on the standards outlined in ch. 429, F.S., and does not include other subject matter. Other states have more expansive training curriculums for ALF administrators. California, for example, requires an administrator of a residential care facility for the elderly to complete 40 hours of training, including training that covers subject matter outside of statutory requirements. The subjects covered under those 40 hours are as follows:[155]

- Law and Regulations (8 hours)
- Business Operations (3 hours)
- Management/Supervision of Staff (3 hours)
- Psych/Social Needs (5 hours)
- Community & Support Services (2 hours)

[152] The list of core trainers was last updated on July 7, 2011 and includes 39 trainers. The list indicates that five of these trainers are not currently training. The list is available at: http://elderaffairs.state.fl.us/english/docs/Trainer%20Web%20List.pdf (Last visited on August 24, 2011).
[153] Information received by Senate professional staff during a meeting with DOEA staff on July 27, 2011.
[154] The full curriculum, including the objectives for each module, is available at: http://elderaffairs.state.fl.us/english/ruleforms/ALFCT-001.doc (Last visited on August 17, 2011).
[155] California, Department of Social Services, *Residential Care Facility for the Elderly (RCFE) 40-Hour Initial Certification*, available at: http://www.ccld.ca.gov/res/pdf/Core.pdf (Last visited on August 17, 2011).

- Physical Needs (5 hours)
- Medication (5 hours)
- Admission and Assessment Retention (5 hours)
- Alzheimer's and Dementia Training (4 hours)

In North Carolina, a person applying to be certified as an Assisted Living Administrator must complete a 120-hour Administrator-in-Training (AIT) program. The training consists of 75 hours of coursework or study and 140 hours of on-the-job training under an approved preceptor.[156]

It may be beneficial to expand the core training curriculum in Florida to include topics outside of the current statutory standards and train administrators in additional subject areas such as best practices in the ALF industry or financial planning.

Additionally, because it appears that ALFs may be using physical and chemical restraints beyond what is authorized in ch. 429, F.S., it may be beneficial to include in the core training curriculum training as to the appropriate use of physical and chemical restraints.

The DOEA has also reported that the competency test for administrators, which is administered by the University of South Florida (USF), is outdated and does not include any legislative changes since 2008.[157] The Legislature may wish to require the USF to annually update the competency test as needed for relevant statutory changes and require the DOEA to verify that the test is current and adequately assesses competency in the required curriculum.

Administrator Qualifications

The qualifications to become an ALF administrator could be improved. Currently, Florida law requires the same age, education, and testing requirements of those applying to become an administrator of an ALF, regardless of the size of the ALF or whether that ALF has a specialty license.

Other states require some post-secondary education, which may depend on the size of the ALF or the population served in the ALF, or require a certain amount of experience or hands-on training, which also may depend on the size of the ALF or the population being served. For example, unlike Florida, which only requires administrators to have a high school diploma or a G.E.D., other states such as Indiana, Massachusetts, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Wisconsin, and Wyoming, require some post secondary education (usually including coursework in gerontology or health care) or a specified number of years of experience in assistive living care. Some states, such as California, New Hampshire, New York, North Carolina, Texas, and West Virginia require additional education or experience depending on the size of the facility or the number of residents living at the facility. Other states such as Maine, Maryland, Michigan, Montana, and Utah require additional education and experience depending on the type of facility or if a certain type of population (for example, mental health residents) is served.[158]

The Legislature may wish to change the qualification requirements for administrators of ALFs to ensure an administrator's education and experience levels correlate to the type of residents or the size of the facility that he or she oversees.

Staff Training

Staff that provide direct care to residents are required to complete several hours of in-service training. The administrator is required to document such training in the staff's personnel files. The AHCA reports that when inspecting personnel files to determine if direct care staff has received the required in-service training, they rely

[156] North Carolina, Division of Health Service Regulation, *Assisted Living Administrator Certification Requirements and Guidelines*, available at: http://www.ncdhhs.gov/dhsr/acls/adminguidelines.html (Last visited on August 17, 2011).
[157] Information received by Senate professional staff at a meeting with DOEA staff on July 27, 2011.
[158] National Center for Assisted Living, *Assisted Living State Regulatory Review 2011*, March 2011, available at: http://www.ahcancal.org/ncal/resources/Documents/2011AssistedLivingRegulatoryReview.pdf (Last visited on August 17, 2011).

on representations by the administrator and may ask a sample of staff random questions to ensure they have received the appropriate training.[159] To ensure that the staff has received complete and appropriate training, it may be appropriate to use other mechanisms, such as a competency test, for assessing the amount and adequacy of training that has been provided.

Staffing Ratios

Under Rule 58A-5.029, F.A.C., Florida requires a certain number of staff hours per number of residents in an ALF. There is no requirement that staffing be increased based on the type of population being served at the ALF, although some ALFs with specialty licenses have populations that need enhanced care. It may be useful to change the staffing requirements to allocate staffing resources based not only on the number of residents served, but also on the type of the population served.

Elopement Training

An estimated 5.4 million Americans have Alzheimer's disease in 2011. This figure includes 5.2 million people aged 65 and older, and 200,000 individuals under age 65 who have younger-onset Alzheimer's.[160] In 2010, an estimated 450,000 Floridians had Alzheimer's disease. It is projected that Florida will have an estimated 590,000 residents with Alzheimer's disease by 2025.[161] Estimates from various studies indicate that 45 to 67 percent of residents of ALFs have Alzheimer's disease or other dementia.[162] Over 60 percent of those with dementia will wander at some point.[163] The potential increase in the number of residents in ALFs with Alzheimer's in the future highlights the importance of elopement training, drills, and responses in ALFs.

Not only do the Alzheimer's statistics highlight the importance of elopement training, but also, the Miami Herald's investigative series exposed cases of elopement that lead to the death of ALF residents.

Currently, there is no requirement that staff receive training on elopement for a certain duration, although other in-service training requirements have certain training time specifications. The AHCA inspectors rely on the administrator's records to determine whether the required elopement drills have been appropriately carried out. Therefore, an administrator may spend five minutes telling an employee to read a policy and procedure packet about the facility's elopement practices and that may satisfy the training requirement. Also, there is no requirement that a state agency representative attend elopement drills to make sure they are carried out appropriately.

Additional Regulation of ALFS with Limited Mental Health Residents Needed

Since the 1960s, when community mental health centers were established, there has been a movement to deinstitutionalize and integrate those diagnosed with mental health disorders into the community, including placement in long-term care facilities.[164] While states have often encouraged the laudable goal of integration by funding the placement of mentally ill persons in long-term care settings, such as nursing homes or ALFs, the focus has often been on the placement of such persons and not on the type of skills, care, or even social interests, that are required for this population (which may include younger persons) to ensure a safe and appropriate transition from institutional care.[165]

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[159] Information received by professional staff during an interview with AHCA staff on July 7, 2011.
[160] Alzheimer's Association, *2011 Alzheimer's Disease Facts and Figures*, pg. 12, available at: http://www.alz.org/downloads/Facts_Figures_2011.pdf (Last visited on August 17, 2011).
[161] *Id.* at pg. 18.
[162] *Id.* at pg. 40.
[163] Alzheimer's Association, *Wandering*, available at: http://www.alz.org/living_with_alzheimers_wandering_behaviors.asp (Last visited on August 17, 2011).
[164] Kaiser Commission on Medicaid and the Uninsured, *Learning from History: Deinstitutionalization of People with Mental Illness as Precursor to Long-Term Care Reform*, August 2007, available at: http://www.kff.org/medicaid/upload/7684.pdf (Last visited on August 17, 2011).
[165] *Id.*

Florida has taken steps to recognize that a different level of care is required for mental health residents of an ALF. Section 429.075, F.S., requires facilities licensed to provide services to mental health residents to provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents. An LMH licensee must maintain a cooperative agreement with the mental health care services provider, and assist the mental health resident in carrying out his or her community living support plan. Also, a facility with an LMH license may enter into a cooperative agreement with a private mental health provider, who may act as the case manager. However, not every mental health resident has a case manager, who is required to work with the resident. This might occur for a variety of reasons, such as the resident does not meet the eligibility criteria for publicly funded mental health services and the resident cannot afford or does not choose to engage his or her own case manager, or a private mental health provider does not actively coordinate with the ALF administrator.

Although these requirements recognize that LMH facilities should have additional measures to ensure resident safety and appropriate care for this population, there could be improvements made to make sure that integration of those with mental illness into the ALF setting is appropriate and safe. For example, only ALFs with three or more mental health residents must obtain an LMH specialty license and meet the increased requirements applicable to that specialty license.

An administrator of a facility that serves mental health residents is not required to have any formal education or experience in mental health disorders, other than the 6 hours of required training, to qualify as an administrator of an LMH licensed facility in Florida. However, the administrator is required to provide "appropriate" supervision and staff and continually assess whether a mental health resident is receiving appropriate care and services in his or her facility.[166] Resident care may be lacking because administrators may not have the requisite education and experience to make such determinations.

Although direct care staff currently must complete a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses, training by mental health providers or professionals would ensure that staff is better prepared to work with a mental health population. In addition, staff could be better prepared to work with mental health residents if they received specific types of training (for example, aggression control training to properly address combative mental health residents and training pertaining to the appropriate use of physical and chemical restraints). This training might be especially important to address the needs for the residents who do not have active case managers.

Section 394.4574, F.S., requires the DCF to ensure the community living support plan for a mental health resident has been prepared by the mental health resident and a mental health case manager of that resident in consultation with the administrator of the facility or the administrator's designee. The plan must be provided to the administrator of the ALF with a LMH license in which the mental health resident lives. In practice, this appears only to apply to mental health residents who are eligible for and participating in the publicly funded mental health program.

The DCF reports that its staff reviews the content of the community living support plan for compliance with the requirements under s. 394.4574, F.S., but because of the staffing differences across the state, the plans may be monitored in different ways. However, the DCF has reported that, as of July 1, 2011, contract language was added to community mental health provider contracts to ensure all components of s. 394.4574, F.S. are included in the plans. Despite the recent measure to amend community mental health provider contracts to ensure better compliance with the law, inconsistent monitoring of the plans may still take place because of the staffing differences across the state. The DCF does not monitor the frequency of contact between the case manager and the mental health resident.[167] As a result, changes in the community support living plan that are appropriate because of the resident's changing needs may not be occurring timely.

Section 394.4574(2)(b), F.S., requires the DCF to ensure a cooperative agreement[168] is developed between the mental health resident's mental health care services provider and the administrator of the ALF with a LMH

[166] *See* Rule 58A-5.0182, F.A.C.
[167] Senate professional staff received this information via e-mail from DCF staff on August 19, 2011.
[168] Section 429.02(8), F.S.

license in which the mental health resident is living. Although the DCF reviews the content of the cooperative agreements to make certain they contain directions for accessing emergency and after-hours care for mental health residents, the DCF reports that because of staffing differences across the state, these cooperative agreements may be monitored in different ways. Therefore, similar to the DCF's review of community living support plans, monitoring of the cooperative agreements may be inconsistent across the state.

The AHCA's survey also includes a check of the required documentation for the community living support plan and the cooperative agreement, however the absence of the documentation is not a deficiency if the facility made a good faith effort to obtain the documentation.[169]

Deficient Enforcement Measures and Penalties

The AHCA's fining authority under s. 429.19, F.S., allows the AHCA to have some discretion as to whether an ALF receives the low-end or high-end of the range of fines that may be assessed against a facility. ALFs may be held more accountable if less discretion were provided and if fines were automatically increased under certain circumstances, such as when recurring violations are committed.

Currently, under s. 429.14, F.S., the AHCA has the discretion to deny, revoke, or suspend a license issued to an ALF if any of several circumstances occur. ALF residents may be better protected if the AHCA's discretion to deny, revoke, or suspend a license were removed when a facility has committed the most egregious acts, such as when a death occurs due to an intentional or negligent act for which the facility was complicit.

Under s. 408.814, F.S., the AHCA may impose an immediate moratorium or emergency suspension on any provider if the AHCA determines that any condition related to the provider or licensee presents a threat to the health, safety, or welfare of a client. This is another instance under which it may be effective to remove the AHCA's discretion to impose a moratorium or emergency suspension.

The following is a chart of penalties that have been paid to the AHCA by ALFs over the last 4 years.

Fiscal Year	Fines/ Penalties	Licensure Denials	Licensure Suspensions	Licensure Revocations
06/07	$678,641	8	3	3
07/08	$866,377	6	0	5
08/09	$609,040	11	2	4
09/10	$530,637	7	1	12
10/11	$546,262	5	2	7

Governor Rick Scott requested the AHCA to take aggressive action to protect residents from abuse and neglect in Florida's ALFs.[170] In response, the AHCA took administrative action against 46 ALFs during May 2011, issued an immediate moratorium on admissions for two ALFs, issued one emergency suspension order, denied one application for license renewal to a facility with a history of deficiencies, and assessed more than $125,000 in fines to 44 facilities for the failure to comply with state standards.[171]

Fragmented System of Agency Oversight

There are multiple state agencies or state entities that oversee or regulate ALFs. The key regulatory agencies or state entities with some type of oversight or enforcement role include the AHCA; the DOEA, including the Office

[169] Rule 58A-5.029(2)(c), F.A.C., and the AHCA survey standard in ST-AL241-LMH, pages 118-122, at 122, available at: http://ahca.myflorida.com/MCHQ/Current_Reg_Files/AssistedLivingFacility_A300.pdf (Last visited on August 22, 2011).
[170] The Office of the 45th Governor of Florida Rick Scott, *AHCA Responds to Governor Rick Scott's Call to Crack Down on Assisted Living Facility Neglect*, June 14, 2011, available at: http://www.flgov.com/2011/06/13/ahca-responds-to-governor-rick-scott%E2%80%99s-call-to-crack-down-on-assisted-living-facility-neglect/ (Last visited on August 17, 2011).
[171] *Id.*

of the State Long-Term Care Ombudsman; the DCF; the State Fire Marshal; the DOH; the Office of the Attorney General; and state law enforcement agencies.

The following is an abbreviated summary of the roles that each aforementioned state agency plays in the regulation or oversight of ALFs. The AHCA is the regulatory agency that oversees the licensing of ALFs, which includes the function of inspecting and monitoring the ALFs to determine whether such licensure should be maintained.[172] The DOEA is the state agency that develops and enforces rules related to training ALF staff, including administrators.[173] The Ombudsman program serves as an advocate for ALF residents to make sure ALF residents are getting the appropriate level of care and services.[174] The DCF serves as a resource for residents, family members, or staff of ALFs to report the abuse of ALF residents and investigates reports of alleged abuse, neglect, or exploitation.[175] The State Fire Marshal is responsible for developing and interpreting the uniform fire-safety standards for ALFs and conducting fire safety inspections.[176] The DOH inspects facilities to determine compliance with sanitation standards.[177] The Office of the Attorney General may investigate allegations of abuse or neglect or Medicaid fraud,[178] while law enforcement agencies respond to criminal allegations against ALFs.

The industry has reported that many problems arise when several different entities enter facilities, sometimes more than once a week, to inspect facilities. This is problematic in that it takes staff away from their responsibilities. Additionally, some of the inspections seem to be redundant or the expectations of each agency may be hard to fulfill because there is no consistency between each agency's application or interpretation of the laws.[179]

Another problem with the fragmented system of agency oversight is that residents, family members, or staff may be confused as to which entity is best to contact should a certain concern arise.

Further, with overlapping jurisdiction in some instances (e.g., a complaint of abuse to the AHCA, DCF, and Ombudsman simultaneously), it may be difficult to determine which agency has final authority to carry out administrative penalties.

Fragmentation of agency oversight may also lead to communication problems between the various agencies. Although the agencies have entered into memoranda of agreement[180] with each other to facilitate communication and the coordination of resources, there may still be gaps in communication concerning the timeliness or absence of reporting. For example, Senate professional staff discovered in a meeting with the DOEA that there is a memorandum of agreement between the Ombudsman and the AHCA requiring the Ombudsman to report verified complaints to the AHCA if the complaint rises to a certain level of importance.[181] However, there is no definition of "serious and immediate risk," the term used in the memorandum of agreement, and no protocol in place to determine what type of instance would rise to the level of mandatory reporting.

Communication discrepancies may exist because under s. 415.1034, F.S., AHCA staff or staff of other regulatory agencies are not included in the requirement to immediately report the knowledge or suspicion that a vulnerable adult has been or is being abused, neglected, or exploited to the central abuse hotline operated by the DCF. Instead s. 415.106, F.S., provides that inter-program agreements or operational procedures are to set out such requirements. Such agreements or procedures could have inconsistent or nonexistent timeframes for such reporting.

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[172] Section 429.04, F.S., and part II, ch. 408, F.S.
[173] Section 429.52, F.S. and Rule 58A-5.0191, F.A.C.
[174] Section 400.0061, F.S.
[175] Section 415.103, F.S.
[176] *See* ch. 69A-40, F.A.C.
[177] Chapters 64E-12, 64E-11, and 64E-16, F.A.C.
[178] Sections 415.1055 and 409.920, F.S.
[179] Professional staff received this information during a meeting with the Florida Assisted Living Association on June 19, 2011.
[180] These memoranda of agreement are on file with the Senate Health Regulation Committee.
[181] Professional staff received this information at a meeting with the DOEA on July 27, 2011.

Consumer Resources

Consumers presently do not have a user-friendly source to quickly determine the best facilities for their needs, the level of resident satisfaction with the quality of service, and which facilities are not in compliance with the law. Although a consumer can search an AHCA website for ALFs and view reported deficiencies, it is cumbersome and difficult to comprehend the information presented.[182] The website does not provide any indication whether residents are satisfied with the facility's level of care or the services provided.

Additionally, the Miami Herald developed a database of ALFs that the public may use. Search results of a facility include the facility's address, owner, administrator, number of beds, license type and whether it is active, substantiated and unsubstantiated complaints to AHCA, number of inspection citations, number of fines or other disciplines, and complaints to the State Ombudsman.[183] However, a consumer still has to sift through much information to determine whether a facility is a good or poor service provider.

The U.S. Department of Health and Human Services has developed a website that provides a five star rating system for nursing homes.[184] The website search tool is called Nursing Home Compare and it has detailed information about every Medicare and Medicaid-certified nursing home in the country. Using the tool, a consumer can find a nursing home by entering in the nursing home's name, a zip code, a city, a state, or a county. The five star quality rating is an overall rating of a nursing home and depends on health inspections, nursing home staffing, and quality measures.[185] Five stars means the nursing home is much above average; four stars means above average; three stars means average; two stars means below average; and one star means much below average. It would be beneficial for consumers in Florida to have this type of user-friendly rating system for ALFs.

Although consumers may report complaints to the Ombudsman Program using a toll-free number and the identity of the complainants and content of the complaints are required to be confidential and exempt from Florida's public records laws, many ALF residents may not be aware of this confidentiality provision. Florida law does not require a long-term care facility to notify residents that the complainant's identity and the content of that person's complaint are confidential. If long-term care facilities were required to notify residents that such information is confidential, that may reduce residents' fear of retaliation by the facility and may foster better reporting of complaints.

Options and/or Recommendations

Senate professional staff recommends a myriad of options for the Legislature to consider to improve the regulatory oversight of ALFs. Enacting a blend of these options might better protect the residents from abuse, neglect, or otherwise harmful conditions in ALFs in Florida.

Reporting

Senate professional staff recommends the Legislature require ALFs to report quarterly to the AHCA occupancy rates and demographic and resident acuity information (such as the types of services received). Access to this information will assist policymakers in assessing the adequacy of available ALF beds for long-range planning. In addition, the information will assist regulators in assessing whether the appropriate level of care is being provided to residents and facilitate surveys and inspections.

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[182] *See* Agency for Health Care Administration, *Public Record Search*, available at: http://apps.ahca.myflorida.com/dm_web/(S(zbv120kprqjdek1hsdzstv4p))/Default.aspx (Last visited on August 17, 2011).
[183] The Miami Herald Database is available at: http://www.miamiherald.com/cgi-bin/alfs/ (Last visited on August 17, 2011).
[184] U.S. Department of Health and Human Services, *Medicare.gov: Nursing Home Compare*, available at: http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True (Last visited on August 17, 2011).
[185] Quality measures are self-reported by the nursing home and comes from data that nursing homes routinely collect on all residents at specified times.

AHCA Surveys and Inspections

The AHCA's survey and inspection procedure could be improved by authorizing more abbreviated inspections for those facilities in compliance with the law while requiring more frequent and extensive inspections of those facilities that have recurring or observed deficiencies. This type of inspection program would focus the AHCA's resources where it is most needed. Additional legislation might be appropriate to successfully implement a more targeted inspection plan.

The Legislature may want to consider options to ensure that the surveyors conducting the AHCA's inspections of ALFs are sufficiently trained to do so and are performing the inspections consistently and uniformly throughout the state. The Legislature might require a specific number of lead surveyors in each area office to specialize on ALF inspections and be dedicated to ALF inspections only. Such an approach might require additional FTEs and funding to accomplish this successfully. Additionally, the Legislature might require a dedicated FTE to monitor surveyors and their field work to ensure consistency in inspections, citing deficiencies, and enforcement throughout the state.

To ensure that the surveys and inspections are adequately assessing whether the ALFs are in compliance with the law and meeting the needs of and protecting ALF residents, Senate professional staff recommends the Legislature create a workgroup that includes Ombudsman members to assess the AHCA's inspection forms and recommend changes to such forms.

Because the AHCA has had difficulty meeting the inspection requirements with the available resources, the Legislature may want to consider funding the inspection process through additional fees. To provide adequate funding the Legislature could:

- Require licensure fees for OSS beds. Florida law exempts facilities that designate their beds as OSS from licensure fees. The current fee for non-OSS beds is $61 per bed in addition to the $366 standard licensure fee. Some of the facilities that receive this exemption for the majority of their licensed beds require significant regulatory resources. There are currently 15,678 OSS beds in Florida, so revenues generated would be $478,179 annually (15,678 x $61/bed every 2 years for biennial licensure).
- Increase the per bed, per facility, and/or specialty licensure fees for all providers to offset program deficits.
- Assess higher fees at renewal for those facilities that required greater regulatory oversight based on the number of complaint inspections, violations cited, follow up visits required to determine correction of violations, and adverse sanctions such as moratoria, suspension, fines, or other actions.[186]
- Remove the prohibition on imposing an administrative fine when a Class III or Class IV violation is corrected within the time specified.[187]

Alternatively, the Legislature might privatize the inspection program, which may achieve some cost-savings to the state. However, a privatized inspection program would require sufficient oversight by the AHCA to avoid inconsistent inspections, conflicts of interest, and reduced accountability of ALFs.

The Legislature may wish to also require additional monitoring inspections of LMH facilities. If this recommendation is pursued, Senate professional staff further recommends that these monitoring inspections include the attendance of a mental health professional to help ensure that the appropriate care is being provided.

Training and Qualifications

Core Training Providers

Senate professional staff recommends improvements to the current system of training administrators since the quality of ALF administrators may directly impact the level of care and services that are provided to the ALF's residents. This might be accomplished by returning the responsibility of core training to the DOEA. The cost of

[186] These suggestions and information were received by professional staff from AHCA staff via email on August 10, 2011.
[187] *See* s. 408.813, F.S.

the DOEA resuming core training could be offset by requiring applicants seeking training to pay the DOEA a training fee. If the DOEA were to resume responsibility over core trainers, they could ensure core trainers:

- Meet the qualifications to be a trainer;
- Are teaching curriculums that are consistent throughout the state; and
- Are accountable for their training practices, by having the authority to penalize trainers for certain activities, such as not adhering to the curriculum or participating in fraudulent acts.

If the core training providers remain privatized, Senate professional staff recommends that the DOEA be provided with specific authority to oversee the core training activities. Additional oversight might include authorizing the DOEA to sanction core trainers with administrative fines, which could help fund the monitoring of core training providers, requiring continuing education in order to maintain certification to provide core training, and authorizing the DOEA to revoke or suspend certifications to provide core training when appropriate.

Core Training Curriculum and Competency Test

Florida's core training curriculum could be expanded to include subject matter to better prepare administrators for carrying out their responsibilities. It may be beneficial to form a workgroup, including personnel from the DOEA and the Ombudsman program, to analyze those ALFs that are excellent performers to develop a list of best practices that could be used in the core training curriculum. These best practices could also be available in continuing education courses. Additionally, expanding the curriculum to include information on financial planning, including financial resources that may be utilized to make an ALF more successful, and the day-to-day administration of an ALF might be helpful for potential administrators. Other subject matter that could be addressed is elopement, emergency procedures, and the appropriate use of physical and chemical restraints.

Senate professional staff recommends the Legislature require the competency test provider to annually update the competency test, and the DOEA to verify the updated test to ensure that test-takers are tested on the most current law requirements and best practices. Additionally, the Legislature might increase the minimum passing score for the competency test from 75 percent to 80 percent, which may help ensure a better pool of potential administrators.

Administrator Qualifications

Residents might benefit if the qualifications to become an administrator of an ALF were enhanced, the extent of which could be dependent on the size or licensure type of the ALF. Senate professional staff specifically recommends requiring additional qualifications of those administrators who are overseeing facilities that provide more specialized care such as limited nursing services and mental health services.[188] It may be appropriate to require these administrators to have a 2 or 4-year degree that includes some coursework in gerontology or health care. Additionally, for administrators of an LMH licensed facility, the administrator could be required to have completed some mental health coursework or have a degree related to the mental health field. Such education requirements could be substituted by a specified length of experience in the appropriate field (e.g., long-term care, nursing, mental health).

Staff Training

Because the AHCA currently determines whether ALF staff has received appropriate in-service training by inspecting personnel files and interviewing a random sample of employees, there currently may be misrepresentations made or the training may be inadequate to convey the subject matter. Therefore, the Legislature may wish to require all staff to take a short exam after their requisite training to document receipt and comprehension of such training. Some of the exams that are not facility-specific might be provided online through the AHCA.

[188] There are already additional education and experience requirements for administrators of ECC facilities. Rule 58A-5.030(4)(a), F.A.C.

Staffing Ratios

Currently staffing ratios as set out in rule are the same regardless of the type of ALF licensee. Because those facilities with specialty licensees care for populations that need more assistive care, it may be appropriate to increase the staffing ratios or specify ratios for staff with certain specialized training for facilities with specialty licenses.

Elopement Training

Because elopement is a frequent and very dangerous occurrence in ALFs, Senate professional staff recommends increasing elopement training requirements and requiring an AHCA staff person to periodically attend elopement drills. The elopement training requirement could be increased to require at least one hour of elopement training, as currently there is no time requirement. Additionally, staff could be required to sign an affidavit under penalty of perjury that they have read and understand the ALF's policy and procedures on elopement and the affidavit would have to remain in the staff person's personnel file.

Limited Mental Health Licensees

Administrators who oversee facilities that house residents with mental illness should be prepared, experienced, and educated to work with the challenges that come with this specific population. Therefore, Senate professional staff recommends the Legislature increase the education and experience requirements for administrators of LMH facilities or require managers of LMH-licensed facilities to have specialized education and experience. The Legislature could require these administrators or managers to have a two or four year degree that includes coursework relating to mental health care. In addition, the Legislature could require such administrators to have a certain number of years of experience working with those with mental illness.

In addition, Senate professional staff recommends the Legislature require an LMH specialty license for an ALF that accepts *any* mental health residents, except pursuant to an emergency placement.

Not only should administrators of LMH facilities be better prepared to work with a mental health population, but so should direct care staff. Although direct care staff currently must complete a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses, this requirement could be supplemented by requiring professional development training by mental health providers or professionals. In addition, staff could be required to receive aggression control training or similar training in order to properly address combative mental health residents and training as to the appropriate use of physical and chemical restraints.

Unlike LNS and ECC licensees, LMH licensees are not subject to additional mandatory monitoring inspections outside of the required biennial inspection. Because LMH licensees are responsible for an especially vulnerable population needing additional care and services, Senate professional staff recommends the LMH licensees be subject to additional monitoring inspections. Further, the monitoring inspection teams should include a mental health expert.

Senate professional staff recommends that the Legislature specifically require the DCF to have one FTE review staff's monitoring practices to ensure consistency in their monitoring of community living support plans and cooperative agreements. Further the Legislature might require the DCF to enhance the monitoring of the responsibilities of the mental health resident's case manager.

Penalties and Enforcement

To ensure that penalties are enforced by the AHCA, the Legislature might enact legislation to remove AHCA's discretion to assess administrative penalties and instead require the AHCA to assess certain penalties. For example, the Legislature could require the AHCA to fine an ALF in increasing increments after certain recurring deficiencies. The Legislature could also remove the AHCA's discretion to impose a moratorium or revocation of license when residents' health, safety, or welfare is at stake. The AHCA could be required to automatically revoke a license when a resident dies at a facility because of intentional or negligent conduct on the part of the facility.

Reorganization of Regulatory Oversight

To make the regulatory process of ALFs more streamlined, Senate professional staff recommends the establishment of a workgroup that includes members of the various state agencies having ALF oversight responsibilities to determine those functions that are performed by more than one agency. The workgroup could recommend to the Legislature the most efficient manner to streamline, while not degrade, the regulatory process of ALFs.

Until the Legislature is able to respond to the workgroup's recommendations, Senate professional staff recommends the Legislature address the more immediate need to designate a specific agency as the lead agency to coordinate all complaints or other problems related to ALFs. Even with memoranda of agreement existing between the agencies, it is difficult to determine which agency takes the lead when a specific complaint is made. Senate professional staff recommends this lead responsibility be assigned to the AHCA. The Legislature should require each agency to establish a direct line of communication to the AHCA to immediately communicate a complaint received or observed deficiency concerning an ALF. The direct line of communication should also be used to timely communicate the investigator's findings as well as the results of action taken by the investigating agency. The AHCA should maintain a database of this information to monitor and trend events at each ALF.

Senate professional staff further recommends that the Legislature amend s. 415.1034, F.S., to explicitly require AHCA staff or staff of other regulatory state or local agencies to immediately report the knowledge or suspicion that a vulnerable adult has been or is being abused, neglected, or exploited to the central abuse hotline operated by the DCF, instead of relying on inter-program agreements or operational procedures to set out such requirements.

Consumer Resources

An easy-to-use rating system, similar to the Nursing Home Compare, should be developed to facilitate consumers making informed decisions about choosing an ALF. The rating system should report on quality in terms of deficiencies and penalties, as well as resident satisfaction with the quality of life at the facility. The Ombudsman's might be assigned responsibility for gathering information concerning resident satisfaction.

To foster the reporting of complaints to the Ombudsman, Senate professional staff recommends the Legislature amend s. 400.0078, F.S., to require long-term care facilities to notify residents that the complainant's identification and the substance of their complaints are confidential and exempt from Florida's public record laws.

AL Workgroup Recommendations for Discussion **November 1, 2011**

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

Consumer Information

1. Require the state to contract with an objective outside party to provide improved consumer information including ALF ratings.

2. Develop a consumer ALF guide similar to the AHCA nursing home guide in an electronic format to help people learn important facts such as deficiencies found at inspection, number of beds, languages spoken, inspection results, rates charged for a standard set of services, whether the facility accepts Medicaid waivers, and other information.

3. Require ALFs to enter capacity, capability, and cost of care into a statewide database allowing consumers, families, advocates, and hospitals to determine which facilities have the ability to best meet the individual needs and choices of each person.

4. Amend S.400.0078 to require long-term care facilities to notify residents that the complainant identification and the substance of their complaints are confidential and exempt from Florida's public record laws.

5. Consolidate and expand existing consumer resources. Currently Florida ALF information is available through the AHCA FloridaHealthFinder.gov website as well as the DOEA Affordable Assisted Living website (http://elderaffairs.state.fl.us/faal/consumer/facilityselect.html). Both sites contain information regarding how to evaluate an ALF, questions to ask and a resource to search for facilities (DOEA links to http://www.floridahousingsearch.org/). Each facility search contains unique information; AHCA www.FloridaHealthFinder.gov provides more regulatory information such as inspection reports, sanctions, owner and administrator names, while DOEA allows the ALF to update information about funding sources, available services, and other accommodations. (AHCA recommendation)

ALF Administrator Qualifications

1. Create a workgroup of providers and stakeholders to evaluate the current educational requirements and curriculum for certification as an administrator of an ALF, education and training requirements for staff, continuing education requirements, and training and education requirements for administrators and staff of specialty licensed ALFs.

2. Raise standards to become an ALF administrator including:

    - Be at least 21 years of age,
    - Have an associate degree or higher from an accredited college (in a health care related field) or,

- A bachelor's degree in a field other than in health care from an accredited college and (one year experience) working in a health care related field having direct contact with one or more of the client groups or,
- A bachelor's degree in a field other than in health care from an accredited college and have successfully completed an assisted living administrator's training course approved by the department or the department's designee or,
- At least two years experience working in a health care related field having direct contact with one or more of the client groups and have successfully completed an assisted living administrator's training course approved by the department of the department's designee or,
- A valid nursing home administrator's license.
- A valid registered nurse license.
- Grandfather existing Administrators with certain training and experience, and no serious deficiencies in their past.

3. Require administrators to have a two year mentorship under an ALF administrator with no Class I or II violations.

4. Increase administrator requirements for an ECC facility. Allow a registered nurse license to satisfy.

5. Create ALF Administrator licensure with a Department of Health board to track and monitor discipline and core training. No exceptions for small facilities.

6. If there are increased requirements for ALF Administrators, consider accepting licensure as a nursing home administrator or a registered nurse to satisfy requirements. (AHCA recommendation)

7. Prohibit facility administrators from owning or serving as administrator of any facility if an action to revoke or deny a license is upheld at a facility they were previously employed.

Training/Staffing

Core Training

1. Create ALF Core Trainer Oversight. Consider a dedicated source of income and more explicit authority to enhance DOEA's ability to provide more oversight of core training providers.

2. Return core training responsibility to the Department of Elder Affairs (DOEA) and use training fees to fund the initiative.

3. Raise the qualifications of trainers and have AHCA strengthen review of their certification and training methods.

4. Require trainers to have experience in the industry.

5. Adopt a de-certification process for trainers.

6. Authorize DOEA to develop a partnership to conduct one standardized core curriculum course in English and Spanish that is updated as needed. This will increase the credibility and professionalism of the training process and will align the training of ALF administrators with other paraprofessionals. Options include existing accredited educational institutions or existing professional healthcare associations that currently provide continuing education. Allow existing registered trainers to provide training until July 1, 2013, when training will be turned over to either the educational institutions or professional associations. This will allow current trainers an opportunity to develop affiliations with training entities. (DOEA recommendation)

7. Develop a standardized, CORE curriculum, either through the Department or in partnership with educational institutions, and allow the Department to monitor and sanction training providers that do not follow the standardized curriculum.

8. Expand the number of minimum CORE training curriculum hours from 26 to 40 to include specific minimum training hours in each area and to include additional topics such as:
    - Use of physical and chemical restraints.
    - Elopement prevention.
    - Aggression, de-escalation, behavior management, and proper use of the Baker Act.
    - Do Not Resuscitate Orders.
    - Infection Control.
    - Admission, continuing residency and best practices.
    - Phases of care giving and interacting with residents.
    - Human resource management, finance and business operation, and supervision topics.
    - Require additional 8 training hours for administrators employed or to be employed in an Extended Congregate Care and Limited Mental Health licensed facility.

9. Raise the passing score for the Core exam from 70 to 80 or 85.

10. Require the competency exam be taken within 90 days of completing the initial core training. If an applicant fails the core exam, the applicant must wait 30 days to retake the exam and must reapply and pay the exam fee. If an applicant fails the exam three times, the applicant must retake the initial core training including payment of any course fees. (DOEA recommendation)

11. Develop supplemental core competency exams for ECC and LMH licensure. (DOEA recommendation)

Continuing Education

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

2. Revise continuing education requirements for administration and care. Include de-escalation techniques.

3. Expand the number of continuing education hours from 12 to 18 in topics similar to the initial core curriculum. (DOEA recommendation)

4. Establish in statute a procedure and fees similar to that used by the Department of Health in Section 456.025(7), F.S., to approve continuing education trainers and courses. This establishes an online education tracking system for approving training providers, initial core training, and continuing education credits for each biennial renewal cycle. Training entities shall provide information on course attendance to the department necessary to implement the electronic tracking system. The department shall specify the form and procedures by which the information is to be submitted and monitored. (DOEA recommendation)

5. Prepare and provide a well designed curriculum in a wide array of subjects by highly skilled trainers using readily accessible technology. Training should demonstrate methods and techniques for staff. Administer tests by an independent party on-line or at a testing center after the training is completed.

6. Allow flexible training to meet individual needs of direct care, frontline staff. Allow alternatives to instructor-led training. Create flexibility to accommodate staff who work nights and weekends. Offer training in staff native languages. Consider varying skill levels of staff.

7. Require the state to contract for the development of on- line courses similar to the DCF funded online series of Baker Act related courses (through USF/FMHI) that can be found at www.BakerActTraining.org. Courses are available to anyone at no cost. Consider "subscription-based" online service to meet the needs of direct care workers, but recognize that a fee for classes may create a disincentive for participation.

8. Require staff to pass a short exam after initial and in-service training to document receipt and comprehension of the training.

9. Require one hour of elopement training for all staff.

10. Update the competency tests annually to ensure that the tests are informed by the best research and best practices knowledge.

11. Enable costs associated with training changes be borne solely by the trainers, administrators, and assisted living facilities and remain revenue neutral to the state. Reasonable fees should be imposed in a manner that will not be a barrier to job creation. (DOEA recommendation)

Limited Mental Health Training

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

2. Require all staff members who have contact with residents with mental health issues, even incidental contact, to complete the mental health training.

3. Establish a panel of mental health experts to develop a comprehensive, standardized training curriculum for mental health training for assisted living facility staff members.

4. Require the 6 hour mental health training as a pre-service requirement. Currently, ALF staff can work directly with individuals for up to 6 months before getting trained. (DCF SAMH recommendation)

5. Increase the training hours for staff members working in facilities with an LMH license from 6 hours of limited mental health training to 12.

6. Require staff members to complete a test following their training in mental health and score a minimum of 80%.

7. Allow the Department of Elder Affairs to monitor and sanction trainers providing the mental health training course.

8. Collaborate with NAMI (National Alliance on Mental Illness) in each community with an active chapter to provide free training of residents (Peer-to-Peer), caregivers (Family-to-Family), and Provider Education, as well increased oversight when NAMI members are present in the facilities.

Surveys and Inspections

1. Modify survey frequency. Inspect facilities with a problematic regulatory history more frequently than once every two years. Require more frequent and extensive inspections of those facilities that have recurring or observed deficiencies.

2. Require the Agency for Health Care Administration to survey ALFs annually.

3. Require additional inspections for certain facility types.

4. Establish a quarterly inspection cycle for facilities with a limited mental health license.

5. Conduct inspections of LMH facilities on an annual basis and include a mental health professional on the inspection team.

6. Authorize more abbreviated inspections for facilities in compliance. Create a streamlined regulatory process for facilities with a favorable regulatory history.

7. Conduct unannounced visits to facilities during evenings and on weekends as well as during weekday hours by the Agency and by LTCOC volunteers.

8. Deemed status is authorized in the statute for facilities that have undergone accreditation or certification by a nationally recognized body such as CARF might be helpful to reduce the number and frequency of on-site surveys. Any deemed status must be based on a nationally recognized accreditation body or upon a documented history of high performance without serious or repeated citations.

9. Acknowledge CARF accreditation – allow lighter inspection.

10. Require AHCA surveyors to rely more on site-based observations than paper review. While it is more difficult to measure quality care than technical compliance, rules must be created to provide objectively reasonable basis for surveyor judgment to be applied and the surveyors must be adequately trained to use the probes.

11. Require a specific number of lead surveyors in each area office to specialize on ALF inspections and be dedicated to ALF inspections only.

12. Require dedicated AHCA staff to monitor surveyors and the field work to ensure consistency in inspections, citing deficiencies, and enforcement throughout the state.

13. Require AHCA surveyors complete core training and continuing education hours equivalent to ALF Administrators.

14. Assess AHCA Inspection Forms. Create a workgroup that includes Ombudsman members to assess AHCA inspection forms to assure they adequately assess ALF compliance with the law, resident protection, and meeting resident needs. (Add Note: Senate Health Regulation report recommendation 5)

15. Require dedicated AHCA staff to focus on assisted living facilities including one position to monitor state-wide issues and lead surveyors in each field office.

16. Exercise caution when making changes to any business or industry to avoid having unintended consequences

Licensure

1. Seek legislative changes to Chapter 429, FS, that are resident-care focused (Alzheimer's secured units, safekeeping of residents funds) and ensure that regulations are appropriately and consistently enforced (keep violations in Chapter 429, FS) yet streamlined where appropriate (advertising – use of "ALF", combined adverse incidents reporting)

2. Create rigorous initial ALF license requirements to prevent persons who are unprepared or uncommitted to providing quality care from becoming licensed. Consider education and training of the administrator, background checks on the owner and proposed administrator regarding previous facility ownership and operations, and appropriateness of the facility.

3. Establish a more in-depth licensure application and background screening process for ALF licensure applicants.

4. Utilize the provisional license permitted in Ch 429, F.S., for initial licensure, then followed up within a specified period after the facility has opened, to conduct the more complete survey.

5. Revise regulations to be appropriate for specific persons served in an ALF including persons with serious mental illness and those serving a geriatric or medical needs.

6. The ALF licensure and regulatory provisions be placed back into Part I of Chapter 429, F.S.

7. Examine the current array of ALF specialty licenses and determine if they are still needed or should be modified.

8. Evaluate expectations for quality of life and care in an ALF. Focus can not be limited to physical health and safety – it must extend to other quality of life factors, including staff who are kind and focused on the individual wants / needs of each resident. Consider questions raised during public testimony "Would I want to live in this facility?" or "Would I place my mother in this facility?" No lower expectation should exist for other individuals.

9. Prohibit an administrator or property owner associated with an ALF with a regulatory record that would qualify for license revocation or denial, from future affiliation with an ALF. This provision would require disclosure of property ownership. (AHCA recommendation)

Resident Admission

1. Hold state and local hospitals accountable for discharge planning that matches individual needs and desires to an appropriate and available setting that best integrates individuals into the community. Modify Chapter 395, F.S., to require hospital document consideration of an individual's choices in discharge placements. Address hospitals that do not consider the individual's preferences and community integration in discharge planning.

2. Adopt an ALF pre-admission screening process implemented by an independent body (a simplified and expedited version of PASRR). This "single point of contact" would permit choice counseling and referral to an ALF most appropriate to align with the individual resident needs.

Resident Discharge

1. Enact legislation that provides ALF residents a formal appeal process for disputed discharge.

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

3. Reduce the resident discharge notice from 45 to 30 days and provide an option for the resident to appeal with a decision within 15 days.

4. Clarify in statute that a written notice, with the reason for the relocation or termination listed, along with an explanation of the reason, be given to the resident 45 days before the relocation or termination of residency. The resident or legal representative should sign indicating receipt. Require the facility to send a copy of the written notice to the local long-term care ombudsman office within 5 days of providing the notice to the resident.

5. Establish in statute that relocation or termination of residency from an assisted living facility may only occur if one of the statutorily specified reasons has been documented. These reasons should include a change in the resident's health, nonpayment, or the health and safety of other residents is in danger.

6. Permit the resident to appeal the relocation or termination to a neutral third party.

7. Permit the ombudsman to represent the resident at an appeal hearing.

8. Require assisted living facilities provide prospective residents with a statement acknowledging the continued residency requirements to allow owners to initiate transfer of a resident to a more appropriate setting when they no longer meet the requirements of an assisted living facility. Require residents sign this acknowledgement.

9. Clarify that a temporary transfer such as a Baker Act is not a discharge and the resident may return to the facility once released. Require ALFs to hold the resident bed / room during the absence.

Resident Safety and Rights

1. Increase amount and quality of activities made available to ALF residents. Require ALFs to seek out individualized activities and services independent of the facility that are chosen by each resident and expedite participation in these activities and services. Activities must be meaningful activities and allow residents the opportunity for productive learning, life skills, and job experience. This may include meaningful part-time work or volunteer activities, depending on the preferences of the resident. Some structured and meaningful activities can be provided in the ALF, but those integrated in the community with non-disabled persons should be encouraged.

2. Prohibit practices that lock residents out of the facilities during certain hours to cut costs or give staff a break. Positive activities of each resident's choice during these hours should be substituted.

3. Examine ALF staffing ratios.

4. Prohibit ALF related staff from serving as Representative Payees. This creditor / debtor relationship places the resident under the control of the ALF for all aspects of their life, preventing them from moving to another ALF or a more independent living environment.

5. Prohibit any binding arbitration agreement language in resident contracts. These contract clauses limit a resident's right to access due process whenever care disputes arise.

6. Enact legislation that encourages residents and families to establish independent groups within each ALF focused on improving conditions and care for residents without interference from staff.

7. Ensure an anonymous method of regularly seeking input from ALF residents about the nature of the care received in a facility without relying only on complaint investigations or on-site surveys. CARF provides such a mechanism, as does the LTCOC.

8. Clarify in statute that the ALF administrator is responsible for ensuring that the resident receives adequate care and services.

9. Enact public record exemption for AHCA complaints. Complaints filed with AHCA are not protected from disclosure. Consider adding confidentiality to AHCA complaints equivalent to Ombudsman. (AHCA recommendation)

ALF Information and Reporting

1. Require ALFs to report quarterly to AHCA on occupancy rates, demographics, resident acuity, and the services rendered to the residents.

2. Require minimal online data submission to the Agency. ALFs currently submit data to the agency in a variety of online applications including adverse incident reporting, monthly liability claim reporting and participation in the Emergency Status System (over 85% of ALF have online accounts). ALF data submission to the Agency should include:
   Number of residents (census)
   Number of residents requiring specialty license services: Limited Nursing Services (LNS), Limited Mental Health (LMH), Extended Congregate Care (ECC)
   Number of residents on Optional State Supplementation (OSS)
   Number of Medicaid recipients whose care is funded through Medicaid by type of waiver (AHCA recommendation)

3. Require maintenance of a resident roster available upon request including name, Medicaid ID, guardian or representative name and contact information, source of resident admission and care manager name and contact information. (AHCA recommendation)

4. If ALFs are required to report to the Agency occupancy rates and resident acuity (above), they need to have an online reporting system that requires no more than 30 minutes per quarter for data entry. ALFs will also need to be able to pull up congregate occupancy rates and resident

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

5. Require AHCA to investigate the types of technology currently available for cost effective methods of collecting, reporting, and analyzing client information and allow facilities to select the type of technology most appropriate to each individual facility. Easy to use swipe / scan handheld devices may be available. The fiscal impact of equipment, software, training, and staff time must be considered.

6. Require all ALF staff to collect and identify client information that would indicate a change of condition and notify the resident's case manager to enable early intervention and prevent escalation of symptoms that might result in a transfer, discharge, Baker Act, police involvement, injury to staff or resident, or other adverse event. Electronic collection and sharing of this information will improve timely response.

7. Require AHCA to examine the "Dashboard" technology used by DCF in measuring the outcomes of Community Based Care agencies serving dependent children. Some aspects of this oversight should be applicable to long-term care settings.

8. Use a document vault where all critical documents can be stored related to an individual resident. This prevents the loss of such documents, increases access to them by authorized persons to prevent duplication of effort, and reduces costs. Protection of such documents and criminal sanctions for misuse needs to be considered to prevent fraud by unauthorized persons or for unauthorized purposes.

Enforcement

1. Enforce existing regulations, and retain due process protections for providers.

2. Utilize existing regulations to evict unethical or incompetent providers from the system. Recognize that most ALF residents are currently being well taken care of under the current regulatory environment. Do not undermine a social model of care that works.

3. Maintain current law that fines will only be imposed for low-level citations if uncorrected, to focus penalties on poor performers without adverse impact on competent providers.

4. Evaluate the ALF enforcement process beyond a punitive approach. Although the punitive approach is necessary for chronically poor performing facilities, it is not he best way to elevate quality across the ALF community. Examine the Wisconsin model for ALF regulation which is similar to the AHCA abbreviated survey with the addition of a consultative/collaborative regulatory model.

5. Give AHCA more power if necessary to place sanctions, fines, moratoriums, as well as deny, revoke or suspend licenses for poorly performing facilities. Fines for non-compliance should be increased and immediately paid. Such sanctions would be subject to due process through

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

6. Evaluate discretion of sanctions and determine if some should be removed, but allow some AHCA discretion. Removing discretion more broadly may cause unintended consequences and needs to be discussed much further

7. Require AHCA to assess certain administrative penalties such as increasing sanctions for recurrence of serious deficiencies affecting residents' health, safety, or welfare or failure to pay fine.

8. Fines – mandatory for certain violations, escalating fines for recurring deficiencies. Prescribe fine amounts for non-compliance rather than ranges.

9. Moratorium – mandatory for serious violations (Class I or II), and when an ALF fails to correct all outstanding deficiencies and reach full compliance at the time of a follow up visit or by the mandatory correction date.

10. Revocation or denial of renewal license – mandatory for certain violations including resident death at a facility because of intentional or negligent conduct on the part of the facility. Consider the degree of culpability.

11. Provide AHCA the authority to cite for past egregious violations (Class I) even if corrected upon inspection and a mechanism to address evidence presented after an AHCA investigation such as a DCF Abuse report or law enforcement investigation. (AHCA recommendation)

12. Authorize AHCA to cite violations for falsification of information. Current laws authorize licensure action for falsification of a license application [s. 408.815(1)(a)] or authorize criminal penalties for falsification of records (s. 429.49, F.S.), but do not address licensure violations for other falsified documentation submitted to AHCA. (AHCA recommendation)

13. Allow the monies from administrative fines be used in the facility to correct the deficiency allowing the facility to enhance the resident care standard.

Funding

1. Evaluate the actual cost of the current regulatory program and any proposed changes and determine full costs of any law changes before raising fees.

2. Provide AHCA necessary resources to apply the statutory and regulatory measures necessary to protect vulnerable persons. These include political support by the Legislature through substantive laws and financially through appropriations to hire sufficient numbers and quality of staff in its field offices to provide the intensity and frequency of surveys and complaint investigations necessary to protect the public.

3. Consider options in the Senate Committee on Health Regulation Interim Report 2012-128, to fund required inspections including some combination of additional fees, especially higher fees or facilities that require greater regulatory oversight.

    - Require licensure fees for OSS beds. Florida law exempts facilities that designate their beds as OSS from licensure fees. The current fee for non-OSS beds is $61 per bed in addition to the $366 standard licensure fee. Some of the facilities that receive this exemption for the majority of their licensed beds require significant regulatory resources. There are currently 15,678 OSS beds in Florida, so revenues generated would be $478,179 annually (15,678 x $61/bed every 2 years for biennial licensure).
    - Increase the per-bed, per facility, and/or specialty licensure fees for all providers to offset program deficits.
    - Assess higher fees at renewal for those facilities that required greater regulatory oversight based on the number of complaint inspections, violations cited, follow up visits required to determine correction of violations, and adverse sanctions such as moratoria, suspension, fines, or other actions.186
    - Remove the prohibition on imposing an administrative fine when a Class III or Class IV violation is corrected within the time specified.

4. Reevaluate the assisted living fee structure as it relates to paying the cost of regulation.

5. Prohibit fines from going back to the Agency to offset the costs of the licensure program.

6. Address the 15,000 people on the waiting list when asking for additional 'nursing home diversion' slots.

7. Provide more financial support for ALF care and services including increased per diem rates and more funded slots (beds).

8. Provide a real-estate tax exemption to for-profit Assisted Living Facilities, as exists for non-profits in Chapter 196, F.S.

Resident Advocacy

1. Assure independence of the Long-Term Care Ombudsman Program –issues cited by the federal Health and Human Services Administration on Aging in its "Compliance Review of the State of Florida Long-Term Care Ombudsman Program" dated September 1, 2011 should be remedied by Executive Branch practice or by legislative mandate.

2. Relocate the Ombudsman Program to either the Attorney General or the Auditor General, separate from DOEA, AHCA or DCF.

3. Focus Ombudsman oversight on resident advocacy. Focus on communication with each resident of each ALF monitored to elicit information on ways the facility can improve as well as ways in which the facility may excel. Train members on the requirements of and be alert to regulatory

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

4. Enable the State Ombudsman to impose a civil penalty, following notice and an opportunity to be heard, on any facility that retaliates or discriminates against a resident who files a complaint with the program.

5. Ensure volunteers have the right to visit licensed programs at any time for purposes of monitoring as well as for complaint resolution. They should always be encouraged to look at any physical plant as well as other issues in addition to conducting resident interviews. All observations and findings should be submitted to AHCA and acted on in an expedited manner.

6. Contact former members of the State and Local Advisory Council members to expand Ombudsman efforts. These members have great knowledge and skill in mental health related issues that has been lost since the Councils were de-funded by the Legislature in 2010. Establish a sub-committee of each Council focused on ALF's with limited mental health licenses; members would be a resource to other Council members and staff for issues related to mental illness in other types of long-term care facilities.

7. Create an independent statewide ALF Council made up of residents, ombudsmen, and families (at least 2/3 of the membership), in addition to one member from each respective trade association, to meet periodically.

8. Increase funding for the Centers to expand the numbers of persons served and recognize the Centers for Independent Living as an essential part of the ALF statute. Their roles of information and referral, peer monitoring, independent living skills training, advocacy and other services are ideally suited for persons who are living in ALF's and those who wish to live more independently.

9. Require ALFs contact representatives of the Florida Peer Network to seek certified peer specialists for employment or at a minimum, encourage the peer specialists to visit the facilities to make recommendations that would improve the ability of the facility to better serve persons with severe mental illnesses.

Mental Health

1. Require more education and experience for LMH facility administrators with a greater focus or specialization in mental health care such as a two year degree and two years of experience or a four year degree with coursework in a mental health related field seems reasonable. Consider a grandfather provision for current administrators.

2. Require a Limited Mental Health (LMH) license for ALFs with any mental health residents, rather than the current limited definition. Currently the definition of LMH license is an ALF that serves three or more mentally ill or disabled residents must obtain a limited mental health (LMH)

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

3. Recognize the shift of placements for persons discharged from state hospitals, now residing in ALFs.

4. Conduct annual or quarterly regulatory inspections.

5. Identify the features or characteristics of a good LMH ALF for model of programs that best meet the needs of persons with serious mental illness and the associated behaviors.

6. Provide more case management services and advocacy for residents which could contribute more to the resident's quality of care and life.

7. Clarify oversight responsibilities of private case management and mental health treatment providers as it relates to Community Living Support Plans and Cooperative Agreements. Not all individuals in ALFs are served by DCF funded mental health providers, making DCF oversight of those providers difficult. (DCF SAMH recommendation)

8. Maintain the independence between mental health services and case management and assisted living facilities. Shifting services and case management to a facility-based model instead of resident-based may place the needs of the facility over the needs of the resident, and limits resident choice in case managers and living arrangements.

9. Retain role of the designated mental health providers to manage mental health clinical issues and do not shift this role of the ALF. While close working relationships between the ALF and the mental health provider are essential, it is equally essential that no inducements or other devices limit the choice of residents as to where or from whom they receive their mental health services.

10. Do not move the Medicaid Case Management program moved from community mental health centers to the ALF. This Medicaid program, limited to eligible services for eligible clients, requires extensive psychiatric oversight and linkage only available within a clinical context. This is not the "social service" program ALFs desire nor should it be facility-based and dependent on the residence where an individual lives.

11. Do not require DCF to contract with specialized CMHCs to provide case management and other mental health services to residents of ALFs. This would more likely meet the needs of the facility at the expense of the resident. Residents often move between ALFs or to more independent settings and they need to retain the continuity of care possible through the trusted relationship with their case manager.

12. Require DCF/Managing Entity evaluate the cooperative agreements in place to ensure that they are sufficient to meet the mental health needs of ALF/LMH facility residents and that the circuit plans are consistent with the DCF/SAMH district plans related to case management services, including access to consumer-operated drop-in centers, access to services during evenings, weekends, and holidays, supervision of clinical needs of residents, and access to emergency psychiatric care.

13. Require DCF/Managing Entity review a sample of the community living support plans at each ALF/LMH facility to ensure they represent adequate mental health supports as well as activities and services that represent the preferences of the consumers.

14. Require DCF/Managing Entity verify that each mental health resident is assigned a case management and that face-to-face contact has been documented as required by law and rule.

15. Require staff at the DCF to ensure consistency of LMH facility services and increase the monitoring responsibilities of mental resident case managers.

16. Amend Chapters 400 and 429, F.S., to require that before an ALF or nursing home or its agent can initiate an involuntary examination under the Baker Act that it must document a series of efforts have been attempted to prevent this action. The statutory amendment would require DOEA, AHCA and DCF to collaborate in the promulgation of rules defining what these efforts would be. The Florida Health Care Association's Quality First Credentialing Foundation has adopted a Best Practice Tool governing "behavior management/aggression control & involuntary Baker Act guidelines". This Tool is incorporated in the state's Baker Act Handbook (Appendix E-9 through E-12); it could provide the basis of such rules.

Multiple Regulators

1. Form a workgroup involving all agencies involved in ALF regulation and stakeholder groups to develop a new organizational structure streamlining the regulatory process. Designate AHCA as the lead agency for all regulatory activities in the interim.

2. Improve coordination between the various federal, state and local agencies with any role in long-term care facilities oversight; especially ALFs. Including Agency for Health Care Administration, Long Tern Care Ombudsman Program, local fire authorities, local health departments, Department of Children and Families Adult Protective Services and Substance Abuse and Mental Health Programs, Department of Elder Affairs Area Agencies on Aging, local law enforcement and the Attorney General's Office.

3. Agency responsibilities and lines of communication, coordination, and cooperation between agencies with oversight/regulatory responsibility for ALFs be clearly defined and formalized in written inter-agency agreements.

4. Limit the role of AHCA to regulatory oversight – consultation needed by the industry and its members can be obtained from organizations of their choice and at their own expense. AHCA

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

5. Cross-train regulatory staff to reduce duplication and increase effective oversight across agencies and address multitude of inspections by various agencies. Eliminate duplication between entities, only if reduction in oversight would not increase the threat of harm to vulnerable elders and persons with disabilities.

6. Require in law that AHCA staff and other agencies involved in ALF's report knowledge or suspicion of any resident abuse, neglect or exploitation to the central abuse hotline (DCF).

7. Allow AHCA to use DCF Adult Protective Services findings and pursue sanctions for repeated verified abuse findings in a facility. (APD recommendation)

8. Authorize for AHCA to deny, revoke or suspend a license if the licensee is a named perpetrator in a verify report of abuse, neglect, or exploitation, similar to APD licensure authority in section 393.0673, F.S. (APD recommendation)

9. Authorize use of DCF Adult Protective Services finding and investigations in employment matters. Section 415.107(8), F.S., states that "…information in the Central Abuse Hotline may not be used for employment screening." The current statutory construct allows for the verified perpetrators of abuse, neglect, or financial exploitation to continue working with vulnerable populations as long as none of those cases subsequently result in prosecution and conviction (under a disqualifying criminal offense). Allowing ALFs (and other providers) to use the information from the abuse registry to screen out such employees during the hiring process would necessitate a change in this law. Such a legislative change would require that DCF offer due process hearings for perpetrators prior to the closure of all abuse investigations with verified indicators.
   Modification of existing administrative rules should also be considered so that any licensee, direct service provider, volunteer, or any other person working in a residential facility who is an alleged named perpetrator in an active protective investigation of abuse, neglect, or exploitation of a vulnerable adult under Chapter 415, F.S., or abuse, abandonment, or neglect of a child under part II of Chapter 39, F.S., are prohibited from working directly with residents or being alone with residents until the investigation is closed. The only exception to this prohibition would be if the alleged perpetrator is under the constant visual supervision of other persons working in the facility who are not also alleged named perpetrators in the same investigation. This provision would only be applicable in situations where the licensee has been made aware of the investigation. (APD recommendation)

10. Enhance DCF Adult Protective Services electronic case management system (Florida Safe Families' Network) to identify trends in abuse, neglect and exploitation by modifying the system to coding investigations by resident setting (facility type). Currently, all institutional reports are lumped under one category. The system could be modified to capture discrete types of facilities, which would enhance our ability to look for patterns and plot frequencies. (DCF recommendation)

11. Improve ability to share information and data efficiently between DCF Adult Protective Services by enabling integration between the Agency for Health Care Administration's licensure data and the provider data which is used as an identifier in abuse reports. This integration would allow for more immediate identification of unlicensed facilities and would improve accuracy of reports particular to individual facilities. (DCF recommendation)

12. Improve ability to share information and data efficiently between APD and AHCA related to ALFs where APD clients reside. (APD recommendation)

13. Consider a document vault to allow off-site compliance review and share information between regulatory agencies.

14. Retain multiple visitors in non-compliant facilities.

Home and Community Based Care

1. Assist people who need to know what choices are available and what supports are available to make the choice successful. Each person should have access to the most integrated setting that allows interaction with non-disabled persons to the fullest extent possible so they can live, work and receive services in the greater community. Opportunities must be available to receive services at times, frequencies, and with persons of an individual's choosing.

2. Promote the development of and expand the use of alternative housing options for older adults who needed housing supports/assisted care.

3. Enable housing choices beyond ALFs including independent and supported living settings with supports necessary to ensure success through the following:

    - Approve AHCA to implement the Money Follows the Person (MFP) funding and authorize the use of Medicaid-financed assistive care payments in facilities other than ALFs.
    - Allow Optional State Supplement (OSS) funding currently spent in facility settings to follow the person into the community.
    - Reinstate money cut from DCF institutional budgets and allow it to follow the person into the community.
    - Fund the Affordable Housing Trust Fund and eliminate funds sweeps.
    - Make supportive housing services available under Medicaid.

4. Create incentives for placement of disabled residents in Adult Family Homes and supported / independent living settings that may not have the economy of scale available to larger ALFs, but do have the ability to provide individualized attention to resident needs in a home-like setting.

Assisted Living Facilities in Florida

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 Chapter 400, F.S., to part I of Chapter 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."

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
- Help with the activities of daily living (bathing, dressing, eating, walking)
- Giving 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)
- 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's needs do not exceed what is allowable in that assisted living facility or what is specified in the resident's contract with the assisted living facility.

If an ALF in Florida would like to provide any services beyond those allowed in the standard license, it must acquire a "specialty" license. These licenses allow the ALF to accept residents who need more advanced nursing or mental health care. The specialty licenses include:

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 that are 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
- 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 manger but do not meet this specific definition.

A limited mental health license must be obtained if an assisted living facility serves three or more mental health residents. 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,
- provide assistance to the resident in carrying out the plan, and
- maintain 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 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. 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 a 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 the 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 eligible 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.

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

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.

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

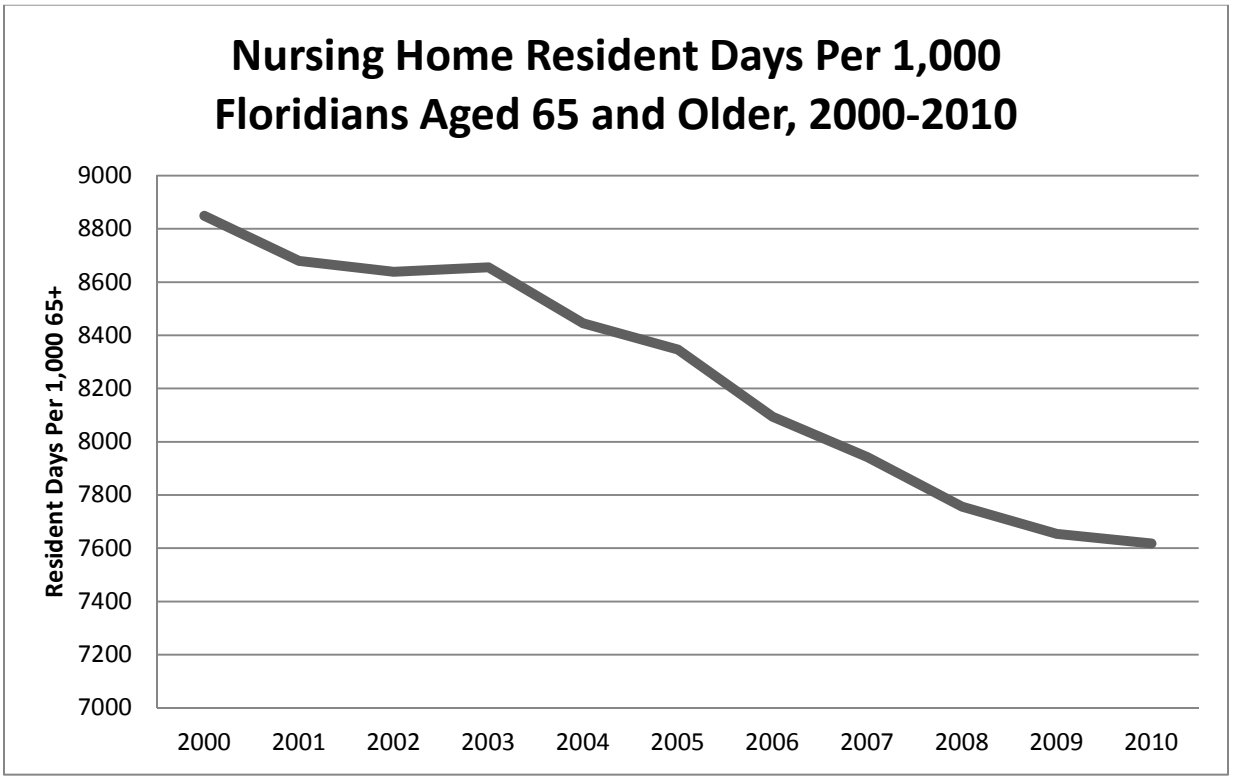
ALF Residents

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

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

We presume that Florida ALFs are also housing people 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

The Agency for Health Care Administration currently licenses over 40,000 services and facilities including:

- Abortion Clinics
- Adult Day Care Centers
- Adult Family Care Homes
- Ambulatory Surgery Centers
- Assisted Living Facilities
- Birth Centers
- Clinical Laboratories
- Crisis Stabilization Units
- Health Care Service Pools
- Home Medical Equipment Providers
- Homemaker Companion Organizations
- Homes for Special Services
- Hospices
- Hospitals
- Intermediate Care Facilities for the Developmentally Disabled
- Nurse Registries
- Skilled Nursing Facilities (Nursing Homes)
- Prescribed Pediatric Extended Care Centers

- Health Care Clinics
- Home Health Agencies
- Health Maintenance Organizations
- Residential Treatment Facilities (Mental Health)
- Short Term Residential Treatment Facilities (Mental Health)
- Transitional Living Facilities

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 conduct of these duties the Agency each year processes approximately:

- 16,000 licensure applications
- 200,000 background screenings
- 8,000 complaints
- 21,000 inspections and investigations
- 1,900 financial reviews
- 160,000 consumer calls
- 2,300 public information requests

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. In 2010, Agency's Division of Health Quality Assurance imposed sanctions (by final order) including:

- 3,900 cases
- $5,728,778 in fines
- Denial of 94 provider applications
- Imposition of 14 emergency moratoria (suspend admissions)

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 Chapter 408, Part II, Florida Statutes and Chapter 59A-35 of the Florida Administrative Code.
- Requirements that are specific to assisted living facilities are found in Chapter 429, Part I, Florida Statutes 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 Acts section 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.

Classification of is 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**
ALF 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

Fiscal Year	**ALF Fines Imposed by Final Order**
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

The following table shows the annual number of ALF license revocations and suspensions from 2006 to the present. The table also contains facilities that we have denied a licensure application and the number of facilities that closed or failed to renew 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

Adverse Incident Reporting

Most state and national assisted living regulatory models include facility self-reporting of "adverse incidents" when a resident has experienced a significant accident or outcome. In Florida, ALFs are required by statute to report such adverse incidents to the Agency. Florida's assisted care adverse incidents are defined in statute (Section 429.23 F.S.) as:

(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or

7. An event that is reported to law enforcement or its personnel for investigation; or

(b) Resident elopement, if the elopement places the resident at risk of harm or injury.

A facility is required to file a preliminary report with the Agency within one business day after the occurrence of an incident that appears to match one of the definitions above. The facility then has 15 days to complete its investigation of the incident and file its final report. This report must include a detailed description of the findings of the investigation. The facility is also required to report any cases of abuse, neglect or exploitation to the Department of Children and Families.

If an adverse incident report appears to describe any risk of a present and ongoing threat to residents, the report is referred to the Complaint Administration Unit in the Agency's Division of Health Quality Assurance. Additionally, all adverse incident reports are provided to the Consumer Services Unit in the Department of Health Medical Quality Assurance to determine if a regulated health care practitioner has engaged in behavior which may warrant inquiry and possible action by a licensing board or the Department of Health. Florida's adverse incident reporting program is limited, however, by debatable definitions of what constitutes an incident.

Civil Liability Claim Reports

When an assisted living facility is notified of a liability claim, section 429.23(5), F.S., requires the assisted living facility to, in turn, file a monthly report to the Agency. The report requires the name of the resident, dates of the incident and the type of injury or violation of rights alleged. The statute provides that the report is not discoverable in any civil or administrative

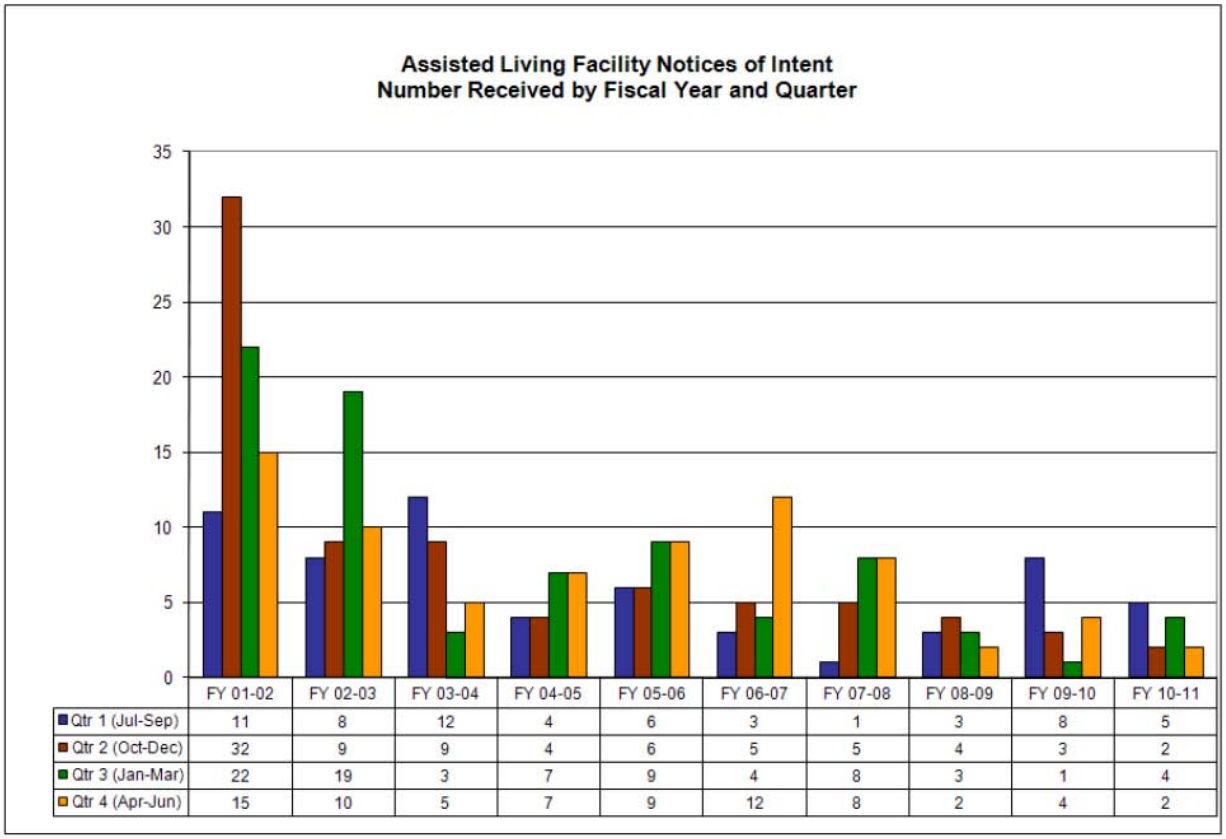
action. The Agency publishes a report on its website demonstrating monthly, quarterly and annual aggregate data of the number of liability claims intended to be filed against assisted living facilities in aggregate – no individual facility names may be provided. The report informs the Agency and the public (providers and consumers) of the number of intended claims filed against all assisted living facilities.

Information reported is not used in any regulatory manner and may be incomplete as only actively licensed ALFs are required to report. If a licensee receives litigation notice after they close or sell the facility, they are no longer obligated to report. Given the very low number of reported claims for almost 3,000 licensed facilities, there is concern that this information may be under reported.

Two reports are produced. One shows the number of intended liability claim reports by fiscal year and quarter from FY 01-02 through FY 10-11 and the second one, the number of intended claims filed calendar year January 2010 – December 2010.

The Agency began collecting information from nursing homes regarding civil litigation in May, 2001. Initial reporting included notices of intent (NOI) to litigate for civil cases. Generally an NOI serves to notify the facility licensee of a plaintiff's intent to sue for some cause of action. Once initiated, cases may be withdrawn, settled or move forward to litigation as represented by a civil complaint.

The following charts provide information about the NOIs and civil complaints reported to the Agency. Data changes over time if reports are submitted late or in error. The most recent liability claim reports are provided at the link below:
http://ahca.myflorida.com/MCHQ/Long_Term_Care/FDAU/docs/LiabilityClaims/ALF_Chart.pdf.



	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11
Qtr 1 (Jul-Sep)	11	8	12	4	6	3	1	3	8	5
Qtr 2 (Oct-Dec)	32	9	9	4	6	5	5	4	3	2
Qtr 3 (Jan-Mar)	22	19	3	7	9	4	8	3	1	4
Qtr 4 (Apr-Jun)	15	10	5	7	9	12	8	2	4	2

Punitive damages awarded from assisted living facility litigation must be equally divided between the claimant and the state Quality of Long Term Care Facility Improvement Trust Fund and collected by the Department of Financial Services as specified in 429.298(4), F.S. The Fund authorized in 400.0239, F.S., was created in 2001 to support activities and programs directly related to improvement of care of nursing homes and assisted living facility residents, however no deposits have been made to this fund from assisted living facility cases.

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 & 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 State Long Term Care Ombudsman – 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
- Mental Health Clients in ALFs - assists in rule development for Limited Mental Health ALFs, facilitates case management for clients living in ALFs
- Specific Medicaid Waiver

Agency for Persons with Disabilities

- Developmentally Disabled Clients in ALFs
- Medicaid Developmental Disability Waiver clients in ALFs

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.

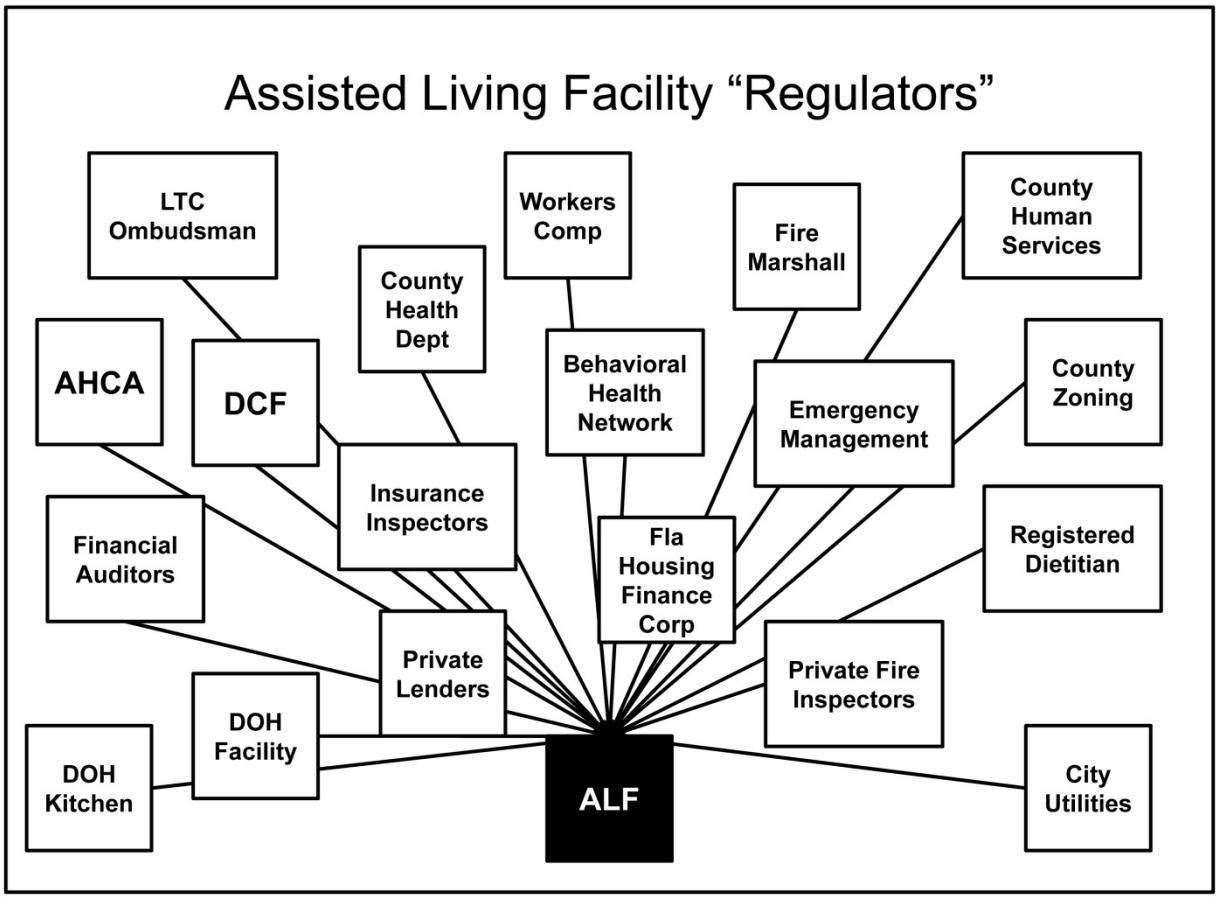
Department of Health

- Health & Sanitation Inspections
- Licensure & Regulatory Oversight of Health Care Practitioners working in Assisted Living Facilities

Local Authorities (ALF)

- Fire Authority – Fire and Life/Safety Approval
- Zoning / Building Code Approval and Enforcement

In addition to the other state agencies, there are a variety of state and local organizations that have some kind of regulatory authority over the operation of an ALF. The following illustration shows a number of the different types of organizations that may be viewed by assisted living licensees as having regulatory authority over some aspect of the operation of the facility.



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.

A quick look at assisted living facility regulation in other states illustrates the variation in approach:

California

California's Department of Social Services licenses what are known as "residential care facilities for the elderly" (RCFEs). The licensing agency no longer annually inspects RCFEs and now randomly selects and inspects 20 percent of the licensed facilities each year. The selection is structured to ensure that every facility is inspected at least every 5 years. Surveyors use a manual that guides the inspection process. The inspection includes interviews with residents and staff and record reviews. The surveyor determines the number of interviews he or she conducts at each facility. Standard protocols are not used. The State expects to make inspection reports available to the public on its Web site in the near future.

Legislation enacted in 2003 requires unannounced inspections of facilities that are on probation, have pending complaints, operate under a plan for compliance, or must have an annual inspection because the facilities receive payment from Medicaid. Inspectors also verify that residents who were required to move from the facility by the department are no longer at the facility.

Texas

The Texas Department of Aging and Disability Services (DADS) licenses assisted living facilities. Facilities are licensed and inspected annually. The inspection team consists of a registered nurse, social workers, and a life safety code specialist. During the inspection, surveyors meet with the person in charge, review the process, and request lists of residents and staff, schedules, training records, incident reports, policies and procedures, the services provided, and the facility's disclosure form. During a tour, the surveyor observes the general operation of the facility and resident activities. General interviews are held with a sample of residents, family members, and staff. A sample of resident records is also reviewed. Residents are asked if they are satisfied with the facility, the services, and food. If they are not satisfied, they are asked for details that may be explored with the manager. Survey reports may be posted at the facility or requested from the department.

New York

New York's Department of Health issues licenses for "adult care facilities" for four years. Facilities are inspected at least annually but no longer than every eighteen (18) months. Inspections include, but are not necessarily limited to, examination of the medical, dietary, and social services records of the facility, as well as the minimum standards of construction, life safety standards, quality and adequacy of care, rights of residents, payments, and all other areas of operation. Two inspections per year are conducted for private proprietary adult homes.

Other types of inspections include:

- Complete inspections prior to certification or renewal
- Complete inspections when there are serious or continual deficiencies
- Summary inspections to determine compliance with key regulatory provisions in all areas of operation
- Partial inspections to examine specific areas of operation
- Inspections in response to a complaint to determine the validity of the complaint
- Follow-up inspections to determine whether deficiencies have been corrected
- Other inspections as necessary

In 2002, New York implemented new policies regarding the oversight of adult homes that included: reinforcement of mandatory death reporting by homes and immediate investigations of such reports; multi-agency profiles of deaths at the homes to identify patterns; and increased surveillance.

Alabama

The State of Alabama does not have a mandated time fame in which to visit every facility and is working on implementing a three year cycle. Alabama implemented a system for rating residential facilities in 2004. Using survey findings, facilities are rated green if they have minor deficiencies, yellow if they have a problem that could pose a substantial risk to residents, or red if the survey found serious risk to residents. Facilities rated red receive full surveys. Shorter surveys are conducted for facilities rated green or yellow. The Alabama scoring system arranges deficiencies into three categories: routine deficiencies that have limited potential for harm; systemic or substantial risk deficiencies that have a high potential for harm; and critical deficiencies that result in actual harm and lead to mandatory enforcement. Routine deficiencies present minimal risk to residents and receive a score only if more serious deficiencies are not present.

Georgia

The Georgia Office of Regulatory Services (ORS) conducts initial, annual, follow-up inspections and complaint investigations of residential facilities. Inspections are generally conducted on an unannounced basis. ORS has the authority to take the following actions against a licensee: fining; license restriction, suspension or revocation; "blacklisting" of individuals or public reprimand. Fines and revocations are the most common actions. Surveyors interview six residents and staff members or ten percent of the residents, whichever is greater, using open-ended questions that elicit information about their well-being, length of stay, how they are treated, if they have had any problems and how they were resolved, and whether they know of problems that other residents have had.

Community-residential care for the frail elderly: What do we know; What should we do?

by
Larry Polivka, Ph.D.

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Introduction

Community-residential care (CRC) is not as easy to define in a precise and straight-forward manner as nursing home care. The concept covers a wide range of congregate living arrangements from room and board housing to adult foster care, assisted living and numerous variations on each of these models based on such variables as facility size, service provision and regulatory standards, funding sources, and resident characteristics. This variation has made it very difficult, if not impossible, to generate a broad consensus in support of a common definition of community-residential care, which could be used for organizing research or developing a universally acceptable regulatory framework. The range of difference within CRC is probably just as great as the difference between CRC and the other long-term care (LTC) settings—home care and nursing homes. The difference between CRC and nursing homes may have begun to shrink in that some assisted living facilities (ALFs) now have highly impaired (cognitively and physically) residents who meet nursing eligibility criteria and some nursing homes have begun to adopt some of the "homelike" features of the assisted living model as advocated by Eden Alternative supporters and the Nursing Home Pioneers group. In my judgment, these trends are not yet extensive enough to justify, on their own, qualitative changes in current regulatory standards for either CRC or nursing homes.

The focus in this paper is limited primarily to the assisted living model of community-residential care. We have also included a short discussion of adult foster care, which has received less research and policy analysis attention than assisted living and is a much smaller part of CRC in most states than assisted living. We think that adult foster care and the small assisted living facilities (5-10 beds), which are often hard to distinguish from adult foster care (1-6 beds) in any substantive fashion, have the potential to play a much larger role in the provision of community-residential care, especially for publicly supported and less affluent elderly persons who need access to a housing and services option. Although the research on adult foster care is even more limited than the relatively small amount of research available on assisted living, we think the findings from the research reviewed in this paper are sufficient to establish the potential benefits of adult foster care and to raise its profile in deliberations over the future of LTC policy.

This review of the literature on assisted living and adult foster care is selective in that we have chosen to focus on the research whose scope and findings we think are most relevant at this point, to the debate over how these programs should be regulated to achieve an adequate quality of care and quality of life and how they can be made more affordable for low-income persons. There are many gaps in the research literature on these programs; and there are substantial methodological limitations, especially in the scope and size of resident and facility samples, in most of the completed research. Nevertheless, we think there are now enough findings of

sufficient scientific quality to justify their use in assessing the relative merits of alternative regulatory and funding strategies. We consider our efforts in this respect to be preliminary and subject to revision as more findings become available.

We have incorporated the results (recommendations and rationales) of the Assisted Living Workgroup (2003) into our discussion of the policy (regulation and funding) implications of our literature review. The workgroup was not of one mind in the formulation of regulatory guidelines. We think, however that the results of the workgroup are important in framing the debate over assisted living regulation and that most of the recommendations, including some that did not gain majority support, are largely consistent with the available research findings on assisted living.

The paper is divided into four sections. The first section includes our selective review of the research literature on assisted living and adult foster care. In the second section we discuss the implication of the findings from this research for several regulatory issues and alternative approaches to ensuring an adequate quality of care and quality of life in assisted living. Our discussion of the results of the Assisted Living Workgroup is also included in this section. The third section is a brief discussion of assisted living affordability issues and the fourth section presents our concluding comments and a suggested assisted living research agenda.

The rapid growth of the assisted living population over the last decade is clear evidence of the appeal of this housing and services long-term care option and of what the industry describes as its core values of privacy, autonomy, dignity and a homelike environment.

However, the assisted living industry has received considerable negative media attention over the last two-to-three years. Most of this attention has focused on the quality of care received by some residents in a few facilities. A GAO study (1999) found that many facilities do not provide residents, or potential residents, with enough information about costs, services and retention policies. Some facilities may not be accurately representing their services and facility rules in their advertising.

Although these media reports are not evidence of extensive quality of care problems in the industry, they have sparked discussions in some quarters about the possible need to regulate assisted living more stringently. This emerging discussion has raised concern within the assisted living industry that it could lead to growing political support for a regulatory approach based on the way we currently regulate nursing homes. Some policy and consumer advocates argue that as the population of more seriously impaired residents and those with acute medical conditions in ALFs grows, the regulatory scheme should become medically oriented and more stringent in terms of who is allowed to enter and remain; what kinds of services can be delivered and by whom; and how the quality of services will be defined and monitored.

The potential for significant regulatory reaction to these negative media reports makes it imperative that policy analysts, policymakers and advocates gain a clear understanding of the currently available research findings on assisted living and pay careful attention to the results of research as they are reported over the next several years.

This is an area where research can have an enormous impact on policy, given the nature of the dilemma facing policymakers. The tension between independence and safety, between a homelike environment and fire-safety, and between autonomy, privacy and the risk of medication errors must be carefully balanced. While no one wants to put assisted living residents at unreasonable risk, it is in defining and operationalizng "unreasonable risk" that the fundamental values of both assisted living and our commitment to protect the health, safety and welfare of vulnerable persons must be weighed and worked out.

What do we know about community-residential care?

The research on assisted living has grown along with the industry over the last ten years with the most extensive and significant findings becoming available in just the last few years. Although there are still major gaps in our knowledge of assisted living and important questions that remain largely unanswered, we now have a good deal of information that can help us think constructively about the future of the assisted living industry.

Among the most important sources of information are the three reports produced by Catherine Hawes, Charles Phillips and their colleagues since 1999. These reports, based on research funded by the office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services, have begun to give us a comprehensive, empirically sound view of assisted living, which addresses, directly or indirectly, many of the issues that are most integrally related to regulation.

In their first report, *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities*, Hawes, Rose and Phillips (1999) have focused their research on a national sample of high-privacy or high-service facilities or facilities that are characterized by both, which they estimate to be about 40% (4,300) of all ALFs across the country housing about 190,000 residents. Their sample consists of 1,500 residents drawn from 300 facilities.

The second report, *High Service or High Privacy Assisted Living Facilities, Their Residents and Staff: Results from a National Survey* (2000), contains several findings relevant to regulatory and other policy issues in assisted living. During a 12-month period, 19% of the residents in the sample facilities were discharged. Only 8% were discharged to nursing homes and almost 4% to other ALFs. Overall, 60% of those who moved did so in order to receive a higher level of care. Only 12% of those who moved indicated, through proxy respondents (family members), dissatisfaction with the care they had received in the facility they left. A decline in cognitive status was the only resident variable that significantly increased the likelihood of entering a nursing home. The authors also found that:

> Residents in facilities with a fulltime RN involved in direct care were half as likely to move to a nursing home. When different formulations of staffing/service variables were used (any RN staffing, RN hours per resident, aide staffing, arranging for nursing care), the relationship between services and outcomes was not significant. It appears that these alternative staffing arrangements, or just better staffed facilities, are no substitute for a fulltime RN who does direct care. These findings, along with those about the effects of cognitive status, would seem to have major policy implications for aging in place.

In their third report, *A National Study of Assisted Living for the Frail Elderly: Final Summary Report*, Hawes and Phillips (2000) found that resident and staff assessments of their facilities were generally positive.

- The majority of residents reported that they were treated with affection (60%) and dignity (80%).
- They also, however, reported some level of concern about staffing levels and turnover rates; and
- 26% indicated that they needed more help with toileting activities.
- Ninety percent of the residents thought they could stay in their facility as long as they wanted to remain, but most were uninformed about policies governing retention and discharge from their facility. This supports the GAO findings and indicates a need for more public disclosure regarding these and other (service costs) policies.
- The vast majority (85%) of their respondents reported that their top two priorities on entering the ALF were the availability of a private bath (#1) and private bedroom.
- Among those who had left an ALF (19% over 12 months) most (65%) continued to identify these same privacy-oriented priorities. The other 35% of those discharged identified the presence of an RN or staff and the quality of the staff as their top two priorities.

Rosalie Kane and her colleagues (1998) found that ALFs and nursing homes in Oregon achieve comparable outcomes in terms of activities of daily living (ADL) trajectories, pain and discomfort levels and psychological well being, after controlling for differences in baseline conditions. Although nursing home residents were substantially more impaired than those in ALFs, these findings are encouraging in terms of the capacity of ALFs to accommodate "aging in place" by providing necessary healthcare services. It should be recognized that Oregon has a relatively mature assisted living industry, regulatory policies and public funding strategies designed to maximize the nursing home diversion potential of ALFs and the opportunity for assisted living residents to exercise choice, including the decision to "age in place."

We know that there are many seriously impaired residents in ALFs across the country and not just in Oregon. In Florida, about 25% of ALF residents in 1995 had three or more ADL impairments or had serious cognitive impairments (Polivka, Dunlop and Brooks, 1997). A recently completed study (Mitchell, Salmon, Chen & Hinton, 2003) found that Florida's Medicaid waiver-funded Assisted Living Program (about 3,500) had a far higher percentage of persons with no caregiver (87%) and with a dementia diagnosis than any other home- and community-based program and even higher percentages in each of these categories than in the nursing home population.

A recently reported study by Hedrick , Sales, Sullivan et al. (2003) on assisted living, adult foster care and adult residential care in Washington state found that persons at every impairment level, including the highest (limitations in all six ADLs) residing in assisted living, although the adult foster care homes tended to have a higher percentage of more impaired residents and lower payment rates. The study also found very high levels of resident satisfaction in the assisted living and adult foster care programs, with 92% of the residents reporting that moving to the setting was a good decision. The residents also reported "very high levels of satisfaction with each aspect of care (p. 480)."

Payment rates ($50-70 per day) in Washington's assisted living program are higher than the rate for adult foster care ($40 per day in 1998), mostly because of state regulations requiring them to provide private rooms (single occupancy) and kitchenettes, which allow for greater resident autonomy and privacy. Hendrick and her colleagues note that:

> . . . AL residents were significantly more satisfied with respectful treatment from staff and with their apartment or room, possibly indicating the influence of the stated AL philosophy of autonomy and privacy, and the required physical layout of separate apartments with lockable doors, kitchenettes, and the like (p. 481).

These are important "facts on the ground" that have major implications for the future of assisted living regulation and its role in the long-term care system. These studies are based on relatively small samples and much more research on these questions is needed. We can speculate, however, about the significance of these findings for long-term care policy generally, and regulation more specifically. For example, to the extent that personal control and autonomy are important determinants of quality of life in long-term care, assisted living may be the optimal setting of care, including many now receiving care in their own homes. This is optimal in the sense that assisted living may be for many frail elderly persons the best setting for achieving an effective balance between control/autonomy and supportive services including healthcare, and more human interaction to combat loneliness. For many frail elderly persons with thin or non-existent caregiver networks, assisted living may also be the best setting in which to achieve personal control and autonomy. Recently completed research in Florida highlights the significance of these values to long-term care consumers. In a study of quality of life in nursing homes, assisted living facilities (ALFs) and in-home long-term care programs in Florida, Salmon (2001) found that the major predictor of quality of life was the degree of personal control the respondent experienced. Those in ALFs expressed the greatest satisfaction with their quality of life and the level of personal control they experienced. The respondents in the home care programs expressed a clear preference for home care over nursing homes, but they reported less satisfaction with both their quality of life and personal control than the assisted living respondents.

ALFs can offer the kinds of resources, especially staff services, transportation and social activities, necessary to make the achievement of control/autonomy a far more practical matter than may be possible in many in-home environments, where achieving the same level of opportunity to exercise personal control is beyond the financial means of most individuals or the public sector to provide, or too great a burden on the individual's informal care providers. These possibilities should be kept firmly in mind as we think about assisted living regulation and the full potential of assisted living as a long-term care program.

Indirect, but compelling evidence supporting this perspective is provided in the third Hawes and Phillips (2000) report. The vast majority (85%) of their respondents reported that their top two priorities on entering the ALF were the availability of a private bath (#1) and private bedroom. Among those who had left an ALF (19% over 12 months) most (65%) continued to identify these same privacy-oriented priorities. The other 35% of those discharged identified the presence of an RN or staff and the quality of the staff as their top two priorities. The importance

of these privacy provisions indicates that many residents value the opportunities for privacy in assisted living very highly and expect to find these provisions in place. It should also be noted that privacy is often a necessary, if not always sufficient, condition for the effective exercise of personal control/autonomy and for maintaining interpersonal relations.

Privacy may be especially important for the quality of life for cognitively impaired residents. A recent study by Zeisel, Silverstein, Hyde et al. (2003) of 427 residents in 15 Alzheimer's special care units, ranging in size from 20 to 50 residents, found that:

> The environmental features associated with both reduced aggressive and agitated behavior and fewer psychological problems include (privacy) and personalization in bedrooms, residential character, and an ambient environment that residents can understand. Characteristics of the environment associated with reduced depression, social withdrawal misidentification, and hallucinations include common areas that vary in ambiance and exit doors throughout the SCU that are camouflaged.
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> . . . the design features, by providing residents with greater control over their own lives, empower them and thus reduce their tendency to withdraw and even to be situationally depressed.
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> . . .SCUs should strive to model their interior environments after homelike settings to reduce aggressive and other symptoms. Applied in design of SCUs, these findings will lead to more private and less shared rooms, variation in common room design within an SCU, common rooms for activities located at ends of hallways, and doors located along side walls whenever possible instead of at the end of hallways where they act as "attractive nuisances." (p. 709)

Sheryl Zimmerman and her colleagues (2001) have conducted extensive survey research in assisted living facilities and nursing homes in New Jersey, North Carolina, Florida and Maryland. They broke their assisted living sample into small (under 16 residents), traditional (16 and over residents) and new model facilities (purpose built and with 16 residents), and surveyed a total of 233 facilities in the four states. Among some of the more interesting, policy relevant findings, they found that:

> . . . with the exception of a discharge policy related to the inability to walk, it makes no difference whether residents are in small, traditional, or new-model facilities in terms of whether the facility is likely to discharge them based on resident characteristics. Factors that do seem to make a considerable difference are the state in which the facility is located, who owns the facility, and the age of the facility. (p. 234)

For example:

> Compared with facilities located in North Carolina, facilities in Florida are more likely to have a discharge policy for residents who are unable to get out of bed, who are unable to feed themselves, or who are unable to care for their appearance. . . . For-profit status is also associated with a greater tendency to discharge for ADL-related reasons, particularly an inability to bathe, dress, or maintain continence. Finally, as the age of the facility

> increases, so does the propensity to discharge residents who are unable to walk, eat independently, or maintain urinary or fecal continence. (p. 234)

The new model facilities score higher on policy choice, privacy and policy clarity than the other facility types. The traditional and new-model types both provide more health and social services than the small facilities.

These findings indicate that the larger and newer facilities are better able to provide services and meet the privacy and autonomy desires of residents. Small facilities, however, may provide more familial, homelike settings that many impaired elderly seem to prefer and are willing to give up some privacy and autonomy in order to live in such facilities. Many may also prefer to age in place in small facilities, even in the absence of some of the health services offered by larger facilities. The major point is that potential residents should have an array of facility types, including small, less-sophisticated facilities, to choose among. It should also be noted that smaller facilities are often more willing to take Medicaid and SSI-supported residents than larger facilities, which has major implications for state long-term care policy, as Medicaid-waiver funds are increasingly used to expand congregate alternatives to nursing homes.

Morgan, Eckert, Gruber-Baldini and Zimmerman (2002) suggest that researchers, policymakers and regulators exercise caution in defining and comparing facilities for purposes of descriptive and evaluative analysis, and for regulating the range of facilities that may be described as assisted living. Small facilities, for example, may not be able to offer the same level of control and autonomy, or service as larger, purpose-built (new paradigm) facilities, but residents, as noted above, may well find them more homelike, more affordable and accommodating enough in terms of autonomy/control, especially in comparison to the nursing home setting or even their own homes. In sum, the advantages and shortcomings of the whole range of assisted living options should be recognized without claiming that one style of assisted living is necessarily superior to another or better designed to meet everyone's needs, preferences or ability to pay.

Policies, funding and regulatory strategies should reflect our awareness of and support for the different forms of assisted living and the need to provide the consumers with as many options as possible to choose from, as long as they are consistent with the basic values of the assisted living philosophy and basic safety requirements. This means that small facilities should not be held to precisely the same standards, which they are not likely to meet as the larger, purpose-built, new paradigm facilities. Zimmerman, Eckert, Morgan et al. (2002) note that if regulation and funding turns on adherence to the new paradigm's parameters, it may mean the demise of the smaller facilities. This perspective will undoubtedly complicate the way assisted living is regulated, but if it results in maintaining, or supporting the expansion of the range of community-residential options available to consumers of housing with services, then it should be considered worth the additional complexity.

Community-residential care may also be provided in adult foster homes, which are much smaller and less formal than conventional assisted living facilities. Adult foster care (Adult Family Care Homes) in Florida is provided in small group residential settings, usually private

homes, which, in Florida, are allowed to have up to five residents. Stark, Kane, Kane and Finch (1995) have described adult foster care homes as:

> . . . a cottage industry of sorts. Typically, foster homes cannot make a profit unless they have a lean staff—perhaps limited to family members of the foster care provider and a few hired helpers for peak hours. Such foster homes obviously cannot use an elaborate division of labor; they depend on a flexible ability to handle whatever needs to be done. Ordinarily, they will be unable to care for Medicaid or low-income clientele with heavy levels of disability unless state regulation permits nursing functions to be done by foster care personnel without nursing licenses or unless (for Medicaid) reimbursement is high enough to permit contracting with nurses.

In a comparative study of adult foster homes and nursing home residents in Oregon, Stark et al. found that functional outcomes, controlling for a wide range of client health functional status and demographic characteristics, were comparable in the two settings and social and psychological outcomes have a propensity to favor foster care. These kinds of findings should help allay fears that adult foster care cannot serve seriously impaired persons and reduce nursing home utilization.

This type of long-term care setting may be especially appropriate for persons with early-to-mid-stage dementia who could benefit from the small scale and relatively intimate environment of foster care. Oregon made adult foster home care a major pillar of its home- and community-based long-term care system in the 1980s, and now has over several thousand foster home beds compared to fewer than 2,000 in Florida. Oregon covers adult foster homes under their home- and community-based Medicaid waivers, but 70% of the residents are paying their own way (private pay), which reflects both the affordability and consumer appeal of the program.

In short, adult foster care in Oregon has become a mainstream long-term care option available in both upscale, elaborate homes and in modest homes in less affluent neighborhoods. The Oregon experience demonstrates that Florida is absorbing considerable opportunity costs by not maximizing the potential of adult foster care. If Florida had the same ratio of foster homes in relationship to its 65+ population as Oregon, there would be as many foster home beds as Medicaid-supported nursing home beds—over 60,000.

Findings from Morgan, Eckert and Lyon's (1995) study of small board and care homes in Baltimore and Cleveland also support the view that adult foster care homes have the capacity to serve a wide range of residents, including those with serious impairments, in a fashion consistent with the preferences of residents for the most homelike settings available. The authors point out, however, that the popularity of small board and care, or foster homes could increase the perception among policymakers that they need to be more rigorously and conventionally regulated, which they think could eventually lead to their extinctions, or at least substantially reduce their affordability and overall appeal.

Instead of trying to abolish risk through the imposition of extensive regulatory requirements, the authors recommend several policy initiatives designed to strengthen foster care and make it more available. They recommend:

- More financial support including increased per diem rates and more funded slots (beds).
- More case management services and advocacy for residents which could contribute more to the resident's quality of care and life from annual or even quarterly regulatory inspections.
- Policymakers should accept the notion that care cannot be given without some risk to the vulnerable. The authors note that:

> . . . to eliminate risk beg the question of whether it is possible to achieve this goal in light of the severely and multiply impaired populations housed in board-and-care homes. It is unclear whether regulation simply provides the illusion of control in caregiving systems that are, at their core, reliant on the goodwill of workers to meet the desired goals.
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> The great majority of the homes that we saw were of good quality without regulation. They relied upon the altruism and motivation of their operators to guarantee that the needs of residents were met and that their safety was protected. If the personnel are key to ensuring care of high quality, then all of the emphasis on physical structure and recording of routine care is misdirected. Regulations would best be directed at initial screening of operators and ongoing observation of them during interactions with their residents, rather than checking for adequate hallway width and food storage. (p.205)

The authors also note that ensuing a high quality of care for residents is significantly dependent on policymakers and the general public acknowledging and respecting the work of caregivers.

- Finally, Morgan and collegues' fundamental recommendation is "to preserve the small home." The authors' research revealed that:

> Small size also permits flexibility, personalization, and building of more direct, ongoing linkages that characterized the best of the homes we visited in both of our locations. As the twin pressures of cost-containment and quality control push care toward an assembly-line, rationalized state, it was encouraging to us to see the personalization of care achieved in the small board-and-care homes. Attention to individual detail in planning meals and outings can, for example, separate adequate care from a more personal ideal to which many in American society would readily subscribe. (p. 204)

Community-residential care, whether in the form of assisted living or foster care, is not for everyone requiring long-term care assistance, especially those with extensive, complex medical care needs. As noted by Stephen Golant (2003), "ALFs will be neither the initial nor the final home for most frail older adults who seek alternatives to nursing homes."

Golant also points out, however, that ". . . older residents who are admitted to these facilities may be able to enjoy relatively long stays—on average as much as three years. Thus, although they probably will not age in place in their ALFs, they may receive sufficient benefits to justify their having to move again to a higher care facility."

I am a bit more optimistic in that I think a substantial amount of "aging in place" is already occurring in ALFs and the number of residents who "age in place" without ever entering a nursing home is likely to increase in the future. I also think that, unless the federal government expands its commitment to subsidized housing, assisted living will increasingly become the "by default" housing option for many low-income, impaired elderly persons over the next 20 years.

As the population of more highly impaired residents increases, the pressure to impose a more medical-model oriented regulatory scheme on assisted living is likely to grow. Some of these regulatory changes may be necessary on a facility-by-facility basis. On the whole however, I think they should be resisted in order to continue the effort to achieve the original vision of assisted living as a values-driven housing and services model of long-term care.

Implications of what we know for regulating assisted living

Before addressing assisted living policy specifically, we should recognize that the vast majority of older people and their families strongly prefer home- and community-based alternatives to nursing home care. They simply and understandably do not want to live in a highly regulated institutional environment. The primary reasons for this strong preference are the desire to maintain a modicum of personal control and to preserve their privacy and dignity to the maximum extent possible. This consumer preference is the fundamental rationale for creating a far better balanced system of long-term care than is currently available to the frail elderly, particularly those dependent on public support. Over 80% of all public long-term care funds are spent on nursing home care in most states. Both assisted living and home care should be vastly expanded in response to the deep preference among the elderly for alternatives to nursing homes. At this point, however, assisted living is probably the most under-developed alternative program, at least in the public sector. Eighty to ninety percent of the assisted living growth since 1990 has occurred in the private sector and states, on the whole, are just beginning to develop and expand their assisted living programs, primarily through Medicaid waiver initiatives.

The pervasive preference among the elderly for alternatives, including assisted living, to nursing homes should not be frustrated by excessive or inappropriate regulation. Assisted living has demonstrated the capacity to serve seriously impaired residents effectively (resident satisfaction, quality-of-care outcomes, etc.) and regulations should be designed to maximize this potential through the use of flexible, inclusive admission/retention criteria. Providers can help maximize this potential by providing necessary care, including fulltime RN care, for residents with healthcare conditions that require continuing care. Older people highly value autonomy, privacy and the opportunity to age in place and the preservation/enhancement of these values should be the top priority in the development of assisted living regulations.

As noted earlier, for many frail elderly, assisted living is a more propitious setting for achieving these values than even in their own homes. The only sure outcome of imposing a nursing home mode of regulation of assisted living would be precisely what we have achieved in nursing homes—a rigid, institutional environment that leaves little room for consumer-direction and resident autonomy, privacy and spiritual well-being. We should pay more attention to reversing these outcomes in nursing homes and avoid creating a regulatory framework that could

have the same results in assisted living. The wide variance in assisted living regulation across the states represents a natural laboratory and every effort should be made over the next five-to-ten years to determine the relative costs and benefits of their regulatory strategies. We need this information before we prematurely decide to move to a single national regulatory framework. Researchers are already developing a body of knowledge that will be very helpful in the development of reasonable regulations over the next decade. Anecdotal accounts in the media should not lead to a "rush to judgment" and the implementation of conventionally stringent regulations that could kill the very thing we should be most committed to preserving—the fundamental values of assisted living.

Serious consideration, however, should be given to Hawes and Phillips (2000) findings concerning the impact of cognitive decline and the role of RN care in preventing movement to a nursing home or in facilitating aging in place. Providers should be prepared to use this information in the development and deployment of their services and policymakers/regulators should monitor these areas carefully and consult closely with providers and advocates before deciding how they should be interpreted from a regulatory perspective. Clearly, however, the provision of sound dementia care and skilled nursing care are essential components of any efforts to maximize the aging-in-place potential of assisted living.

I think we could also enhance the quality of care by requiring that residents taking more than four medications have their medication regimen evaluated by a consultant pharmacist at least annually. Pharmacists are more generally knowledgeable than physicians or nurses about medications, and physicians are usually willing to listen to pharmacists and adjust prescriptions accordingly.

Given these research findings and their policy implications, we think states should, for the most part, continue to take a very cautious approach to assisted living regulation. We need to learn more about the effects of the different regulatory schemes across the states, the impact of Medicaid waiver funding on the demographics of assisted living and a wide range of outcomes, including the extent of assisted living's capacity to substitute for nursing home care and the capacity of assisted living to provide specialty care, especially dementia care. The already valuable body of research findings will grow substantially over the next few years and help us make far more informed decisions about regulation than we are prepared to make now.

Our discussion of specific regulatory domains includes a review of some of the results of the Assisted Living Workgroup (2003). The Workgroup was formed in response to congressional concerns about assisted living regulation. The recommendations, rationale statements and responses of the several organizations that participated in the Workgroup constitute an informative commentary on current views of assisted living and long-term care policy in general. The recommendations and responses to them reflect basic philosophical differences among trade and professional associations and advocacy organizations about how to regulate assisted living. Generally speaking, participants divided into three groups with the majority supporting a regulatory approach based on the assisted living principles of resident choice, autonomy and privacy and programmatic flexibility, a second group supporting a substantially more prescriptive approach based on safety and quality of care priorities and a

third, smaller group which felt that many of the recommendations were too prescriptive on regulatory issues that should be left to the states.

In our view, the vast majority of these recommendations are sound in that they effectively reflect the philosophical framework that is the source of assisted living's value to residents and are consistent with the currently available research. The recommendations, on the whole, provide a workable framework for the development of state regulations—they provide a clear direction without being burdensomely prescriptive. We respectfully disagree with the several participating organizations in whose view:

> . . . most of the recommendations from the Assisted Living Workgroup are not appropriate for adoption by the states. For states that have recently revised their assisted living regulatory approach, adoption of the recommendations in the Assisted Living Workgroup report would in nearly every case be a step backwards, increasing the risk of adverse outcomes to thousands of consumers. Rather than follow the report's recommendations, those states seeking to revise their current assisted living regulations should consider measures adopted by other states in recent years. (p. 31)

Limiting the risk of adverse outcomes is certainly a critical regulatory goal. Adverse outcomes, however, include more than healthcare related safety issues. They also include imposing regulatory standards that would undermine the qualities that make assisted living such an attractive housing and services option for thousands of cognitively and physically impaired people by implementing admission and retention criteria that eliminate assisted living as a choice for many people, safety-oriented regulations that would create a more regimented environment and diminish the freedom of residents, staffing standards and qualifications that would make assisted living even less affordable for both private-pay and publicly supported residents than it is now with rapidly growing waiting lists for potential residents who qualify for Medicaid waiver-supported assisted living programs.

Regulatory standards vary across the states, but the history of assisted living regulation in Florida does not support the opponents position that "adoption of the recommendations in the Assisted Living Workgroup report would in nearly every case be a step backwards . . . (Assisted Living Workgroup, 2003, p. 31)." Florida began to make assisted living available to more impaired persons in 1991 with the development of a "values-based" assisted living licensure category called extended congregate care (ECC), which is referred to favorably by the opponents in one of their dissents. The evolution of ECC regulations over the last ten years can best be characterized as steady movement toward adopting the regulatory standards contained in most of the Workgroup's recommendations. This movement toward a less restrictive, medically oriented regulatory model has been motivated by a desire to accommodate consumer preference and increasing confidence on the part of regulators, policymakers and advocates that an effective balance between achieving the assisted living values (choice, privacy, dignity) and ensuring sufficient safety can be maintained. This confidence is based on ten years of experience (over 400 facilities now have an ECC license) and the research findings we discussed earlier, especially findings related to consumer preference, resident satisfaction and the relative cost-effectiveness of assisted living as a long-term care program. Regulatory vigilance is certainly necessary; but, at

this point, there is little reason to think this regulatory trajectory will be reversed in the future, given the popularity and demand for assisted living.

This division among workgroup participants is evident in responses to many of the most important, defining recommendations. The following excerpts from written responses to the recommendation on components of a state accountability and oversight system for assisted living are reasonably representative of the positions taken in support of and opposition to many other pivotal recommendations. The recommendation states that:

> The regulatory system for assisted living is founded on these principles:
> - A regulatory system for assisted living is responsible for abating harm and support the resident's decision-making control.
> - The regulatory system ensures that there is meaningful assisted living stakeholder participation, especially resident participation, when defining regulatory standards.
> - The regulatory system specifies that the practices, protocols and methods by which are provided are respectful of, and responsive to individual resident preferences, needs and values and that resident values guide care and service delivery decisions.
> - Regulatory requirements should be periodically re-evaluated to determine whether or not they are achieving their intended effect (p. 36).

> This approach seeks to combine elements of traditional regulatory systems having to do with deterrence and abatement of harm with other modes for monitoring and improving performance and quality of care. . . . This new approach would align the values associated with assisted living (autonomy, choice, dignity) with the outcomes to be accomplished and the means to evaluate the effectiveness of services within a system that encourages and rewards excellence while retaining traditional state responsibility for vigorous rule enforcement when necessary. (p. 38)

The Workgroup participants who oppose this recommendation and support a more healthcare and safety-oriented regulatory approach throughout the report take the position that although they support much of this recommendation, they do not support the assumption that:

> . . . the most significant problem faced by AL regulators is ensuring that residents have enough decision making control. . . . The introductory principles, by elevating resident choice above all other concerns would be an impediment to an effective regulatory system. The majority diverts attention from the truly important issues. Ignoring the prevalence of care and safety problems in the assisted living setting, it directs regulators merely to make sure that residents have the right to make choices. This is neither useful nor rational as a response to the growing crisis in resident safety and well-being. (p. 39-40)

We discuss several more specific regulatory issues in the following section.

1) **Disclosure**. The Assisted Living Federation of America (ALFA) and other organizations have already moved to develop programs for fully informing (potential) residents and their families about what services facilities offer, how much they cost and how costs change in response to changes in resident need, aging-in-place policies, physical environments and other issues identified by the GAO as full disclosure problems in assisted living. This is an

issue that probably needs to be clarified by state regulators, especially in the area of dementia care. Residents and their families should not be surprised by provider decisions.

The Assisted Living Workgroup recommendations regarding disclosure for specialized programs of care provides a useful framework for developing regulations in this area:

> At a minimum, the ALR shall disclose the following information to each prospective resident prior to admission:
> - The ALR's philosophy of the special care program.
> - The process and criteria for placement in, and transfer or discharge from, any specialized unit and/or the ALR.
> - The process for assessing residents and establishing individualized service plans.
> - Additional services provided and the costs of those services relevant to the special care program.
> - Specialized (condition-specific) staff training and continuing education practices relevant to the special care program.
> - How the physical environment and design features are appropriate to support the functioning and safety of residents with the specific conditions(s). (p. 274)

The importance of these provisions is highlighted by the fact that a large portion of the assisted living population is cognitively impaired and is likely to grow rapidly in the future. In fact, assisted living may well become the long-term care setting of choice for most persons with significant cognitive impairment, if current trends continue and confidence in assisted living's capacity to provide optimal care for the cognitively impaired increases across the country. Already in Florida, the Medicaid waiver-supported assisted living program has a far higher percentage (50-73%) of residents who have been diagnosed as cognitively impaired than are among the populations of any other waiver-supported program.

2) **Fire safety**. Appropriate fire protection provisions should be part of any regulatory scheme and there may be some need to standardize requirements across jurisdictions in order to ensure efficient approaches to a uniform level of safety, which does not unduly restrict access to and availability of community-residential care.

3) **Admission and retention criteria and staffing levels**. In order to maximize consumer choice, admission and retention criteria should be as inclusive and flexible as possible and staffing should be sufficient to meet the needs of individual residents. Restrictive criteria would keep many frail elderly out of assisted living, diminish the quality-of-life conditions they want or force them into nursing homes, as would uniform staffing standards, by making assisted living less affordable. Staffing should be based on assessed resident needs and regulated accordingly.

The failure of the Assisted Living Workgroup to provide two-thirds majority support for the recommendations promoting access to assisted living for individuals with personal healthcare needs is disappointing. No healthcare need treatable in a person's own home should be a barrier to admission to assisted living or an automatic trigger for discharge. As noted by supporters of the failed recommendation:

> Many individuals with personal healthcare needs are capable to manage their care. Others have the ability to self-direct their care with occasional assistance from qualified caregivers or trained staff. These conditions can be easily managed in a home environment, and therefore are manageable in the ALR. It would be discriminatory to exclude individuals with personal healthcare needs from living in an ALR. (p. 156)
>
> The failure of Recommendation D.14, by one vote, on March 4, 2003, represents a major setback for people with disabilities and other older Americans who may develop personal healthcare needs and wish to choose assisted living as an alternative to nursing home care. . . . Current state assisted living regulations prohibit many individuals with disabilities and other aging individuals who may acquire conditions later in life from admission to assisted living because these individuals require the use of a catheter, require oxygen, or have some form of medical ostomy. Additionally, current state assisted living regulations can also require a person with a disability to leave their assisted living home when they develop a temporary medical condition that requires bed rest, i.e., severe colds or Grade I or II pressure ulcers. (p. 157)

As an alternative to this recommendation, one group of opponents recommended:

> . . . a system that would establish levels of care within assisted living—for example, the Florida system that licenses assisted living residences for either Limited Nursing Services or the more extensive Extended Congregate Services. (Florida Administrative Code Ann. R. 58A-5.030- 5.031). Such a system would help assure that an assisted living residence would be prepared to meet the needs of a resident with a significant health care condition. (p.158)

It is interesting to note here that the initial version of the Extended Congregate Care (ECC) licensure category included a number of healthcare procedures that could not be provided in ECC licensed facilities, restricting admission and retention to a much greater extent than intended by originators of the ECC proposal. Since then, however, prohibition on these procedures have been gradually removed and the only restriction now is the one contained in the Assisted Living Workgroup's recommended definition of assisted living—that is, only those requiring 24-hour care are not allowed in assisted living. The Assisted Living Workgroup staffing recommendations state that:

> The ALR shall ensure that the right number of trained and awake staff are on duty and present at all times, 24 hours a day, 7 days a week, to meet the needs of residents and to carry out all the processes listed in the ALF's written emergency and disaster preparedness plan for fires and other natural disasters. (p. 313)

The evidence to date indicates that assisted living has a highly diverse population, including a large number of residents who are seriously impaired, both cognitively and physically. These "facts on the ground" should reassure policymakers and advocates that properly managed facilities have the capacity to serve the frail resident and support extensive "aging in place." As noted elsewhere in this paper, we think that regulations and funding levels will probably have to be modified as the number/percentage of seriously impaired residents with substantial medical needs increases in the years ahead, especially in regard to the availability of RNs and training/retention of direct care workers. We also think, however, that experience and research, to date, indicate that these modifications can be made without

materially interfering with the pursuit of the goals (values) of assisted living or making it qualitatively less affordable. Imposing staffing standards like those required of nursing homes, however, would most certainly reduce affordability.

There is no compelling evidence that requiring assisted living facilities to staff at levels commensurate with resident needs, as recommended by the Assisted Living Workgroup and currently required by many states, jeopardizes resident safety or systematically threatens their quality of care. Staffing at assessed need levels is a more challenging regulatory approach than relying on simple, uniform staffing standards, but it can and is being done (in some states for several years) and the affordability benefits seem to outweigh any downside risks at this point. I think this recommendation takes us about as far as we need to go at this point in developing a regulatory standard for retention. The Assisted Living Workgroup's recommendations regarding reasons for resident transfer or move-out provides guidance in determining when a facility's staffing and other resources may no longer be sufficient to provide adequate care.

> . . . Following a documented assessment, ALR is no longer able to care for the resident due to his/her physical, or mental/cognitive status or behavioral issues based on the scope of services offered or coordinated by the ALR as disclosed to the resident upon move-in and as required by, state licensing requirements; and, wherever practical and except in an emergency, the ALR has attempted to work with the resident so that move-out or transfer would be unnecessary and this attempt has been unsuccessful. (p. 128)

Findings from a recent study by Ball et al. (2004) demonstrate the complex and often idiosyncratic nature of "aging in place" in assisted living facilities: there may be as many ways of "aging in place" as there are ALF residents and regulations specifying the terms of retention very precisely are likely to end up displacing many residents whose quality of life is entirely dependent on remaining in their ALF. Ball et al. conclude that resident pathways to "aging in place" are:

> . . . influenced by multiple factors relating to the wider community outside the home, the physical and social environment of the facility, and the individual resident. The relationship between these factors was complex and dynamic, and the phenomenon of aging in place represented a balancing act that depended on how various factors acted and interacted in the context of each ALF. Central to a resident's ability to age in place was ultimately the "fit" between the capacity of both the facility and the resident to manage resident decline. (p. 205)

The regulatory framework for aging in place should probably focus on disclosure by requiring that facilities clearly indicate what residents can expect in terms of services and the capacity of the facility to meet the needs of seriously impaired or sick residents. Even then, however, facilities may decide to accommodate the desires of seriously declining residents for many uniquely personal reasons (friendship bonds) and policy makers must be careful to avoid heavy-handed regulatory intrusion into the facility-resident relationship.

4) **Negotiated risk**. Negotiated risk contracts, if clear, non-coercive conditions are met, should be permitted on an expansive basis in assisted living. The use of risk contracts will continue

to evolve in response to law and regulation over the next ten years and are likely to become an increasingly important vehicle for consumer choice and direction and aging in place. Special provisions will need to be made for those who are cognitively impaired.

The Assisted Living Workgroup's recommendation concerning shared responsibility agreements provides a workable framework for developing equitable (no waiver liability) agreements between providers and consumers, which are simply necessary if many persons are to be admitted or allowed to remain in an assisted living facility. As noted by several supporters of the recommendation:

> Perhaps the most useful part of the recommendation is its detailed outline of a process for negotiating such agreements. Many states require negotiated risk or shared responsibility agreements without providing guidance on how they should and should not be developed. The process recognizes that the provider has a responsibility to identify the consumer's preferences as well as potential risks that may be associated with certain behaviors. The process also recognized that not all courses of action are possible or reasonable, but that resident preferences should be honored even when the provider does not believe them to be in the resident's best interest. (p. 153)

Opponents of the recommendation feel that:

> The rationale emphasizes that the "shared responsibility" process is to be employed when the assisted living residence disagrees with decisions made by the resident, even if the only person affected is the resident himself or herself. This raises the inference, confirmed by the debate within the Workgroup, that shared responsibility agreements are designed almost exclusively to protect the facility from regulatory requirements and legal action. (p.154)

This concern, however, must be weighted against the desire of the consumer to enter or remain in a facility under terms of negotiated exception to facility rules and procedures and at some recognized risk to the consumer; precluding such agreements would seem to place an undue restriction on resident choice.

5) **End-of-life care.** As the number of assisted living residents with serious healthcare needs grows and many of them with terminal conditions do not want to move to a nursing home or hospital, or return home, facilities will increasingly have to provide hospice care. There is little reason to think that assisted living cannot provide effective end-of-life care if sufficient accommodations are made. The Assisted Living Workgroup's recommendation for hospice care states that:

   1. If the ALR is able to provide or arrange for the provision of hospice care, the ALR should inform terminally ill residents of the availability to receive hospice care at the ALR. The ALR should identify and make available to residents information about hospice services and the names and addresses of providers in the geographic vicinity.
   2. When a terminally ill resident is receiving hospice care, transfer from the ALR may not be required, if the needs are being met.

3. The ALR and hospice communicate, establish, and agree upon a coordinated service plan that reflects the hospice philosophy and is consistent with regulatory requirements.
4. The service plan identifies the provider/caregiver/family members that is to be held responsible for implementing the service plan.
5. The ALR and hospice determine a process by which information from the hospice interdisciplinary team and the ALR interdisciplinary team will be exchanged when developing, and evaluating outcomes of care and updating the service plan. (p. 135)

6) Dementia care. The industry should develop a set of model guidelines for dementia care which could be used by states to develop regulatory standards designed to ensure an acceptable level of care for residents with dementia. Initially, these standards should be applied only to providers who claim to provide specialty services. There are a number of unresolved controversies (separation of residents) in this area and standards should be developed and implemented very carefully and in close collaboration with the industry. Assisted living has great potential to serve residents with dementia, including those in advanced stages, and every effort must be made to prevent regulation from curtailing this potential unnecessarily. The significance of this issue is evident in Hawes et al. findings that cognitive impairment is an extremely important variable in accounting for movement to a nursing home. The Assisted Living Workgroup recommendations regarding care for residents with cognitive impairment provides an effective framework for serving this population. These recommendations include the following:

ALRs shall have in place procedures and services that 1) meet the needs of residents with cognitive impairment/dementia, 2) accommodate and balance concerns about safety and autonomy, 3) recognize and build on strengths, capacities, choices, and values of the resident, and 4) reflect the likelihood that the cognitive status of many of these people will change and deteriorate over time. Such procedures and services include:

Part 1: Care for People with Cognitive Impairment/Dementia

1. Staff training about cognitive impairment, dementia, and dementia care;
2. Procedures for assessing and reassessing the resident's cognitive status, abilities, and related care needs;
3. Procedures, including supervision, to help direct care staff understand and respond effectively to residents' behavioral symptoms;
4. Specialized activities that are appropriate for residents with cognitive impairment/dementia;
5. Procedures for working with the resident and the resident's family to define and clarify responsibilities of the resident, the family, and the facility;
6. Procedures for designating and working with a surrogate decision maker, if the resident is not capable of making decisions for him/herself;
7. Policies and procedures to protect residents who wander and/or are at risk of physical harm;
8. Regular monitoring to assure resident safety and health care status, consistent with impairment; and
9. Policies and procedures for involving and supporting family members.

> Resident needs related to cognitive impairment/dementia differ depending on the severity of the cognitive impairment. An ALR should have in place procedures and services that are appropriate for the severity of cognitive impairment of its residents.
>
> Part 2: Dementia Special Care Units and Facilities
> ALRs that choose to serve only individuals with cognitive impairment/ dementia or to establish a special dementia unit or units(s) should define precisely the purpose of the unit(s) and develop admission and discharge criteria, staff training activity programs, and physical design features that are consistent with that purpose. (p. 145)

7) **Physical plant/environmental design**. Physical plant/environmental design regulations should be designed to create as homelike a living environment as possible to provide privacy and enhance autonomy.

Victor Regnier's (2003) defining criteria for assisted living requires that facilities appear residential in character and appear as small in size because these are essential features that contribute to a facility looking and feeling homelike. As one reviewer of Regnier's book on assisted living has noted, Regnier reports that:

> . . . building design is one of the most important attributes consumers cite when describing why they moved to a particular assisted living building. The economics allow facilities to capitalize on this fact. Regnier points out that a $300,000 reduction in the cost of a building translates into only a $3 per day reduction in the overall cost and represents only a savings of 5% in a daily charge. This is not enough savings, he says, to justify the impact that such a cost reduction would have on the building's appearance, given how important design is in attracting residents. (Binstock, 2003, p. 594.)

We know from research by Kane, Hawes and others that assisted living residents and potential residents place a *very* high priority on privacy as a quality-of-life value. Most fundamentally, this means a strong preference for private rooms and bathrooms and, to a lesser but still very significant extent, kitchenettes. There seems to be a clear consensus in the industry and among policymakers that this level of privacy is not affordable for many assisted living residents, especially those who are publicly supported. The assisted living experience in Oregon and Washington, which requires these privacy provisions and where costs are within the industry norm, would seem to indicate otherwise. This affordability vs. desirability issue is extremely important and is likely to grow in significance over the next ten years as quality of life becomes as important as quality of care in shaping the future of long-term care policy and practice and consumer preference and satisfaction become increasingly important factors in shaping long-term care policy. We should not forget that privacy is a necessary condition for the exercise of autonomy, maintaining dignity and achieving an adequate quality of life among residents, including those who are cognitively impaired, as found in the study of Alzheimer's special care units by Zeisel et al. (2003). A majority of the Assisted Living Workgroup participants supported a provision for single occupancy rooms in their definition of assisted living.

Quality of life and privacy in assisted living

As stated above, we think states should also begin to address the fundamental issue of privacy in assisted living—of single occupancy units for those who prefer them. Rosalie Kane (2001) has noted that the case for privacy needs to be made on two levels—value and price. According to Kane, the case for intrinsic value can be easily established. Private-pay assisted living residents overwhelming (88%+) chose single occupancy units:

People not yet in a facility dread the shared space above most things, and people already in facilities say they would much prefer to have private rooms and baths, and would be willing to accept much less in the way of planned programs and activities in exchange. People with Alzheimer's disease are often unable to speak for themselves on this issue, but many of their advocates believe that they too would, in the whole, flourish better if not forced to share living space.

As noted earlier, recent research by Hawes and Phillips (2000) found that:

> The vast majority (85%) of their respondents reported that their top two priorities on entering the ALF were the availability of a private bath (#1) and private bedroom. Among those who had left an ALF (19% over 12 months) most (65%) continued to identify these same privacy-oriented priorities.

The major issue then is not consumer preference, but rather price, which most providers think would be too high to be affordable for publicly supported residents. Kane (1998), however, thinks this may be true, at least in the case of new developments.

> According to one analysis, modeled by considering a 39-unit building under more or less expensive construction and more or less favorable lending arrangements, the difference between building for 78 residents in 39 units versus 39 residents in 39 units would range from $6.30 a day to $3.20 a day per tenant. This slightly higher construction cost and, therefore, higher debt service was projected to be offset by sharply lower operational costs in the single-occupancy apartments.

Among the reasons for greater costliness in operating shared facilities were higher maintenance (since frequent roommate switches cause more wear and tear and more need for moving assistance; higher housekeeping costs (because higher needs or costs in maintaining common-use areas and more demand for entertainment; increased needs for highly paid staff to deal with conflict resolution and behavior management; higher demand for tray service in rooms since the time a roommate is in the dining room is the only time the other roommate can be assured of being alone; and greater dependence than residence-provided snacks. By far the greatest extra cost of shared space, however, relates to the costs of vacancies and the difficulties in roommate matching. If a unit is vacant for a week more because of the difficulty in finding a new occupant, a whole year's savings on the development and construction costs are more than wiped out.

Given the deep preference of residents for single-occupancy rooms, the state should pay careful attention to Kane's argument for their financial feasibility, at least in the case of

regulations governing new developments. Oregon and Washington have operated with single occupancy provisions in their publicly assisted living programs for the past several years and have found them affordable and consistent with their long-term care containment priorities.

8) **Training**. The industry tendency to have employees play multiple roles is generally positive in that it can help dilute the stifling effects of hierarchy and avoid the alienation and detachment of command and control structures and help maintain staff morale, creativity and commitment. The tendency toward "generalist worker" roles can also contribute to a more integrated, familial, homelike environment and help contain staff costs. It also creates a greater need for cross training, both pre- and in-services training, especially for workers in facilities serving more physically and cognitively impaired residents. The training should also be designed to focus on the values of assisted living in all phases of caregiving and interaction with residents. The industry can expect more regulatory activity in this area and should create guidelines in anticipation of state initiatives.

   Many of the Assisted Living Workgroup's direct-care recommendations either directly or indirectly address training issues, which are largely consistent with the approach suggested here. Opponents of the recommendations felt that some of the recommendations required too little training or were too prescriptive and preempted the role of the state in setting training requirements.

9) **Quality of life criteria**. Greater priority should be placed in the development and use of resident-oriented quality-of-life outcomes measures based on the fundamental values of assisted living—autonomy, privacy, dignity and the experience of a fuller life, however impaired one may be. This approach to performance accountability would emphasize systematic consumer feedback on such variables as enjoyment, meaningful activity, quality of relationships, spiritual well-being, autonomy, privacy and dignity as well as the resident's sense of security and physical comfort. Robert and Rosalie Kane's research (2004) on the use of these measures in nursing homes should be carefully assessed for use in assisted living. Even in the current absence of regulatory requirements, assisted living providers should begin using these measures (as some already are) as essential components of an internal quality-monitoring program.

10) **Certificate of need**. A certificate-of-need approach to containing the growth of assisted living would be, for the most part, ill advised at this point. Assisted living is overbuilt in some areas now, but market forces and the growth of the Medicaid waiver funded sector (and other sources of public funding) are likely to close the gap over the next five years.

11) **Nurse delegation and medication management**. Properly supervised by nurses, non-nursing staff should be allowed to assist in administering medications. There is no evidence that current nurse delegation acts in several states, including Oregon and Washington, are harmful to residents who, in fact, benefit from the capacity of these acts to help contain costs. Universal workers will not be able to achieve their full potential without some form of nurse delegation and the training that delegation would require.

One of the principal purposes of nurse delegation is to create an effective balance between containing the cost and the risk of medication management. The Assisted Living Workgroup developed several medication management recommendations, most of which focus on the roles, training and monitoring of medication management assistants working under the supervision of a nurse according to the provisions of nurse delegation acts. Many of these recommendations were opposed by organizations which supported a generally more restrictive, medically oriented regulatory approach and greater involvement of nurses (RNs and LPNs) in all aspects of caregiving in assisted living facilities, including medication management, than are generally required by nurse delegation acts. The available research on the effects of nurse delegation offers little guidance in the formulation of rules for medication modification. The experience of states with nurse delegation in assisted living and adult foster care, however, suggests that delegated medication management is achieving an adequate balance between costs and risks. Oregon and Washington, which have extensive community-residential programs, have more than a decade of successful experience with delegated medication management. This experience offers evidence that the proper delegation of medication management as defined and operationalized by the Assisted Living Workgroup's recommendations are sound and can be confidently used by states as a framework for legislation and rulemaking.

A recent article by Sloane et al. (2004) found that many AL residents with serious chronic conditions are not receiving appropriate medications (under-medicated), which is a problem in all care settings. This may indicate a need for better regulations regarding medical assessments and protocols—role of physicians, nurses and pharmacists (quarterly evaluations for certain residents).

- Medication under-treatment in AL settings. Sloane et al. state:

  > This study demonstrates that older persons residing in RC/AL facilities have high rates of undertreatment, adding to existing reports from community, hospital, and nursing home settings. Among 328 RC/AL residents with CHF 62.2% were not receiving an ACE inhibitor; of 172 persons with a history of MI, 60.5% were not receiving aspirin, and 76.2% were not receiving a [beta]-blocker; of 435 persons with a history of stroke, 37.5% were not receiving any anticoagulant or antiplatelet agent; and of 315 with an established diagnosis of osteoporosis, 51.1% were not receiving treatment. Furthermore, the observed pattern of nonprescribing was not explained by age, race, or functional status of the residents. This gap in translating evidence-based medical treatment into practice may have a considerable adverse impact on the health of older persons. (p. 2036)

12) **Resident assessment**. We are not ready for a standard uniform resident assessment and case-planning instrument in assisted living á la the Minimum Data Set (MDS) now used in nursing homes. Maine's initiative in this area is interesting and may prove helpful in the future. But, we need more research and development and debate about tradeoffs before requiring a single instrument. This is another area where states are a natural laboratory and we need to learn much more about comparative results and allow time for the emergence of a consensus.

In addition to more conventional regulatory approaches to quality assurance described above, there are two other strategies that I think can be used that are more consumer (resident) oriented than conventional nursing home regulatory schemes.

13) Case management and case advocacy. I have long felt that the use of case managers as care advocates for publicly supported assisted living residents is as efficacious an approach to ensuring an adequate quality of care and life as annual or semi-annual surveys and episodic reporting to ombudsmen and Adult Protective Services, as important as these activities often are. This approach has been built into the Florida Assisted Living Medicaid Waiver Program. As long as caseloads are kept manageable (40:1) and the case managers are appropriately trained as care advocates and quality monitors, I think this approach has the potential to be an effective method of ensuring that the individual resident has an acceptable quality of life and receives sufficient care. This approach also helps avoid the adversarial, spot check approach to regulation by allowing the case manager (care advocate) to work with providers, residents and family members in a kind of continuous quality assurance manner based on common agendas and collaboration.

14) Consumer-direction. The Assisted Living Federation of America's call for making Medicaid "portable," so that recipients can choose where they will receive care and who will provide it, has considerable quality improvement potential. The Medicaid Consumer Account Program would reimburse the consumer (resident) rather than the provider and allow the states to determine the value of the consumer account based on the results of the functional and health assessment and the type of services required. This takes consumer-directed care from in-home care, which has been the major focus of advocates for consumer-directed care, into residential care and substantially expands opportunities for consumer empowerment. This program is a logical extension of the guiding values (autonomy and control) of assisted living. The evaluations of consumer-directed programs in California (Benjamin, Matthias, Franke, & Mills, 1998); Arkansas (Foster, Brown, Philips, & Schore, 2003); and in Europe (Wiener, Tilly & Cuellar, 2003) indicate that these programs generate high consumer satisfaction and are cost-effective. I also think that consumer direction of the kind proposed in the Medicaid Consumer Account Program represents an effective way of ensuring long-term care quality in all of its dimensions by giving the consumer and her family the ability to make choices and exercise power in the assisted living market.

The Assisted Living Workgroup was evenly divided over a recommendation for the creation of a consumer-directed federal long-term care program that would include assisted living. The rationale for the recommendation notes that:

> In light of the various disability statutes and the recent Olmstead decision, the federal government and states should move to a long-term care funding system that provides funding in the least restrictive environment possible. To ensure consumer choice, the system should provide consumers the capacity to direct how and where their funding will be spent. This model of consumer directed care could be similar to the Cash and Counseling demonstration program currently being evaluated by HHS. (p. 56)

In explaining their opposition to this recommendation to give consumers qualitatively greater control over the use of long-term care resources, some of the opponents state that while they support expanding opportunities for consumer choice, they:

> . . . object to the mythology about assisted living that pervades the rationale for this recommendation.
>
> We support individuals' rights to live in the least restrictive environment possible. We cannot support a statement that implies that all assisted living facilities are always less restrictive than all nursing homes. Without a common and meaningful definition of assisted living, we cannot agree to this conclusion, which is more a statement of faith than a statement of fact. . . . We reject the majority's implication that innovation and good practices lie solely with assisted living. . . . Under current law, individuals have choice about where they will receive their healthcare. Consequently, the second sentence in the second paragraph of the Rationale states nothing unique. The distinction for purposes of these recommendations is that nursing facilities are entitlements under the Medicaid program, while assisted living is not. (p. 57)

Most of this rationale for opposing consumer-directed care reflects the opponents' hostility toward assisted living as it exists or might exist under provisions included in the Workgroup's recommendations. This hostility or deep suspicion of assisted living is evident in such phrases as "mythology about assisted living" and statement of faith rather than a statement of fact" about the reality of assisted living. They also claim that the nursing home entitlement does not restrict choice in deciding where care can be provided, which would come as a surprise to many people who cannot receive public support for any long-term care program but a nursing home. In my view, opponents of consumer-directed care have claimed far more than they can prove or use to convince consumers that consumer-directed care should not become at least as available as nursing home care.

Assisted living affordability

Most of the organizations opposing consumer direction are also opposed to all or most of the Workgroup's affordability recommendations, including expansion of the assisted living Medicaid waiver and HUD-funded programs related to assisted living. The recommendation to expand waiver funding is based on the fact that "in most states, waiver funding is quite limited and over-subscribed and that as an intermediate strategy to a fully implemented consumer-direct long-term care program, the federal government should encourage states to increase their waiver-funded programs (Assisted Living Workgroup, 2003, p. 58)." which might include incentives like increasing the federal share for waiver funds by 10%; this would build on the CMS Long-term Care Real Change and System Change grant initiatives. Oregon and Washington have used waivers to transform their long-term care system by expanding home- and community-based services, including assisted living, over the last ten years.

Most of the opponents of the funding for consumer-directed care recommendation also opposed this recommendation because expanding:

> Medicaid funding of assisted living through home and community-based waiver is not good public policy in the absence of meaningful quality of care standards. In order to be eligible for home and community-based waivers, Medicaid beneficiaries have sufficiently significant health care needs to require a nursing home level of care. Nursing home-eligible individuals should not be placed in assisted living residences that are neither staffed nor otherwise prepared to meet their needs. The majority recommendations do little to guarantee a high quality of care in assisted living residences. (p. 59)

The Assisted Living Workgroup generated several more affordability/funding-related recommendations which included proposals to expand (HUD) programs for assisted living, increase SSI spending to cover assisted living room and board costs and allow supplemental support by family members for assisting living residents. Several organizations also opposed these recommendations because they support increased funding for a program (AL) they consider inadequately regulated and that other recommendations in the report failed to address sufficiently. Another group of participants supported most of the affordability/funding recommendations but qualified their support for the expanded Medicaid waiver recommendation by referring to it as a band-aid approach that:

> . . .will not help to avert a growing crisis in long term care financing. It is important to understand that our current financing system, rooted in the Medicaid welfare program, will not withstand the huge influx of seniors in the coming decades. Therefore, it is imperative that a permanent comprehensive solution for the funding of the entire spectrum of long term care be developed. Research by the health policy experts at Abt Associates indicates that creation of an insurance-based public/private program offers a viable alternative to today's unsustainable financing system. Additionally, there must be recognition of the need for personal and family responsibility in the planning for future payment of long term care. State and federal governments, in conjunction with providers of care and services, consumers, researchers, actuaries and other stakeholders should meet and develop a strategy to reach a permanent, multi-faceted solution. (p. 59)

It is clearly a good idea to begin now the hard work of developing a comprehensive, multi-faceted proposal to address the looming fiscal crisis in long-term care. Absent the implementation of a long-term care benefit in Medicare or something similar, however, it is difficult to imagine a feasible alternative to Medicaid, especially as a source of funding for the extensive expansion of waiver funding for home and community services, including assisted living. Long-term care insurance is important but no plausible scenario for the future of long-term care funding, even with substantial public sector involvement, can depend primarily on long-term care insurance to resolve the emerging fiscal crisis. Medicaid waivers are far more than a band-aid approach to long-term care financing as demonstrated by the way they have been used to transform care for the developmentally disabled over the last 20 years and long-term care for the elderly in Oregon, Washington and Arizona over the last decade. These examples indicate the capacity of waivers to change the fundamental nature of long-term care on a permanent basis and help address the fiscal crisis by containing overall long-term care costs. We should avoid dismissing the Medicaid waivers as a band-aid fiscal strategy when we have barely begun, in most states, to tap their potential to fund systemic long-term care changes, including increased availability of assisted living for impaired older people who are dependent on publicly supported services.

Conclusion and a research agenda

The best available information indicates that the assisted living industry, with the support of policymakers and the regulatory community, has built a sound foundation for continuing success. The industry is not perfect and some course corrections are in order. I am impressed, however, by the extent of progress achieved over the last ten years. As head of the Florida State Aging Agency in 1989, I felt that the biggest gap in our long-term care system across the country was the absence of a congregate care program that would allow the frail elderly to "age in place" and offer them the same freedom (personal control, privacy) and level of service that had been made available in their own homes since the late 1970s. This kind of community-residential care has been substantially achieved through the growth of the assisted living industry for private-pay residents and is arguably the most positive development in long-term care in the last decade.

The biggest problem in assisted living at this point is not insufficient regulation. The major problem confronting policymakers and those in need of long-term care is the relatively meager number of assisted living beds available to the less affluent elderly who require public support, have limited access to community resources and want to avoid ending up in a nursing home. For many of these people, assisted living offers the optimal long-term care setting for not only receiving the physical care they need, but also for achieving a quality of life (autonomy, privacy) that may not be available in their own homes. Our primary goals for assisted living should be to expand access for publicly supported residents and avoid regulatory schemes that would undermine the quality of life features that constitute the fundamental appeal of assisted living as a long-term care program.

The majority position on most of the Assisted Living Workgroup's recommendations is consistent with both of these goals and represents a major advance in the continuing development of a consensus framework for the expansion and regulation of assisted living. The current body of research, as summarized in this paper, is also consistent with these goals, especially to the extent that it demonstrates the importance of assisted living goals/values (privacy, autonomy, dignity, homelike ambiance) to residents and the apparent capacity of assisted living to achieve outcomes that reflect these values more often than not. Consumer advocates have a special responsibility here to recognize and respect these outcomes which reflect what we know about consumer preferences, and to resist regulatory interventions that would make assisted living significantly less affordable or less livable from a quality of life perspective.

Policy makers, assisted living providers and residents will continue to struggle for the foreseeable future with "a number of issues that require reconciliation of what appears to be inherently contradictory goals (O'Keeffe and Wiener, 2004, p. 4). According to O'Keeffe and Wiener, these issues include:

- Meet expectations for privacy, amenities, and quality services that have been set by the private pay dominated model of "assisted living" when Medicaid cannot afford to pay private pay rates.
- Cover the actual costs of serving frail older individuals with chronic care needs in residential care settings, when Medicaid is not permitted to pay for room and board and the payment sources available to cover room and board are insufficient.

- Given consumers a sense of what they should reasonably be able to expect from a setting that calls itself "assisted living" or "adult foster care" or some other name, without imposing uniform definitions through state regulation.
- Assure a minimally acceptable quality of care without imposing rules that stifle improvements and without the regulated "floor" becoming the "ceiling."

At this point, I think the available research indicates that most of the recommendations of the Assisted Living Workgroup and the state regulatory standards governing "quality of care" (standards setting minimally acceptable quality) and "aging in place" (standards allowing flexibility in terms of facilities deciding whom they will admit and retain) are generally sound, but that disclosure standards need to be more fully developed. The financing issues, however, will remain problematic in terms of both funding levels and reimbursement rates and restrictions (no room and board coverage) until federal and state policy makers decide to make assisted living and adult foster care as available as institutional care in the publicly funded long-term care system.

Assisted living is a relatively fragile form of housing and long-term care that is largely sustained by the fact that many older people very much prefer it to nursing home care and may, in many cases, find it preferable to in-home care. It would not take the application of very many nursing home style regulations, however, to make assisted living substantially less affordable *and* far less attractive than it has proven to be over the last ten years. Every effort should be made to contain these risks by always assuming the perspective (her needs and preferences) of the consumer and by supporting rigorous research, the results of which can be used to guide policy and dilute the distorting influence of purely anecdotal accounts of bad *or* good outcomes. In the absence of advocacy in support of what older people want and research designed to identify how these preferences can most effectively be met, the combination of media attention on bad outcomes, however unrepresentative of assisted living as a whole, and the efforts of professional groups to assert their regulatory authority could eventually make assisted living indistinguishable from the impersonal, uniform and routinized environments and day-to-day life of most nursing homes.

In our judgment, the research agenda for assisted living should be as comprehensive as possible but with a focus on the following areas, most of which are related to the regulatory and financing issues addressed in this paper.

- We have suggested that assisted living may be an especially appropriate setting for the housing and care of cognitively impaired residents. It is also apparent, however, from the Hawes, Phillips et al. research that cognitive impairment is a major reason for discharge from assisted living and transfer to a nursing home. We need to know more about the kinds of assisted living settings and services that are most effective for the cognitively impaired and that have the greatest potential to allow them to age in place with an adequate quality of life. The research by Zeisel et al. on special care units represents the kinds of research (behavioral outcomes) that we need much more of on this issue. (p. 697)

- We also need much more research on the capacity of assisted living to serve residents with serious healthcare needs, including end-of-life care. This area of research overlaps

with the need to learn more about the utility of negotiated risk contracts and the limits (resident competence, facility capacities, etc.) within which they can be executed.

- Given the documented value of privacy to assisted living residents and the essential role it plays in the rationale for assisted living, we simply cannot accept the assumption that single occupancy is too expensive for the less affluent residents and those who are publicly supported. We need systematic research designed to determine the cost feasibility of private rooms and to identify methods that can be used to maximize their affordability.

- Although the results to date appear to be reassuring, we need more research on the effects of nurse delegation acts, especially in the areas of medication management and care for chronic conditions (colostomy care injections, etc.) that require training and routine supervision. These are contentious issues, as demonstrated by the debates in the Assisted Living Workgroup and they are likely to become increasingly salient as the population of assisted living residents with serious healthcare needs grows and tests the capacity of facilities to allow residents to age-in-place, as many residents would like to do as long as possible.

- In what ways does size matter in assisted living and adult foster care? Does the small size of adult foster homes and five-to-ten bed assisted living facilities provide enough quality-of-life benefits (as reported by residents) to compensate for diminished economies of scale and reduced (potentially) access to more sophisticated forms of healthcare? Should regulatory distinctions be made between larger, better-capitalized facilities and small (mom and pop) facilities?

- Within the next three-to-five years, quantitative quality-of-life measures, based on resident responses and extensive systematic research, need to be developed for use in assisted living and other long-term care programs. Quality of life is not likely to gain parity with quality-of-care regulatory criteria without the development of a set of widely recognized quantitative measures designed to operationalize assisted living goals/values.

- Research of case management demonstration projects should be conducted to determine the efficacy (cost-effectiveness) of case managers as a source of quality assurance (quality of care and life of residents) in assisted living. We have suggested that case managers (care advocates) can be more effective than regulatory surveys in assuring adequate quality in assisted living. This notion needs to be tested and its cost feasibility determined.

- Finally, assisted living should be part of comprehensive evaluations of all long-term care programs, especially those supported by public funds. This means conducting research comparing the risk adjusted (health characteristics, impairment levels, etc.) costs and outcomes (consumer satisfaction with quality of life and care, changes in health conditions and impairment levels, movement to more restrictive settings, etc.) of all home- and community-based programs, including assisted living, adult foster homes and nursing home care. This is difficult research to conduct given current data limitations,

but we can begin by using Medicaid claims data for waiver-funded programs, consumer data collected by states and by conducting surveys.

These are just some of the priorities that should be part of a comprehensive research agenda for assisted living, but they are critical to the development of a more informed debate about the nature and future of assisted living.

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LONG-TERM CARE OMBUDSMAN RECOMMENDATIONS:

(1) SPECIALIZED TRAINING IN MENTAL HEALTH ISSUES: In addition to the core training requirement, a designed program of instruction using subject matter experts in the mental health fields should be established. This program would be administered by a State mandated responsible party to ensure the program material is maintained up to date and provides quality training and testing. Training would include initial course work and annual continuing education requirements.

(a) Training should include recognizing residents with mental health issues as individuals with a disease, not a diseased individual.

(b) Administrators and staff in limited mental health licensed assisted living facilities would be required to successfully pass an initial examination and subsequent continuing education training with a minimum score of 80.

(c) Certificates for satisfactory completion of the initial training and continuing education would be issued by the designated authority and would be the only acceptable documentation.

(d) The training would be required by all staff who come into contact with residents. The training must be received and successful completion of the exam must occur prior to staff's employment in a facility where limited mental health residents reside.

(2) LIMITED MENTAL HEALTH LICENSE: Any facility, which has one or more residents categorized as limited mental health, shall be licensed as such and all staff shall be required to be trained in accordance with recommendation 1 above.

(3) SHARED RESPONSIBILITY: To ensure continuity of effort and a continuum of care for each resident being served by a case manager, the relationship between the administrator and the case manager shall be one of shared responsibility for all prescribed care, thus requiring uniform training for all parties. A minimum amount of contact between the resident and the case manager must be established. Optimally, a minimum monthly contact would be ideal.

(4) ADMINISTRATOR RESPONSIBILITY: To ensure that each resident receives the needed services, the administrator shall be responsible for the range of care the resident needs including third party services. The administrator shall report to the case management agency any problems in the resident's receipt of services prescribed by that agency.

(5) APPEAL RIGHTS: Assisted living residents should be given the same appeal rights as nursing home residents. Many residents, who live in assisted living facilities, and particularly in the case of limited mental health residents who are especially vulnerable to any action a staff member may or may not take, have no one to represent them. If they complain about problems, in many cases they are immediately given a discharge notice. This places the resident at risk because often times they are discharged "to the streets" since the facility is not required to find alternative living accommodations. Administrators simply state they can no longer meet their needs.

(6) BAKER ACT REVISION: The Baker Act statutes should be revised to exclude individuals with brain injuries, dementia or other related disorders, and disorders included in the definition of "mental illness."

(7) ALF CORE TRAINING: All new ALF providers should be required to receive a minimum of 40 hours of core training including additional topics such as culture changes (currently the requirements is 26 hours and includes overview of statutes and rules governing ALFs) ; and must successfully pass the competency exam with a score of 80 instead of 70.

(8) LICENSED ADMINISTRATORS: ALF administrators should be licensed and held accountable by a board of assisted living administrators under the Department of Health; or at a minimum the licensure for ALF administrators with 17 beds or more and administrators of facilities licensed for Limited Mental Health, Limited Nursing Services and Extended Congregate Care.

(9) INCREASE IN AHCA SURVEYOR STAFF: AHCA should be given appropriate staff to increase the inspections of ALFs. Currently, the biennial requirement is not sufficient.

(10) INCREASE IN OMBUDSMAN STAFF: The Long-Term Care Ombudsman Program should be given additional professional staff and funds to recruit and train new ombudsman specifically for ALF issues.

SUMMARY OF AARP'S REMARKS
DELIVERED 8/8/11 to the
ASSISTED LIVING WORKGROUP

Presented by Jack McRay, Advocacy Manager

●Initial review of statutory authorities indicates many of the provisions re: regulation of ALFs should be sufficient. For example, see the intent statement in s. 429.01, F. S. That provides a good statement of what the ALF industry and services should be about. However, some of the egregious matters recently chronicled in the press raise the question of whether there is the WILL in Florida to forcefully use the authorities for consumer protection. By analogy, it is as much or more the delivery instead of the package that is faulty. Florida should strengthen education, training and credentials for ALF owners, managers and controlling interests. Consumers must have good and transparent information from which they can make sound decisions re: long-term care. Florida consumers also need more ALF omsbudmen and training for those volunteers.

●Some disturbing trends are evident:

-The Legislature recently has focused on extension of sovereign immunity to long-term care industries and on tort reform favorable to those industries. This legislative focus has threatened consumer protections and remedies. In light of the exposes in the ALF industry, in light of the state's need to communicate a positive image as a place where seniors can get needed long-term care services, and in order to prevent injuries and other harms to consumers, the Legislature should turn its attention to enhancement of consumer protections in ALFs.

-The ALF industry should be riding a wave of increasing demand due to the aging of "baby boomers." However, with that increasing demand and with escalating costs for nursing home care, there is concern that ALFs are and will house residents for whom their services are inappropriate. Inappropriate assessments are ticking time-bombs for ALF resident welfare. The recent Medicaid reform espouses greater use of home-and-community-based services, and the state's move to capitation will give managed care organizations a built-in incentive to use non-NH settings. AARP supports greater use of HCBS, but only if consumers are getting the care they need in those facilities. ALFs should reject resident applicants (private pay or Medicaid recipients) who are not appropriate for the care ALFs offer and they should take action to place residents in other settings as soon as alternative need becomes apparent. The assessments are done by the ALFs. Perhaps assessments should be done or reviewed by persons independent of the admitting facilities, and assessments should be updated regularly and in response to changes in residents' mental/physical conditions and other circumstances.

●Some suggestions for the Workgroup to consider:

-Omsbudsmen are not, and should not be, regulators. Their independence is critical to success of the program. They are invaluable eyes and ears for consumers of ALF services. Their role should not be diminished in any way. However, omsbudsmen could benefit from additional and recurring training. AARP suggests, too, that the process set forth in s. 400.0075 (complaint notification and resolution procedures) could

be speedier, perhaps by eliminating some of the steps. The omsbudsmen should be used to identify and expedite resolution of grievances, and they should be a part of an early-warning system that "prevents" grievous harm to consumers.

-There should be a new focus on "early intervention" for problem ALFs. "Process" and "benign oversight" as excuses for inaction too often only amount to complicity in the ALFs' problems . Early attention to ALF problems doesn't have to be intrusive and/or punitive in nature. It could be focused on improving ALF performance.

-The regulatory agencies have ample authority under Ch. 120 to take action (including emergency suspensions of and restrictions on licensees) in response to complaints. However, the disciplinary process most often is based on actions/incidents that have occurred. The Legislature should consider how it can give adequate authority and tools to early interventionists. For example, if an omsbudsman's observations lead to heightened concern over cleanliness, unpalatable food, professionalism of staff, or adequacy of staffing levels, those observations need to be communicated immediately and there should be rapid-response on-site inspections or evaluations of the ALF.

-The Legislature should consider establishing locally/regionally based rapid-response teams (something akin to the basis for SWAT teams when there is risk of serious and imminent harm to persons). Those teams could include regulators, local legal counsel (hired or volunteer), peer ALFs [those not in competition with an ALF being provided assistance], representatives of FALA and other persons or organizations who can offer ALFs expertise and assistance directed to correcting or reducing the particular threats of harm or injury to residents. Perhaps the Aging Resource Centers (ARC) could play a role in coordinating/recruiting/training participants for these teams. The ARCs should be the best source about all alternatives available for long-term care. The ARCs could be especially valuable when there is a need to quickly identify alternatives when an ALF resident is at risk (by actions of others or by their own actions). An ounce of prevention is worth a pound of cure. The industry would benefit from assisting wayward ALFs before adverse incidents mar the reputation of the industry.

-Punitive actions for egregious preventable harm to ALF residents should be certain and strong. The Workgroup should review Part II of Ch. 501, Florida's Deceptive and Unfair Trade Practices statute, to see if any portion of that could be useful (even with amendment) to punish and deter the types of incidents chronicled in the Miami Herald. Section 501.202(2), F. S., establishes that Part II is: "To protect the consuming public and legitimate business enterprises from those who engage in …unconscionable, deceptive or unfair acts or practices in the <u>conduct</u> of any trade or commerce." Also, see section 501.203(8), F. S. . Any ALF which holds itself out to the public and which commits such offenses would be deceiving the public, because nothing about those incidents could be described as "assistance" or even "living" for harmed residents. In short, the title of their service would be "misleading." Section 501.2077, F. S. already relates to violations involving senior citizens or handicapped persons. However, to be remotely applicable to the ALF circumstances at hand, s. 501.212(3), F. S., "Application," would need to be amended. That subsection provides that Part II does **not** apply to a claim for personal injury or death. The exclusion would need to be eliminated. This would be a potential way to remove bad ALF offenders from the industry—see s. 501.207 (remedies of enforcing authority). That section provides that a remedy (among others) is "to order any defendant to divest herself or himself of any interest in any

enterprise, including real estate." That might help prevent reappearance of a wayward ALF owner into the industry.

-The Workgroup should look at ways to go after the personal assets of officers and directors of corporations that own or operate ALFs and which engage in egregious/preventable harm to residents. Those types of harms arguably can not be within the protections afforded by the corporate veil.

-The Workgroup should look at ways to educate/encourage prosecuting authorities to seek felony convictions under statutes applicable to abuse of the elderly and disabled or other vulnerable adults (see, e.g., s. 784.08, F. S.).

-The Workgroup should look at increasing the standards/training/education required for owners/operators/controlling interests/staff of ALFs and it should look at increasing the staffing levels in ALFs.

-The Workgroup should prohibit ALFs from using pre-dispute arbitration agreements. In many cases, those contractual agreements are entered into when consumers are at a bargaining disadvantage (e.g., arising upon imminent discharge from a hospital).

-The Workgroup should consider recommending that ss. 429.11(2) and 429.275(3), F. S, be amended to establish a minimum amount of liability insurance to be carried by ALFs/owners upon ALF licensure application and for all periods of operation. The minimum amount should be sufficient to cover egregious harm or injury to residents and to cover attorneys' fees.

Assisted Living Workgroup 2011

8/8/11

Carol Berkowitz, Esq.
Sr. Director of Compliance and Legal Affairs

Florida Association of Homes and Services for the Aging

About FAHSA

- Florida Association of Homes and Services for the Aging has more than 500 members, including approximately 370 continuing care retirement communities (CCRCs), nursing homes, assisted living facilities (ALFs), home and community-based services and affordable senior housing
- Over 85,000 seniors reside in FAHSA-member communities
- FAHSA-member homes are sponsored primarily by community-based nonprofit civic, religious, fraternal, mission-driven organizations

Recommendations for Improvement:

- Survey Process
- Consumer Information
- Regulations

Recommendations for Improvement:

- **Survey Process**
  - Improve Survey Consistency so that there is no misunderstanding about expectations
  - Implement Joint Training for ALF providers and surveyors (In person and Web based)
  - Target resources so that more surveyor time is focused on ALFs that have serious regulatory problems
  - Implement an abbreviated survey for ALFs with a better than average survey track record, a traditional survey for ALFs that provide acceptable care, and a more intense survey for poor performers (These terms would have to be defined)

Recommendations (con't.)

- **Consumer Information:**
  - Strengthen information available to the public so consumers are in a better position to make informed decisions when selecting an ALF

Recommendations (con't.)

- **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 ALFs are not homogeneous
  - Avoid increased regulations that apply to both good and bad performers and instead focus efforts on the early detection and correction of serious regulatory problems in facilities with a history of regulatory problems or marginal care
  - Carefully evaluate current public policy to determine if ALFs should be given the authority to provide additional services

Recommendations (con't.)

- Eliminate the limited nursing service license and instead allow ALFs with a standard license and a nurse on staff to provide any or all of the services currently permitted in an ALF with a limited nursing service license. (This flexibility was proposed in an interim senate report and bills filed by Rep. Hudson during the 2010 and 2011 legislative sessions)
- Encourage coordinated communications among state agencies regarding resident care
- Case managers must communicate to coordinate care
- Require case managers associated with Medicaid reform to immediately report ALF quality of care problems to AHCA. With the push to decrease Medicaid spending on nursing home care, the risk of inappropriate placement in an ALF increases and could result in care problems

Questions?

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Florida Assisted Living Association

Promoting Excellence in Assisted Care Communities

Assisted Living Talking Points
August 8, 2011

On behalf of the Florida Assisted Living Association, and Patricia Lange, our Executive Director (who is attending the FALA Annual Conference in Bonita Springs) , we would like to thank the Agency , Dr. Larry Polivka, Chair and all the members of the Assisted Living Workgroup for allowing us the opportunity to present some concerns and proposed solutions for your consideration.

I. Fragmented Regulations

- ALF oversight is stretched out among too many agencies and departments.
- Providers are confused and perplexed trying to wrap logic around the many directions they are pulled.
  - Part I, Chapter 429, F.S. continues to be stripped of the ALF regulations.
  - The ALF website causes many problems for the providers.
  - Providers are overwhelmed by the Proof of Financial Ability to Operate Statement.

Recommendations: FALA recommends that the workgroup put the ALF licensure and regulatory provisions back in its own statutes, Part I, Chapter 429, F. S. The regulations shouldn't be written to make it easier for the agencies and the departments; rather written to be public friendly.
FALA recommends that the ALF website be revisited to be public friendly.
FALA recommends that AHCA develop a financial statement that is appropriate for a residential program.

II. The Initial Survey Process is Flawed

- The Licensee is surveyed before a license is issued.
- Field Office surveyors are inconsistent in how they survey.
- There are no records, staff or residents.
- The ALF laws are resident driven.
- When the survey is completed (with no, staff, records or residents), AHCA is not required to re-survey for 2 years.

Recommendations: FALA recommends that the Provisional license criteria in Part I, Chapter 429, F.S. be utilized by AHCA. Again, these are residential homes and should be recognized as such.

III. Survey Inconsistencies

- There are inconsistencies from Field Office to Field Office and between facilities within that same Field Office.
- There are inconsistencies in how regulations are interpreted.

Recommendations: FALA recommends that ALF surveyor be core trained and be required to take 12 hours of continuing education biennially.

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IV. Core Training

- The core test has not been updated since 2008.
- There is one person approved to do on-line core training. In this climate, on-line training is very scary.
- Caregivers and direct care staff are taking CPR and First Aid on-line.
- The ALF training requirements are outdated.
- There should be no exemptions from the core training requirements for any individual wishing to become an ALF administrator.
- FALA believes that appropriate and quality training will directly improve the overall services to residents.

Recommendations: FALA recommends that the ALF training requirements for administrators and caregivers be re-evaluated.
FALA recommends that on-line training be vetted properly with DOEA, trainers and other stakeholders.
FALA recommends that other options be pursued for the core testing and for routinely updating the core test.

V. Trainers

- Some trainers are not complying with ALF curriculum.
- Some trainers are not teaching the required hours.
- Some trainers are just passing out materials.
- Some certified trainers do not train at all.
- There are no sufficient regulations to give DOEA authority to sanction violators or to take away trainers certifications.
- It is not certain whether surveyors are aware to check administrators' core certification to make sure they are being trained by a DOEA certified trainer.

Recommendation: FALA recommends that AHCA, in partnership with DOEA and other stakeholders, craft language in rule which will give enforcement authority to deal with non-compliant trainers.
FALA recommends that trainers be required to meet a minimum number of trainings per year, as required by rule, and that the rule includes provisions to de-certify non-compliant trainers.

Florida Health Care Association

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Agency for Health Care Administration
Assisted Living Workgroup Meeting
August 8, 2011

Florida Health Care Association Statement
Marilyn Wood, Opis Management Resources

My name is Marilyn Wood, and I am the President and CEO of OPIS Management Resources. We operate11 skilled nursing facilities and one ALF in Florida, reaching from Jacksonville to Largo.

I am here today representing Florida Health Care Association, in which I serve as the Multi-facility Vice President on the FHCA Board of Directors. On behalf of FHCA, I want to thank you for inviting us to be part of this important ALF Workgroup.

FHCA represents over 500 long term care facilities that provide skilled nursing, post-acute and sub-acute care, short-term rehab, assisted living and other services to the frail elderly and individuals with disabilities in Florida. Specifically, we have 59 Assisted Living Facility members, representing 4,931 ALF beds in Florida.

In May of this year, FHCA hosted an ALF Summit which brought together Association leaders, members from the assisted living community and Agency representatives to discuss the changing long term care environment and challenges that providers face in meeting the care needs of today's seniors.

Below are factors to consider as you move forward and recommendations that came out of the summit:

Factors to Consider

- Public and sector concerns over quality, regulatory requirements and public expectations of long term care.
- There are increasing complexities of residential long term care.
- Consideration of boomers' needs versus available resources, possible ALF administrative licensure and survey repositioning to focus oversight resources on "special focus assisted living facilities."

- Access to services must be addressed, given that there are major differences in assisted living in the urban versus rural areas.

- Assisted living services throughout the state differ in the levels of care and staffing abilities; and as well as by levels of cost per month.

- Today's ALFs serve a more impaired resident population than in 1990 with the establishment of the multiple licenses, but there are concerns about the threshold of resident impairment being preserved so ALFs do not become poorly-resourced nursing homes.

- The importance of the Centers for Medicaid and Medicare Services' potential future direction via Medicaid waivers, controversies over the collection of needed data for accurate planning, the impact of managed care on the future of long term care and the recent focus of the press on ALFs.

- With Florida's move to a managed long term care system, it will be important for this group to discuss options for meeting the challenges of seniors' increasing needs in conjunction with declining state resources. Additionally, if there is an over-reliance on ALFs in the future through managed care, would that change the ALF model to become a slightly less regulated and less expensive nursing home.

- Half of the 2,800-plus ALFs in Florida accept Optional State Supplementation-funded residents, which aligns them with Medicaid support. As Medicaid funding reductions continue for community mental health services, ALFs with a limited mental health license will face challenges in ensuring those mental health supports are available.

<u>Possible Recommendations to Come out of Summit</u>

Working in long term care for nearly 40 years, I have seen how the ALF resident population has changed. The passage of the extended congregate care and limited nursing and mental health licenses 20 years ago paved the way for the "aging in place" in ALFs and the respect for individual choice in the residential setting. Here are some possible recommendations that came out of the Summit for us to discuss and consider:

- The ALF population is increasingly in need of nursing services either through the ALF nurse on staff or through contracted home health services; therefore, discussion on the possible elimination of the multiple licenses, excepted for the limited mental health, is needed. It's important to remember, however, that the original plan for the extended congregate care license was to ensure appropriate care with more regulatory oversight by the survey agency.

- Regulations are important to ensuring good quality of care for long term care residents in all ALFs, however, some are known for providing better care outcomes than others. In addition, there has been enlightening discussion among Congress with CMS on their increasing interest in regulatory oversight at the national level for the public-funded residents in ALFs, especially through the Medicaid waiver programs.

- How do we work together to develop an improved oversight system that focuses the state surveyors' work on the more troubled facilities than those ALFs with a history of providing good care and with satisfied residents and staff.

- The ALF "Residents' Bill of Rights" and the decision-making of "appropriate placement" are the hallmarks of the discussion of good care.

- As the role of assisted living in the publicly-supported long term care system expands, there is an important need for more data on resident characteristics, services provided, quality of care and costs. Policy makers and the public will be asking for more uniform data systems across long term care programs.

Conclusion

The complicated trade-offs of regulatory compliance and oversight, data collection, lines of service demarcation and managed long term care are all national, as well as, state concerns. FHCA is pleased to be engaged with this ALF Workgroup as changes within the long term care continuum continue moving forward. I look forward to serving with each of you throughout this endeavor.

# # #

NAMI Florida
National Alliance on Mental Illness

August 10, 2011

Ms. Susan Kaempfer
AHCA
2727 Mahan Drive
Bldg. 3, Room 1229
Tallahassee, 32308

Dear Ms. Kaempfer,

Thank you for allowing me to speak on behalf of NAMI Florida to the Assisted Living Workgroup. The following are excerpts from my presentation:

- In 2005-2008 NAMI participated in a pilot program, Personal Outcome Measures, funded by the Department of Children and Families. The goal of the program was to interview persons receiving mental health services through various programs and agencies, including ALFs. As I was trained and certified to interview I personally visited several ALFs in Circuit 20, talking to individuals about their quality of life. Questions were asked such as:
    1. What are your goals
    2. Where do you want to live
    3. What do you feel you need for supports
    4. Do you have access to your environment
    5. Are you happy or sad most of the time
    6. Do you feel safe

  There were approximately 25 questions, all to gather information about a person's quality of life and self-direction.
- Ironically many residents were not opposed to living in an assisted living facility but objected to not having choices in their life.
- Residents stated that they perceived staff and other residents as their family.
- Responses to questions were similar regardless of where the person lived or from whom they were receiving services from.
- As we look at housing for individuals with disabilities I believe it is important that we consider how "the person" perceives their living situation whether it be in a group home, ALF, community housing or a homeless shelter.

I respectfully ask the Workgroup to speak to the individuals who live in these facilities and ask what is important to them. Look at their quality of life and ask what can be done to improve what is important to "the person".

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Abuse and neglect was found to be an issue at one specific facility. Their license was revoked but within 30 days they had reopened with a license under another name. I would like the workgroup to address the following:

- How will these facilities be evaluated and by whom?
- What are the expectations and how will outcomes be measured? What will be the criteria?

In conclusion our findings were that persons who had direct contact with persons who had a mental illness were not educated on the illness. They lacked empathy, communication skills, and no 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 resulted in frustration and anger.

One of the comments that was often repeated by several persons at the meeting was that residents were afraid to report abuse for fear of losing their services. I would like to say that the majority of persons that were interviewed had the fear of losing benefits regardless of where they lived or who they were receiving services from. Persons with mental illness are often dependent on the State for food and shelter and have historically had the fear of disclosing information.

Materials were distributed to the Workgroup outlining NAMI Florida's education and support programs. We have a course called Provider Education which would specifically address the needs of Mental Health Education to Providers.

Thank you,

Judith Evans

Judith Evans, Executive Director
NAMI Florida, Inc.

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THE FLORIDA LEGISLATURE Report No. 96-57

Office of
Program Policy Analysis
And Government Accountability

John W. Turcotte, Director

February 19,1997

Review of Assisted Living Facilities Serving Residents With Severe Mental Illnesses

Report Abstract

- **We estimate that between 170 and 300 assisted living facilities serve between 2,000 and 3,600 residents with severe mental illnesses.**
- **Mentally ill residents of assisted living facilities receive personal services from the facilities and may also receive mental health services from community mental health centers.**
- **The Agency for Health Care Administration cites most assisted living facilities for deficiencies. Facilities with poor compliance records may not be inspected often enough.**
- **The new licensing requirement may result in modest service improvements in assisted listing facilities that serve mentally ill residents but could result in the displacement of over 550 residents. The loss of placement options could increase costs to state and local governments if individuals with mental illness become homeless, incarcerated, or institutionalized.**

Purpose of Review

This review was requested by the Joint Legislative Auditing Committee in response to a request from the Senate Health and Rehabilitative Services Committee. Our objectives were to address the following questions regarding assisted living facilities.

- How many assisted living facilities have residents with severe mental illnesses?
- What types of services do assisted living facility residents with severe mental illnesses receive?
- To what extent do assisted living facilities comply with license standards developed by the Agency for Health Care Administration?
- What is the potential impact of the state's limited mental health license on assisted living facilities serving residents with severe mental illnesses?

Background

Assisted living facilities (ALFs) provide housing, meals and personal assistance to frail elders and persons with physical and mental disabilities who need support to live in the community but do not require institutionalization. In November 1996, Florida had 1,914 licensed ALFs, with capacities ranging from a single bed to several hundred. These facilities were licensed for a total of 62,202 beds. Most of these facilities are relatively small with 16 or fewer beds. Assisted living facilities are located throughout the state, and many are in single family houses in residential neighborhoods.

Two state agencies oversee ALFs, while a third provides services to mentally ill residents. The Agency for Health Care Administration licenses and regulates facilities, investigates complaints, and imposes sanctions when required. The Department of Elder Affairs develops licensing rules and trains facility staff. The Department of Children and Families provides services to mentally ill residents of ALFs through several of its program offices.[1]

[1] Effective January 1, 1997, the Department of Health and Rehabilitative Services was reorganized to create two departments: the Department of Children and Families and the Department of Health.

The Alcohol, Drug Abuse, and Mental Health Program Office oversees the mental health system and contracts with local community mental health centers to provide services to individuals with mental illnesses, including those residing in ALFs. The Economic Services Program Office, through its Adult Payments Unit, establishes fiscal eligibility for Optional State Supplementation (OSS) clients. OSS is a state-funded program intended to prevent institutionalization by providing supplemental income to low-income individuals who are aged or disabled, including those disabled because of mental illnesses. The OSS payment enables these individuals to pay for care in ALFs.

Most ALFs are able to deal with the challenges of serving mentally ill residents. Many ALFs screen prospective residents and will not accept individuals who are likely to engage in problematic behavior. As a result, these facilities pose few problems for their residents and neighborhoods. However, some facilities accept residents who are subject to frequent changes in mental health status or who may engage in unpredictable or socially unacceptable behaviors such as public drunkenness, drug abuse, and panhandling. When such behavior appears to be a threat to other ALF or community residents, law enforcement may be called to intervene. Community mental health center staff consider the facilities that accept such residents to be an important community-based placement resource. However, some of these facilities have become a source of community concern.

In 1995, to address these concerns, the Legislature enacted a law requiring ALFs that serve mental health residents to obtain a limited mental health license in addition to the standard license required of all ALFs. Under the implementing rules for the new law, facilities were to apply for a license by October 2, 1996. However, due to concerns about the potential impact of the new law, and in accordance with the provisions of s. 400.451, F.S., the Secretary of the Department of Elder Affairs postponed the license application deadline until April 2, 1997, to allow the Legislature time to address those concerns.[2]

[2] Section 400.451, F.S., provides that existing facilities may be given a reasonable time, not to exceed six months, within which to comply with new rules and standards.

Findings

Question 1

How many assisted living facilities serve residents with severe mental illnesses?

We estimate that between 170 and 300 ALFs serve residents with severe mental illnesses. [3] There are no statewide data on the number of such facilities or the number of mentally ill residents they serve. To estimate these data, we surveyed the owners and administrators of the 482 ALFs that the Department of Children and Families, Department of Elder Affairs, and state mental institutions identified as serving individuals with severe mental illnesses. Of the 266 facilities that responded to our survey, 165 facilities (62% of respondents) reported they serve mentally ill residents. However, some facilities that did not respond to our survey also serve such clients. For example, we visited five ALFs that serve residents with severe mental illnesses but did not respond to our survey. If a similar percentage of the non-responding ALFs serve mentally ill residents, we estimate that 300 ALFs would serve residents with severe mental illnesses statewide.

We estimate that ALFs serve between 2,000 and 3,600 persons with severe mental illnesses.[4] The 165 ALFs that responded to our survey reported serving 1,988 such persons. Based upon these responses, we project that there could be about 3,600 such residents statewide.

Question 2

What types of services do assisted living facility residents with severe mental illnesses receive?

Mentally ill residents of ALFs receive personal services from the facilities and may also receive mental health services from community mental health centers. ALFs provide housing, meals and personal assistance to all of their residents. Facility staff supervise residents, providing oversight of their diet, activities, and general whereabouts, and encourage residents to participate in social, recreational, vocational, treatment services, and

[3] One of the factors compounding efforts to identify the number of facilities that serve individuals with severe mental illnesses is that there is no good definition of what constitutes severe mental illness. ALF operators expressed uncertainty about how to classify their residents. In our survey, we used federal guidelines to define adults with a serious mental illness.

[4] This estimate may be low. In its 1989 study, the Department of Health and Rehabilitative Services (DHRS) estimated that there were at least 5,600 residents with mental illnesses in assisted living facilities. By 1994, in its Agency Strategic Plan, DHRS estimated the number at 7,000 residents.

other activities within the community and the facility. ALFs maintain records pertaining to residents' care and note deviations from a resident's normal appearance, health, or well-being. They are responsible to contact a resident's family, case manager, health care provider, or other appropriate person in the event of an emergency or significant change in health. ALFs are also responsible for supervising activities of daily living, providing opportunities for social and leisure activities, and overseeing residents' health care needs, including managing and (if appropriate) storing residents' medications.

Some ALF residents may also receive mental health services from the community mental health system. These services typically include case management, psychotropic medication, and day treatment. Community mental health center case managers assess the needs of their clients and assist them in gaining access to needed medical, social, housing, educational, or other services. Center physicians prescribe psychotropic medications for these residents to help control the symptoms of their mental illnesses. Community mental health center staff also supervise day treatment services, which are activities conducted away from the clients' residence for part of the day to help teach behavioral skills.

However, community mental health center staff we interviewed generally indicated that their services to ALF residents are limited. Case managers said they do not always visit their clients at least once a month, which is the case management standard. They indicated that better coordination of information about clients' psychotropic medications is needed. Center staff noted that the availability of day treatment was limited by Medicaid restrictions on the number of treatment hours for which it will provide reimbursement. Due to these limitations, the responsibility for mentally ill residents of ALFs falls primarily on the facilities.

While most ALF residents with severe mental illnesses do well in the ALF setting, others do not and may cause problems for the communities where they reside. ALF operators cited weaknesses in mental health services as affecting their clients' ability to function in the community. For example, of the ALF survey respondents who serve mentally ill residents, 19% indicated that case management services seldom or never meet their residents' needs. ALF operators also responded that case management services could be improved if case managers had more direct client contact and knowledge of clients' needs. ALF operators also told us that case managers can be difficult to locate when crises occur, requiring the facilities to call on law enforcement for help. [5] ALF operators also reported that because of poor communication with mental health center staff, facility staff may not know what medications their residents should be receiving. Finally, ALF operators noted that mental health center day treatment programs are not always helpful because they are typically half-day programs, and the centers do not provide structured activities for ALF residents for the remainder of the day. Some mentally ill residents are not interested in attending these day treatment programs. Facility operators who responded to our survey reported that less than half of their residents with mental illnesses went to day treatment.

Question 3

To what extent do assisted living facilities comply with license standards developed by the Agency for Health Care Administration?

AHCA typically cites most assisted living facilities for at least some license deficiencies. AHCA conducts a comprehensive inspection of ALFs every two years in conjunction with renewal of the facility's license. During these inspections, staff review facilities' records to verify that employees meet background and training requirements and evaluate the facilities' adherence to approved procedures for administering medication. Field inspectors also interview residents about the appropriateness of services the facilities provide. Inspectors cite assisted living facilities for any deficiencies found during the inspection, establish a plan of correction, and verify the facilities' compliance with the plan. AHCA also inspects assisted living facilities to investigate complaints against the facilities made by consumers, their families, and others.

AHCA program managers said most inspections find one or more deficiencies, such as poor facility maintenance and housekeeping, problems with medication management, and poor record-keeping. Typically, AHCA establishes a corrective action plan and conducts a follow-up inspection to ensure that deficiencies are corrected; some deficiencies may result in fines. AHCA may impose heavier sanctions on ALFs that have more serious deficiencies or repeated violations by denying, suspending, or revoking the facilities' license or by placing a moratorium on new admissions. AHCA licensure files show that during the two-year period July 1994 through June 1996, many of the ALFs we surveyed were cited for deficiencies and many of these resulted in fines. During the two-year period, AHCA sanctioned 11% of these ALFs (18 of 65) for violations that would affect their ability to continue to serve residents with mental illnesses.

AHCA staff and an industry association assert that ALFs with poor compliance records may not be inspected often enough. When assisted living facilities defer maintenance or otherwise fail to meet state standards, the licensing process is intended to bring them into compliance and

[5] OPPAGA staff met with eight owners or operators of ALFs in Pinellas and Pasco counties who serve residents with mental illness.

thereby help ensure residents' health, safety and welfare. Because of the two-year inspection cycle, it is possible for facilities to operate in violation of licensing standards for several years before the Agency imposes a sanction.

Question 4

What is the potential impact of the state's limited mental health license on assisted living facilities serving residents with severe mental illnesses?

The limited mental health license established by the 1995 Legislature has not been implemented, but it could adversely affect placement options if implemented as currently designed. In 1989, the Legislature first established an optional license for ALFs that serve mental health residents. This optional license was intended to develop facilities with an enhanced capability of serving mentally ill residents by improving the knowledge and skills of facility staff and administrators. However, only two ALFs ever applied for licenses. In 1995, the Legislature repealed the optional license and enacted another law requiring all ALFs that serve residents with mental illnesses to acquire a limited mental health license in addition to the standard license required of all facilities.

Potential Benefits of Limited Mental Health Licenses. The new license requirement has the potential to improve ALFs that serve residents with severe mental illnesses. Facility staff must have two to eight hours of training on mental health concepts such as major mental health diagnoses and behavior management techniques. The implementing rules also require facilities to provide structured leisure activities every day. Further, the new law requires that facilities have a cooperative agreement with a mental health provider and a mental health service plan for each mental health resident.

Potential Problems of Limited Mental Health Licenses. The limited mental health license law could result in the loss of placement options for individuals with severe mental illnesses. As shown in Exhibit 1, about one-fourth of the ALFs now serving residents with mental illnesses either will not qualify for the special license because they have been sanctioned by AHCA in the past, or they have decided not to apply for a limited mental health license. If these facilities could not or did not obtain this license, more than 550 mentally ill residents would be displaced. Another one-fourth of the ALFs now serving residents with mental illnesses indicated uncertainty as to whether they would apply for a limited mental health license or did not answer our survey question. These facilities now serve another 405 residents with mental illnesses.

Exhibit 1
Survey Responses From ALF Operators Indicate Licensing Requirements Could Displace Many Mentally Ill Residents

Facilities That Serve Mentally Ill Residents	Facilities		Residents	
	Number	Percent	Number	Percent
Will not qualify for licenses [1]	18	11%	334	17%
Decided not to apply for licenses	24	14%	224	11%
Total Placements At Risk	**42**	**25%**	**558**	**28%**
Did not respond or did not know whether would apply	43	26%	405	20%
Eligible facilities planning to apply for licenses	80	49%	1,025	52%
Total	**165**	**100%**	**1,988**	**100%**

[1]OPPAGA determined that 18 ALFs will not qualify for the limited mental health license because of a history of sanctions.

Source: Office of Program Policy Analysis and Government Accountability survey of ALF operators who serve residents with mental illnesses.

If these ALFs are no longer available to provide community-based housing for individuals with mental illnesses, it will make the process of finding suitable placements for such individuals more difficult, and state and local governments may incur additional costs. The result will be that many mentally ill individuals will need to be placed in new settings, such as other ALFs. Clients who are now accommodated in ALFs may become homeless, incarcerated, or institutionalized, which may create additional costs for state and local governments. For example, state support for a mentally ill individual residing in an ALF totals about $538 per month for both housing and community mental health services. [6] This figure is well below a typical county's cost of maintaining an inmate in jail at about $1,750 per month, or the state's cost of maintaining an individual in a state mental institution at about $5,364 per month.

Some survey respondents indicated they were concerned that the new licensing requirements would increase their costs. Department of Elder Affairs staff said they tried to minimize the cost impact of the new license by developing rule requirements that differed only marginally from the rules governing all ALFs. Nonetheless, some ALF operators perceive that the new licensing requirement will increase their costs and make it uneconomical to serve

[6] This amount ($538) is the sum of the state's maximum share of the monthly OSS payment ($128) plus the monthly cost of providing community mental health services ($410).

mentally ill residents. For example, these operators indicated concerns regarding additional training, paperwork, and licensing fees associated with the mental health license. Subsequent to our survey, AHCA decided not to charge the limited mental health license fee because it concluded the fee was never intended to be included in the new law. [7]

The licensing requirements also will probably not fully resolve the problem of mental health services for ALF residents. The law requires ALFs to work with mental health professionals to develop service plans for their residents. However, mental health center services are limited and facilities cannot force clients to attend day treatment.

Another problem with the new licensing requirement is that current Department of Elder Affairs' rules do not effectively target those mentally ill individuals who are most likely to need an increased level of care. Current rules specify that ALFs must obtain licenses if they serve persons who have a history of admission to state mental institutions or residential treatment facilities. However, some of these individuals have lived outside of state mental health institutions or residential treatment facilities for years without exhibiting problematic behavior. These more stable individuals may not need to stay in facilities with limited mental health licenses. Conversely, the rules do not require ALFs to obtain licenses if they serve other mentally ill residents, such as those with recent histories of multiple admissions to crisis stabilization units, who may need the more extensive care. As a result, the licensing requirements may not target the clients that most need services or the facilities that need to be licensed in order to serve difficult residents.

Conclusions and Options for Legislative Action

There are no reliable data about the number of assisted living facilities serving persons with severe mental illnesses, but we estimate that there are between 170 and 300 facilities serving from 2,000 to 3,600 such residents. Individuals at assisted living facilities receive housing, meals, and personal assistance to live in the community, and may also receive mental health services from community mental health centers. However, for a variety of reasons, problems have developed at some assisted living facilities. In 1995, in an effort to deal with some of these problems, the Legislature enacted a limited mental health license law. However, without further legislative action, the limited mental health license law could result in the loss of some placement options for individuals with severe mental illnesses.

We identified three options the Legislature may wish to consider to address the issues related to the limited mental health license. These include leaving the current law intact, repealing the license law, and modifying the law or implementing rules.

Take No Action. Under this option, the current law would be retained and implemented. This would likely result in improved services by those ALFs that obtain licenses, as staff would receive additional training, facilities would offer expanded times for recreational and social activities, and coordination between ALFs and mental health providers could be improved. However, this option would not address the likely loss of placement options for persons with severe mental illnesses.

Repeal the Law. The second option is to repeal the limited mental health license law. This would avoid the loss of some placement options that would likely result if the law were implemented. However, repealing the law will not address the problems the Legislature intended to solve by enacting the law. For example, without the law, facility staff may not be trained to meet the special needs that some residents with severe mental illnesses may have, or provide sufficient supervision and recreational activities to such residents. Repealing the law also would result in no improvement in the coordination and delivery of mental health services. As a result, some ALFs that serve severely mentally ill persons would likely continue to pose community and law enforcement problems.

Keep But Modify the Law or Implementing Rules. The third option is to retain the licensing requirements but modify it to make it more effective. We identified the following potential changes the Legislature may wish to consider:

- **Better define in Department of Elder Affairs' rules the types of persons who are considered to have severe mental illnesses that require**

[7] The biennial fee for the limited mental health license is $200 per facility plus $10 per resident, based on the capacity of the facility for limited mental health services. This fee is in addition to the standard license fee, which is $240 per license with an additional $30 per non-OSS resident based on the total licensed resident capacity. In October 1996, AHCA decided not to charge the limited mental health license fee because it concluded the Legislature had not intended to charge a fee for the license. Legislative staff confirmed that the license fee was never intended to be included in the new law.

placement in a specially licensed ALF. The definition should be limited to those persons who, due to a history of placements and/or recent crises, are considered to require a high degree of supervision and support.

- **Reduce regulatory costs for ALFs.** This could be done by eliminating the statutory authorization for AHCA to assess a fee for the new license. The Legislature could also exempt small facilities, such as those serving less than five mental health residents, from license requirements. Due to the small number of persons these facilities serve, they may be better able to supervise mentally ill residents, but compliance costs may be most burdensome to these facilities. Many of the ALFs who reported to us that they may not apply for licenses were relatively small. These facilities served an average of less than ten residents with severe mental illnesses.

- **Require community mental health centers to place a higher priority on providing services to their clients who reside in ALFs.** This could be accomplished by directing the Department of Children and Families to incorporate specific requirements for serving this population in its contractual arrangements with community mental health centers.

- **Require ALFs that serve residents with severe mental illnesses and have poor records of compliance with licensing standards to be inspected more frequently.** Requiring annual, rather than biennial, inspections for ALFs with serious or repeated violations would help ensure that corrective measures are more timely. This requirement should specifically authorize AHCA to impose additional inspection fees as an incentive for ALFs to maintain adequate compliance with state standards.

- **Phase in eligibility requirements based on past sanctions.** The Legislature could phase in the new eligibility requirements that exclude some facilities from qualifying for the license. This would give those facilities serving mentally ill residents time to correct any deficiencies before placement options are lost.

- **Provide additional financial support for ALFS that serve individuals with severe mental illnesses.** For example, this could be accomplished by providing a special supplemental payment to facilities that serve OSS recipients with severe mental illnesses. This supplemental funding could be channeled through the community mental health system to strengthen the relationship between community mental health centers and the ALFs in which their clients reside. This is consistent with the way the community mental health system now provides support for their clients who reside in adult family care homes. Economic Services staff in the Department of Children and Families estimate that between 1,300 and 2,900 ALF residents receive OSS payments because of mental illness. Thus, for example, providing a $100 monthly supplement would require between $1.6 million and $3.5 million in additional funding annually. This may not be feasible given current state funding.

Agency Responses

Agency for Health Care Administration

The Director of the Agency for Health Care Administration provided the following written response to our review.

In reviewing page 3, paragraph 3, right hand column, regarding administrative sanctions, the Agency for Health Care Administration considers fines and moratoriums administrative sanctions. It should be noted that when a facility fails to correct a deficiency, or has a repeat deficiency, a conditional license may be issued and fines may also be imposed. Depending on the seriousness of the deficiency, a moratorium can also be placed on the facility until all deficiencies are corrected.

On page 5, paragraph 3, left hand column, you refer to LMH facilities as those serving persons who have "…a history of admission to state mental institutions or residential treatment facilities." The administrative Rule 58A-5.029(4)(a) also includes those persons eligible for case management services under Rule 10E-15.031(1)(a-c)(e)(g). This is a partial definition of the "specified population" currently in law. The law refers to 394.75(4), F.S. which contains a number of other categories as well.

The following comments are offered about the recommendations on page 6.

- Definition. We agree that a clearer and perhaps more narrow definition would be very helpful in targeting a specific mental health population. The definition may need to include provisions for persons who require ongoing treatment to prevent decompensation

and possible hospitalization. This could be handled in the rule depending on how the law is written.

- Regulatory Costs. The Agency can agree that fees for a limited mental health license should be waived for facilities with a specified number, possibly three or fewer, mental health residents as long as they maintain that number. We believe a $200 application fee for facilities with four or more mental health residents is appropriate in that it helps to offset the additional expenses of processing the application and conducting the survey. Consistent with standard ALF fee structure, there should be no bed fee for Optional State Supplimentation (OSS) residents, which constitutes the majority of the ALF mental health residents. This is not a large sum of money for a two-year license and is actually less than other specialty ALF licenses. As you know, the revenue currently generated through ALF license application and bed fees does not support the cost of administering the program. Therefore, any further reduction in fees without a corresponding reduction in regulation would require funding from an additional source.

- Annual vs Biennial Surveys. The Agency is supportive of this concept but must point out that the current number of staff in the area and central office are having difficulty maintaining the current workload. The ALF caseload has increased from 1704 facilities in 1994 to 1914 in 1996 with no additional staff. In addition, complaint investigations of ALFs increased from 771 in 1994 to 938 in 1996. Additional staff would be needed to assume the additional workload.

Thank you for the opportunity to respond to this report. The Agency is committed to ensuring the success of the ALF limited mental health license program. We will continue to work closely with the Departments of Elder Affairs and Children and Families to promote the quality of care needed for this population. Each agency has a strong and supportive relationship that we believe will ensure the success of this program. Our goal is to make sure the program meets the intent of the Legislature and the needs of mental health and all other residents of ALFs.

Department of Children and Families

The Secretary of the Department of Children and Families provided the following written response to our review.

The current law attempts to improve assisted living facilities (ALFs) serving people with mental illness by placing a higher standard on them, but without additional resources. Although not mentioned in the draft report, residents with mental illness require more supports and services than other people in general. Imposing increased requirements on these facilities without additional resources may result in some finding it impractical to continue serving these individuals, resulting in fewer housing opportunities for them.

The study found that 558 people who have a serious mental illness are at risk of being displaced under the current law. Alternative housing opportunities for these individuals are extremely limited. As pointed out in the study, most of these people would require significantly more expensive and restrictive placements. An appropriation of $3.5 million to provide additional financial support to ALFs would result in a major cost savings compared to the expense of other placements currently available to these individuals.

In our view, it is essential to channel any additional funds through the community mental health system to develop partnerships between the facilities and the community mental health providers.

The two aspects of the law intended to improve facilities with a limited mental health license are likely to have minimal or negative effects on residents with mental illness. First, the law requires that the facilities' staff must receive two to eight hours of training on mental health concepts. However, the additional training required of the facilities' staff cannot be enforced.

Also, the law does not designate a specific curriculum or qualifications for trainers. In addition, it doesn't require trainees to demonstrate proficiency in the training information. Consequently, a person may attend a training session conducted by an unqualified person using a curriculum that would not improve his or her knowledge about working with people who have a mental illness, but would meet the statutory requirement for training.

Furthermore, the law requires facilities to enter into a cooperative agreement with a community mental health provider or a licensed mental health professional "designated by the Department of Health and

Rehabilitative Services." However, the current law does not provide authority to establish designation criteria. Therefore, any licensed mental health professional can enter into a cooperative agreement with an assisted living facility with a limited mental health license, regardless of the professional's past performance or intent.

This factor, combined with the current lax requirements for securing a Medicare provider number, creates the potential and incentive for facilities to operate as a center for mental health treatment without standards, separate from the state-funded community mental health system.

Department of Elder Affairs

The Secretary of the Department of Elder Affairs provided the following written response to our review.

Targeting

The report indicates that Department of Elder Affairs rules do not effectively target the intended residents. If this is the case, the problem stems from the definition of "mental health resident" in the Adult Living Facility law [s. 400.402(15), F.S.], which references portions of Chapter 394, the mental health statute and which has been subject to varying interpretations. The language in the rule was recommended by Department of Children and Families Mental Health program office staff to clarify the meaning of the statutory definition in a way that would be clear to those who must abide by or enforce this provision. The Department believes that amendment of the statutory definition is necessary to correct this situation.

The Department has a bill to amend the limited mental health statutory requirements, including the definition of mental health resident. In drafting this bill we considered a number of variations of functional definitions such as that suggested in the report, but found it difficult to frame a workable definition. Definitions based on the resident's history pre-suppose that facilities and surveyors have access to information that may not be available due to lack of a paper trail or lack of access because of confidentiality of records. Accordingly, the Department's bill recommends basing this determination on eligibility for Social Security Income or Social Security Disability Income due to a psychiatric disability, information that we believe is easily understood and readily documented, although admittedly somewhat narrow in scope.

Delay in Implementation

The report indicates that the Department's Secretary delayed the implementation of the limited mental health requirements. Although the document was issued by the Department's Secretary, it was prepared with the knowledge and concurrence of Agency for Health Care Administration, which has enforcement authority.

Numbers of Facilities and Residents

The number of facilities reported as serving mental health residents probably includes most of the facilities that have a high proportion of mental health residents. However, data from a statewide survey by the Florida Policy Exchange Center on Aging and Department's telephone survey of half the assisted living facilities that have Optional State Supplementation residents strongly suggests that many more facilities have a small number of such residents, so that the actual number of facilities affected by the limited mental health law is much higher. It should be noted that the law currently applies even if a facility has only one mental health resident. In addition, a recent data analysis by the Department of Children and Families which cross-matched clients of the mental health system with Optional State Supplementation recipients showed about 3000-4000 such individuals.

Again, the Department supports the findings and recommendations included within the report and believes the final report should have a positive impact on Legislative review of the issues related to the limited mental health license.

This project was conducted in accordance with applicable evaluation standards. Copies of this report may be obtained by telephone (904/488-1023 or 800/531-2477), by FAX (904/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302).

Web site: http://www.state.fl.us/oppaga/

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CourtSmart Tag Report

Room: SB 401 **Case:** **Type:**
Caption: Children, Families, and Elder Affairs Committee **Judge:**

Started: 11/3/2011 10:32:53 AM
Ends: 11/3/2011 11:55:05 AM Length: 01:22:13

10:32:57 AM Roll Call
10:33:13 AM Senator Storms opening remarks
10:34:24 AM SB 316, Alzheimer's Disease (Senator Wise)
10:35:33 AM SB 316 amendment (barcode 881696) by Senator Rich
10:36:07 AM SB 316 amendment (barcode 121934) by Senator Rich
10:36:42 AM Senator Detert remarks and question
10:38:14 AM Senator Wise's response
10:39:17 AM Senator Gibson question
10:40:41 AM Secretary Charles Corley, Department of Elder Affairs, response
10:41:42 AM Senator Gibson remarks and question
10:42:38 AM Secretary Charles Corley, Department of Elder Affairs, response
10:43:35 AM Senator Gibson remarks
10:44:33 AM Senator Storms remarks
10:45:55 AM SB 316, Alzheimer's Disease, public testimony
10:46:44 AM Senator Storms remarks
10:47:19 AM Senator Wise's remarks
10:48:05 AM SB 316, Alzheimer's Disease vote
10:48:34 AM Director Michael Hansen, Agency for Persons with Disabilities, iBudget progress report
10:49:37 AM Senator Storms remarks regarding SB 274, Child Care Facilities
10:49:58 AM SB 274, Child Care Facilites (Cesar Fernandez, Senator Sach's Legislative Assistant)
10:50:57 AM Senator Latvala remarks
10:51:19 AM SB 274 amendment (barcode 553542) by Senator Rich
10:51:50 AM SB 274, Child Care Facilities, public testimony
10:51:57 AM SB 274, Cesar Fernandez closing remarks
10:52:13 AM SB 274, Child Care Facilities vote
10:52:37 AM Director Michael Hansen, Agency for Persons with Disabilities, iBudget progress report continued
10:53:06 AM Senator Storms remarks
10:54:40 AM Director Michael Hansen, Agency for Persons with Disabilities, response
10:54:47 AM Senator Storms remarks
10:55:14 AM Director Michael Hansen, Agency for Persons with Disabilities, iBudget progress report
10:56:09 AM Senator Storms remarks
10:57:42 AM Director Michael Hansen, Agency for Persons with Disabilities, iBudget progress report
11:02:38 AM Senator Rich question
11:03:32 AM Senator Storms remarks
11:03:48 AM Director Michael Hansen, Agency for Persons with Disabilities, response
11:04:31 AM Senator Rich question
11:04:47 AM Director Michael Hansen, Agency for Persons with Disabilities, response
11:05:51 AM Senator Storms remarks
11:07:26 AM Director Michael Hansen, Agency for Persons with Disabilities, iBudget progress report
11:15:49 AM Senator Storms remarks
11:17:37 AM Senator Detert comments
11:19:05 AM Senator Rich question
11:20:14 AM Director Michael Hansen, Director Agency for Persons with Disabilities, response
11:22:07 AM Senator Storms remarks
11:24:51 AM Michael Hansen, Director Agency for Persons with Disabilities, response
11:24:52 AM Senator Rich remarks and question
11:25:20 AM Director Michael Hansen, Agency for Persons with Disabilities, response
11:27:37 AM Senator Storms question
11:27:40 AM Director Michael Hansen, Agency for Persons with Disabilities, response
11:28:11 AM Senator Storms remarks
11:28:17 AM Director Michael Hansen, Agency for Persons with Disabilities, remarks
11:36:14 AM Senator Storms remarks

11:36:29 AM Senator Gibson question
11:37:10 AM Director Michael Hansen, Agency for Persons with Disabilities, response
11:39:16 AM Senator Gibson questions
11:41:09 AM Director Michael Hansen, Agency for Persons with Disabilities, response
11:41:36 AM Senator Storms remarks
11:43:24 AM Senator Detert remarks
11:44:42 AM Senator Rich remarks
11:45:37 AM Senator Storms remarks
11:48:15 AM Senator Rich remarks
11:48:50 AM Senator Storms remarks
11:49:10 AM Senator Storms, Discussion on issues relating to Assisted Living Facilities in Florida
11:52:15 AM Senator Latvala remarks and question
11:52:38 AM Senator Rich remarks
11:53:32 AM Senator Storms remarks
11:54:16 AM Senator Rich question
11:54:22 AM Senator Storms response
11:55:01 AM Adjourn