



The Florida Senate

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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

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 act¹³ 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

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 supervision¹⁷ 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 services²³ 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

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 plan²⁷ 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 restraints⁴⁹ 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 restraints⁵¹ 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

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 contact⁷¹ 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

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 interest⁸⁶ 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 moratorium⁸⁹ 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

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 persons⁹⁵ 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 abuses⁹⁷ 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 adult⁹⁹ commits a felony of the first degree.¹⁰⁰ A person who willfully or by culpable negligence neglects an elderly person or disabled adult¹⁰¹ 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 molestation¹⁰⁵ of an elderly person or disabled person or commit a lewd or lascivious exhibition¹⁰⁶ in the presence of an elderly person or disabled person.

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 adult¹⁰⁹ 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

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 districts¹²¹ 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

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.

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 sanctioned 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” generation¹³¹ 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.

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_at.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

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.falausea.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 39¹⁵² 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.cclid.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

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 agreement¹⁶⁸ 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 agreement¹⁸⁰ 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.

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.

¹⁸² See Agency for Health Care Administration, *Public Record Search*, available at:

[http://apps.ahca.myflorida.com/dm_web/\(S\(zbv120kprjdek1hsdzstv4p\)\)/Default.aspx](http://apps.ahca.myflorida.com/dm_web/(S(zbv120kprjdek1hsdzstv4p))/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.