The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Sobel, Chair
Senator Hays, Vice Chair

MEETING DATE: Tuesday, January 15, 2013
TIME: 2:00 —5:00 p.m.
PLACE: *Mallory Horne Committee Room,* 37 Senate Office Building

MEMBERS: Senator Sobel, Chair; Senator Hays, Vice Chair; Senators Altman, Braynon, Clemens, Dean, Detert, Diaz de la Portilla, Grimsley, and Thompson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Update on Assisted Living Facilities - Summary of Senate Interim Project 2012-128 and 2012 Proposed Legislation - Committee Staff - Complaints in ALFs - Jim Crochet, State Long-Term Care Ombudsman - Agency for Health Care Administration - Molly McKinstry, Deputy Secretary - Proposed ALF Rule - Susan Rice, Department of Elder Affairs - Recommendations from the Florida Assisted Living Facility Workgroup - Larry Polivka, Chair Public Testimony	Discussed
2		Review of the Independent Living Program for Foster Children - Program Description and Recent Reviews - Jennifer Johnson, OPPAGA and Jane Flowers, Auditor General - Department of Children and Families - David Wilkins, Secretary - Florida Coalition for Children - Debbie Mortham, Acting President - Florida State Foster/Adoptive Parent Association - Trudy Petkovich, President Public Testimony	Discussed
3		Other Related Meeting Documents	

The Florida Senate

Interim Report 2012-128 *September 2011*

Committee on Health Regulation

REVIEW REGULATORY OVERSIGHT OF ASSISTED LIVING FACILITIES IN FLORIDA

Issue Description

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

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

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

Background

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1, 2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[4]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[20]

Limited Nursing Services Specialty License

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

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

Extended Congregate Care Specialty License

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

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

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

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

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

[20] Section 429.28, F.S.

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

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

[23] Supportive services include social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. *See* Rule 58A-5.030(8)(a), F.A.C.

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

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

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

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

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

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

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

Facilities holding an ECC license must also:

- Ensure that the administrator of the facility and the ECC supervisor, if separate from the administrator, has a minimum of 2 years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting or agency serving elderly or disabled persons. A baccalaureate degree may be substituted for 1 year of the required experience and a nursing home administrator is considered to be qualified for the position.
- Provide enough qualified staff to meet the needs of ECC residents considering the amount and type of services established in each resident's service plan.

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

- Immediately provide additional or more qualified staff, when the AHCA determines that service plans are not being followed or that residents' needs are not being met because of the lack of sufficient or adequately trained staff.
- Ensure and document that staff receive required ECC training.

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.[33] A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS).[34,35] The DCF is responsible for ensuring that a mental health resident is assessed and determined able to live in the community in an ALF with an LMH license.[36]

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

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

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

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

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

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

ALF Staffing Requirements

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

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

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

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

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

- Monitor the quantity and quality of resident diets;
- Make daily observations by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual;
- Keep a general awareness of the resident's whereabouts, although the resident may travel independently in the community;
- Contact the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change;
- Contact the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out; and
- Make a written record, updated as needed, of any significant changes such as any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.[42]

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

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

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

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

Other staffing precautions include:

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

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

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

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

Resident Elopement

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

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

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

Use of Restraints

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

ALF Staff Training

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

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

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

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

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

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

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

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

Assistance with Self-Administered Medications

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

[54] Rule 58A-5.0191, F.A.C.
[55] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.
[56] Rule 58A-5.0191, F.A.C.
[57] Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. Rule 58A-5.0191(2)(a), F.A.C.
[58] Rule 58A-5.0191, F.A.C.
[59] Section 429.41(1)(a)3., F.S.
[60] Section 429.52(5), F.S.

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

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

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

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

ECC Specific

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

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

LMH Specific

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

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

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

Special Care for Persons with Alzheimer's Disease

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

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

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

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

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

Do Not Resuscitate Orders

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

Trainers

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

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

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

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

Inspections and Surveys

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

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

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

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

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

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

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

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

Violations and Penalties

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

- Class "I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients, which the AHCA determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation must be abated or eliminated within 24 hours, unless a fixed period, as determined by the AHCA, is required for correction. The AHCA must impose an administrative fine for a cited class I violation, notwithstanding the correction of the violation.
- Class "II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. The AHCA must impose an administrative fine, notwithstanding the correction of the violation.
- Class "III" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. The AHCA must impose an administrative fine and a citation for a class III violation, which must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, a fine may not be imposed.
- Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a provider or to required reports, forms, or documents that do not have the potential of negatively affecting clients. These violations are of a type that the AHCA determines do not threaten the health, safety, or security of clients. The AHCA must impose an administrative fine and a citation for a class IV violation, which must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, a fine may not be imposed.

The AHCA must provide written notice of a violation and must impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation; impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation; impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation; and impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation.[81]

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

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

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

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

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

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

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

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

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

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

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

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

Licensure Fees

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

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

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

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

Criminal Penalties

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adult Protective Services

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

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

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

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

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

[108] *Id.*

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

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

[111] Section 415.103, F.S.

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

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

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

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

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

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

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

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

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

Florida's Long-Term Care Ombudsman Program

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

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

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

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

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

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

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

The Miami Herald Investigative Series on Assisted Living Facilities

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

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

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

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

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

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

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

Governor Rick Scott's ALF Task Force

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

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

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

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

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

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

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

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

Findings and/or Conclusions

Inadequate Reporting

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

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

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

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

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

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

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

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

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

[136] *Supra* note 133.

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

[138] *Supra* note 134.

[139] *Supra* note 133.

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

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

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

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

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

AHCA Survey and Inspection Process Needs Improvement

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

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

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

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

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

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

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

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

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

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

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

Inadequate Training and Qualifications

Core Training Providers

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

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

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

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

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

Core Training Curriculum and Competency Test

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

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

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

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

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

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

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

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

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

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

Administrator Qualifications

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

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

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

Staff Training

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

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

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

Staffing Ratios

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

Elopement Training

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

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

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

Additional Regulation of ALFS with Limited Mental Health Residents Needed

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

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

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

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

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

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

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

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

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

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

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

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

Deficient Enforcement Measures and Penalties

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

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

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

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

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

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

Fragmented System of Agency Oversight

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

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

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

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

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

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

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

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

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

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

Consumer Resources

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

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

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

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

Options and/or Recommendations

Senate professional staff recommends a myriad of options for the Legislature to consider to improve the regulatory oversight of ALFs. Enacting a blend of these options might better protect the residents from abuse, neglect, or otherwise harmful conditions in ALFs in Florida.

Reporting

Senate professional staff recommends the Legislature require ALFs to report quarterly to the AHCA occupancy rates and demographic and resident acuity information (such as the types of services received). Access to this information will assist policymakers in assessing the adequacy of available ALF beds for long-range planning. In addition, the information will assist regulators in assessing whether the appropriate level of care is being provided to residents and facilitate surveys and inspections.

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[182] *See* Agency for Health Care Administration, *Public Record Search*, available at: http://apps.ahca.myflorida.com/dm_web/(S(zbv120kprqjdek1hsdzstv4p))/Default.aspx (Last visited on August 17, 2011).
[183] The Miami Herald Database is available at: http://www.miamiherald.com/cgi-bin/alfs/ (Last visited on August 17, 2011).
[184] U.S. Department of Health and Human Services, *Medicare.gov: Nursing Home Compare*, available at: http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteriaNEW.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home&CookiesEnabledStatus=True (Last visited on August 17, 2011).
[185] Quality measures are self-reported by the nursing home and comes from data that nursing homes routinely collect on all residents at specified times.

AHCA Surveys and Inspections

The AHCA's survey and inspection procedure could be improved by authorizing more abbreviated inspections for those facilities in compliance with the law while requiring more frequent and extensive inspections of those facilities that have recurring or observed deficiencies. This type of inspection program would focus the AHCA's resources where it is most needed. Additional legislation might be appropriate to successfully implement a more targeted inspection plan.

The Legislature may want to consider options to ensure that the surveyors conducting the AHCA's inspections of ALFs are sufficiently trained to do so and are performing the inspections consistently and uniformly throughout the state. The Legislature might require a specific number of lead surveyors in each area office to specialize on ALF inspections and be dedicated to ALF inspections only. Such an approach might require additional FTEs and funding to accomplish this successfully. Additionally, the Legislature might require a dedicated FTE to monitor surveyors and their field work to ensure consistency in inspections, citing deficiencies, and enforcement throughout the state.

To ensure that the surveys and inspections are adequately assessing whether the ALFs are in compliance with the law and meeting the needs of and protecting ALF residents, Senate professional staff recommends the Legislature create a workgroup that includes Ombudsman members to assess the AHCA's inspection forms and recommend changes to such forms.

Because the AHCA has had difficulty meeting the inspection requirements with the available resources, the Legislature may want to consider funding the inspection process through additional fees. To provide adequate funding the Legislature could:

- Require licensure fees for OSS beds. Florida law exempts facilities that designate their beds as OSS from licensure fees. The current fee for non-OSS beds is $61 per bed in addition to the $366 standard licensure fee. Some of the facilities that receive this exemption for the majority of their licensed beds require significant regulatory resources. There are currently 15,678 OSS beds in Florida, so revenues generated would be $478,179 annually (15,678 x $61/bed every 2 years for biennial licensure).
- Increase the per bed, per facility, and/or specialty licensure fees for all providers to offset program deficits.
- Assess higher fees at renewal for those facilities that required greater regulatory oversight based on the number of complaint inspections, violations cited, follow up visits required to determine correction of violations, and adverse sanctions such as moratoria, suspension, fines, or other actions.[186]
- Remove the prohibition on imposing an administrative fine when a Class III or Class IV violation is corrected within the time specified.[187]

Alternatively, the Legislature might privatize the inspection program, which may achieve some cost-savings to the state. However, a privatized inspection program would require sufficient oversight by the AHCA to avoid inconsistent inspections, conflicts of interest, and reduced accountability of ALFs.

The Legislature may wish to also require additional monitoring inspections of LMH facilities. If this recommendation is pursued, Senate professional staff further recommends that these monitoring inspections include the attendance of a mental health professional to help ensure that the appropriate care is being provided.

Training and Qualifications

Core Training Providers

Senate professional staff recommends improvements to the current system of training administrators since the quality of ALF administrators may directly impact the level of care and services that are provided to the ALF's residents. This might be accomplished by returning the responsibility of core training to the DOEA. The cost of

[186] These suggestions and information were received by professional staff from AHCA staff via email on August 10, 2011.
[187] *See* s. 408.813, F.S.

the DOEA resuming core training could be offset by requiring applicants seeking training to pay the DOEA a training fee. If the DOEA were to resume responsibility over core trainers, they could ensure core trainers:

- Meet the qualifications to be a trainer;
- Are teaching curriculums that are consistent throughout the state; and
- Are accountable for their training practices, by having the authority to penalize trainers for certain activities, such as not adhering to the curriculum or participating in fraudulent acts.

If the core training providers remain privatized, Senate professional staff recommends that the DOEA be provided with specific authority to oversee the core training activities. Additional oversight might include authorizing the DOEA to sanction core trainers with administrative fines, which could help fund the monitoring of core training providers, requiring continuing education in order to maintain certification to provide core training, and authorizing the DOEA to revoke or suspend certifications to provide core training when appropriate.

Core Training Curriculum and Competency Test

Florida's core training curriculum could be expanded to include subject matter to better prepare administrators for carrying out their responsibilities. It may be beneficial to form a workgroup, including personnel from the DOEA and the Ombudsman program, to analyze those ALFs that are excellent performers to develop a list of best practices that could be used in the core training curriculum. These best practices could also be available in continuing education courses. Additionally, expanding the curriculum to include information on financial planning, including financial resources that may be utilized to make an ALF more successful, and the day-to-day administration of an ALF might be helpful for potential administrators. Other subject matter that could be addressed is elopement, emergency procedures, and the appropriate use of physical and chemical restraints.

Senate professional staff recommends the Legislature require the competency test provider to annually update the competency test, and the DOEA to verify the updated test to ensure that test-takers are tested on the most current law requirements and best practices. Additionally, the Legislature might increase the minimum passing score for the competency test from 75 percent to 80 percent, which may help ensure a better pool of potential administrators.

Administrator Qualifications

Residents might benefit if the qualifications to become an administrator of an ALF were enhanced, the extent of which could be dependent on the size or licensure type of the ALF. Senate professional staff specifically recommends requiring additional qualifications of those administrators who are overseeing facilities that provide more specialized care such as limited nursing services and mental health services.[188] It may be appropriate to require these administrators to have a 2 or 4-year degree that includes some coursework in gerontology or health care. Additionally, for administrators of an LMH licensed facility, the administrator could be required to have completed some mental health coursework or have a degree related to the mental health field. Such education requirements could be substituted by a specified length of experience in the appropriate field (e.g., long-term care, nursing, mental health).

Staff Training

Because the AHCA currently determines whether ALF staff has received appropriate in-service training by inspecting personnel files and interviewing a random sample of employees, there currently may be misrepresentations made or the training may be inadequate to convey the subject matter. Therefore, the Legislature may wish to require all staff to take a short exam after their requisite training to document receipt and comprehension of such training. Some of the exams that are not facility-specific might be provided online through the AHCA.

[188] There are already additional education and experience requirements for administrators of ECC facilities. Rule 58A-5.030(4)(a), F.A.C.

Staffing Ratios

Currently staffing ratios as set out in rule are the same regardless of the type of ALF licensee. Because those facilities with specialty licensees care for populations that need more assistive care, it may be appropriate to increase the staffing ratios or specify ratios for staff with certain specialized training for facilities with specialty licenses.

Elopement Training

Because elopement is a frequent and very dangerous occurrence in ALFs, Senate professional staff recommends increasing elopement training requirements and requiring an AHCA staff person to periodically attend elopement drills. The elopement training requirement could be increased to require at least one hour of elopement training, as currently there is no time requirement. Additionally, staff could be required to sign an affidavit under penalty of perjury that they have read and understand the ALF's policy and procedures on elopement and the affidavit would have to remain in the staff person's personnel file.

Limited Mental Health Licensees

Administrators who oversee facilities that house residents with mental illness should be prepared, experienced, and educated to work with the challenges that come with this specific population. Therefore, Senate professional staff recommends the Legislature increase the education and experience requirements for administrators of LMH facilities or require managers of LMH-licensed facilities to have specialized education and experience. The Legislature could require these administrators or managers to have a two or four year degree that includes coursework relating to mental health care. In addition, the Legislature could require such administrators to have a certain number of years of experience working with those with mental illness.

In addition, Senate professional staff recommends the Legislature require an LMH specialty license for an ALF that accepts *any* mental health residents, except pursuant to an emergency placement.

Not only should administrators of LMH facilities be better prepared to work with a mental health population, but so should direct care staff. Although direct care staff currently must complete a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses, this requirement could be supplemented by requiring professional development training by mental health providers or professionals. In addition, staff could be required to receive aggression control training or similar training in order to properly address combative mental health residents and training as to the appropriate use of physical and chemical restraints.

Unlike LNS and ECC licensees, LMH licensees are not subject to additional mandatory monitoring inspections outside of the required biennial inspection. Because LMH licensees are responsible for an especially vulnerable population needing additional care and services, Senate professional staff recommends the LMH licensees be subject to additional monitoring inspections. Further, the monitoring inspection teams should include a mental health expert.

Senate professional staff recommends that the Legislature specifically require the DCF to have one FTE review staff's monitoring practices to ensure consistency in their monitoring of community living support plans and cooperative agreements. Further the Legislature might require the DCF to enhance the monitoring of the responsibilities of the mental health resident's case manager.

Penalties and Enforcement

To ensure that penalties are enforced by the AHCA, the Legislature might enact legislation to remove AHCA's discretion to assess administrative penalties and instead require the AHCA to assess certain penalties. For example, the Legislature could require the AHCA to fine an ALF in increasing increments after certain recurring deficiencies. The Legislature could also remove the AHCA's discretion to impose a moratorium or revocation of license when residents' health, safety, or welfare is at stake. The AHCA could be required to automatically revoke a license when a resident dies at a facility because of intentional or negligent conduct on the part of the facility.

Reorganization of Regulatory Oversight

To make the regulatory process of ALFs more streamlined, Senate professional staff recommends the establishment of a workgroup that includes members of the various state agencies having ALF oversight responsibilities to determine those functions that are performed by more than one agency. The workgroup could recommend to the Legislature the most efficient manner to streamline, while not degrade, the regulatory process of ALFs.

Until the Legislature is able to respond to the workgroup's recommendations, Senate professional staff recommends the Legislature address the more immediate need to designate a specific agency as the lead agency to coordinate all complaints or other problems related to ALFs. Even with memoranda of agreement existing between the agencies, it is difficult to determine which agency takes the lead when a specific complaint is made. Senate professional staff recommends this lead responsibility be assigned to the AHCA. The Legislature should require each agency to establish a direct line of communication to the AHCA to immediately communicate a complaint received or observed deficiency concerning an ALF. The direct line of communication should also be used to timely communicate the investigator's findings as well as the results of action taken by the investigating agency. The AHCA should maintain a database of this information to monitor and trend events at each ALF.

Senate professional staff further recommends that the Legislature amend s. 415.1034, F.S., to explicitly require AHCA staff or staff of other regulatory state or local agencies to immediately report the knowledge or suspicion that a vulnerable adult has been or is being abused, neglected, or exploited to the central abuse hotline operated by the DCF, instead of relying on inter-program agreements or operational procedures to set out such requirements.

Consumer Resources

An easy-to-use rating system, similar to the Nursing Home Compare, should be developed to facilitate consumers making informed decisions about choosing an ALF. The rating system should report on quality in terms of deficiencies and penalties, as well as resident satisfaction with the quality of life at the facility. The Ombudsman's might be assigned responsibility for gathering information concerning resident satisfaction.

To foster the reporting of complaints to the Ombudsman, Senate professional staff recommends the Legislature amend s. 400.0078, F.S., to require long-term care facilities to notify residents that the complainant's identification and the substance of their complaints are confidential and exempt from Florida's public record laws.

2012 SESSION
ASSISTED LIVING FACILITIES PROPOSED LEGISLATION

- **ALFs with Mental Health Residents:**

    - Increased the requirements and oversight of ALFs with mental health residents.
    - Expanded those requirements to all ALFs with mental health residents (rather than only those with the Limited Mental Health specialty license).
    - Increased the required initial and continuing education mental health training for ALF administrators and staff.

- **ALF Administrators:**

    - Established licensing provisions for ALF administrators within a Board at the DOH.
    - Allowed each licensed administrator to supervise up to three ALFs as long as there is a trained manager at each facility.
    - Grandfathered in current ALF administrators and people who have completed CORE training and have passed the ALF administrator examination within two years prior to January 1, 2013.

- **ALF Staff and Administrator Training:**

    - Increased the required training for new ALF staff to 20 hours and an online interactive tutorial and the continuing education requirement to 4 hours every 2 years.
    - Increased the required training for new ALF administrators to 40 initial hours and 16 hours of continuing education.
    - Required ALF administrators to pass an examination with a minimum score of 80%.
    - Gave the Department of Elder Affairs oversight over ALF core trainers and the ability to sanction those trainers who do not meet the proper criteria.

- **Inspections and Penalties:**

    - Made the frequency of inspections based on the performance of the ALF. Good performing ALFs will be inspected less frequently than bad performing ALFs.
    - Mandated that AHCA must observe elopement drills during inspections of 10% of ALFs each year.
    - Mandated that AHCA have specialized ALF surveyors.
    - Mandated that AHCA deny or revoke an ALF license in certain circumstances including the court finding that intentional or negligent acts of the facility lead to the death of a resident.
    - Made AHCA the central agency for tracking complaints and ensuring that licensure enforcement action is initiated if warranted.
    - Increased the penalties, both civil and criminal, for certain violations.

2012 SESSION
ASSISTED LIVING FACILITIES PROPOSED LEGISLATION

- **Resident's Rights:**

    - Required that ALF residents be provided with specific information about the confidentiality of complaints to the long term care ombudsman.
    - Established a grievance process for ALF residents who are to be discharged from the ALF.
    - Required that state and local agency employees report suspected abuse to the abuse hotline.

- **Miscellaneous:**

    - Created an advisory council to review the facts and circumstances of unexpected deaths or elopements in an ALF.
    - Created a streamlining task force to review overlapping regulatory functions of the different agencies over ALFs and whether or not efficiency and effectiveness may be increased through consolidation of those functions.

(1) Overview of top ten complaints in Assisted Living Facilities for Federal Fiscal Year (FFY) 2011-2012 (October 1, 2011 through September 30, 2012)

(2) Discussion of total number of complaints investigated during FFY 2011-2012

(3) Discussion of the disposition of complaints investigated during FFY 2011-2012—percentage resolved to resident satisfaction.

(4) Discussion of the accomplishments in the program benefiting staff and residents in particular.

(5) Discussion of goals set for the program.

COMPLAINT DESCRIPTION	FFY 2009/10	FFY 2010/11	FFY 2011/12	Grand Total
Menu (1003)	368	273	223	864
Medications - administration, organization (0605)	343	259	230	832
Cleanliness, pests, general housekeeping (1102)	236	160	179	575
Dignity, respect - staff attitudes (0403)	164	160	183	507
Equipment/Buildings (1103)	218	141	127	486
Shortage of staff (1302)	159	137	128	424
Staff training (1303)	185	112	57	354
Privacy-telephone, visitors, couples, mail (0408)	126	112	108	346
Activities - choice and appropriateness (0901)	135	106	102	343
Personal property (0503)	117	114	110	341
Billing/charges (0501)	92	95	102	289
Grand Total	2,143	1,669	1,549	5,361

Oversight of Assisted Living Facilities
January 15, 2013

Molly McKinstry
Deputy Secretary, Health Quality Assurance
Florida Agency for Health Care Administration

Assisted Living Workgroup

- Governor Scott directed AHCA to examine regulation and oversight of ALFs
- Focus on monitoring of safety and resident well-being
- Diverse sixteen member panel
- 2011 Phase I meetings, online report
- 2012 Phase II meetings, online report
  - Included Behavioral Health Managed Care Sub-Committee summit and continued dialogue

Florida Assisted Living Trends

- 3,010 assisted living facilities - 84,764 Beds
- 32% increase since 2003
- 80% increase limited mental health
- 52% have six or fewer beds
- Smallest ALF size = 2 beds
- Largest ALF size = 495 beds

ADDITIONAL FACILITY STATISTICS

	% Incr. # ALFs	% Incr. # Beds	% of ALFs ≤ 6 Beds	% of ALFs ≤ 25 Beds	% ALFs w LMH Beds	% ALFs w ECC Beds	ECC Beds as % of Total	% ALFs w OSS Beds	OSS Beds as % of Total
2003			37%	65%	27%	18%	25%	52%	18%
2004	0%	-3%	38%	66%	33%	15%	24%	52%	19%
2005	1%	-1%	37%	68%	34%	14%	22%	53%	19%
2006	2%	0%	41%	67%	35%	13%	21%	52%	19%
2007	4%	2%	43%	67%	36%	13%	20%	51%	19%
2008	8%	2%	47%	69%	38%	11%	21%	52%	19%
2009	5%	3%	50%	70%	38%	11%	21%	52%	19%
2010	2%	2%	52%	73%	38%	11%	21%	53%	19%
2011	4%	2%	52%	72%	37%	9%	17%	51%	19%
2012	3%	2%	52%	73%	36%	9%	22%	50%	18%

AHCA ASSISTED LIVING INITIATIVES AND UPDATES

- Weekly facility actions meetings to address licensure and Medicaid issues
- Monthly press releases regarding sanctions, closures, and other actions – all provider types
- Monthly interagency meetings with Agency partners
- Working with DOEA in the negotiated rulemaking process
- ALF awareness training for waiver support coordinators and Agency staff (Joint venture between licensure and Medicaid)

AHCA ASSISTED LIVING INITIATIVES AND UPDATES

- Statewide joint training for administrators, providers and survey staff
- Joint Training activities with other departments and agencies (provider and staff training)
- Access to systems and data used by partner agencies
- Joint inspections with Medicaid Program Integrity
- Enhanced FloridaHealthFinder
  - Medicaid services provided by the facility
  - Smartphone apps to locate facilities faster
  - Sanctions and emergency orders
  - Link to all Agency final orders (legal actions – Medicaid and licensure)

ALF ENFORCEMENT TEAM

- Team of ten ALF surveyors
- Functionally separate from the local survey management staff but are physically located in each of the eight Agency field offices

- Primary functions include:
  - Conducting high priority complaints
  - Collaborating with other agencies and law enforcement
  - Participating in unlicensed activity investigations
  - Performing off hours or weekend inspections and monitoring activities
  - Conducting quality assurance reviews

Revised Assisted Living Survey Process

- Enhanced resident-focused survey process
- Increased resident interviews
- Focus on resident outcomes
- Improve sharing of information with other agencies
- Increase public awareness of compliance histories on FloridaHealthFinder

Revised Assisted Living Survey Process

The revised process focuses review on core areas of compliance with a greater resident outcome focus:

- Resident rights
- Nutrition and food services
- Medication management
- Staff training
- Physical environment

Revised Assisted Living Survey Process

- Focus on information from resident interviews and observation of the provision of services

- Used the Wisconsin assisted living survey collaborative process as a basis for the revisions

- Surveyor worksheets were revised to maximize collection of information regarding the resident's quality of life and the quality of care

- Revised referral matrix to facilitate coordination of exchange of information among local authorities, state/ federal agencies, and advocacy groups

Assisted Living Facility Abbreviated Survey Process

- Abbreviated Survey
  - The abbreviated survey process **focuses** on **observations and interviews** in order to evaluate how the individual needs and preferences of the residents are met
  - Resident interviews are key to this process
  - Allows surveyors to **focus** on **residents** and less on paper compliance

Assisted Living Facility Abbreviated Survey Process

Implemented abbreviated surveys for ALFs with compliance histories as defined in s. 429.41(5), Florida Statutes

- No class I or II
- No uncorrected class III
- No confirmed Ombudsman or licensure complaints within two licensing periods (4 yrs.)
- Must have two survey periods under the current owner

Assisted Living Facility Abbreviated Survey Process

- Abbreviated Survey
  - A standard survey will be "triggered" if any of the following problems are identified
    - Fire safety violations that threaten the life of a resident and which confirmed as serious by the local fire authority having jurisdiction
    - Class I or Class II deficiencies are identified
      - Determined by severity of the deficient practice
    - Staff rendering services for which the facility is not licensed

Contact Information

Assisted Living Workgroup Site:
ahca.myflorida.com/SCHS/CommiteesCouncils/ALWG/index.shtml

www.ahca.myflorida.com

www.floridahealthfinder.com

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Department of Elder Affairs
Summary of Assisted Living Facility (ALF) Rulemaking Activities

January 11, 2013

A negotiated rulemaking proceeding commenced in June 2012 with the goal of elevating quality services and quality staffing across the ALF community. Specifically, the negotiating committee attempted to implement portions of the ALF regulatory proposals from Phase I of the Governor's ALF Workgroup, provisions of the Senate Committee on Health Regulation's Interim Report 2012-128, and various proposals introduced in the 2012 legislative session. The negotiated rulemaking committee was comprised of 15 individuals representing various stakeholder interests, including consumer advocates, ALF industry representatives, health education trainers, and state agency representatives. The committee was tasked with resolving regulatory deficiencies in a manner that would ensure the wellbeing of residents in ALFs.

A proposed rule was drafted based on the language developed by a consensus vote of the negotiating committee. Three rule hearings were held; with the last hearing concluding in December. The Department is currently incorporating changes to the draft rule language based on additional public input received at the hearings. After publication of the Notice of Change, the proposed rule must be presented to "the Speaker of the House of Representatives, the President of the Senate, and appropriate committees of substance for review and comment" prior to submitting the rule for final adoption. § 429.41(3), Fla. Stat.

The proposed rule implements:

- several aging-in-place initiatives for residents to reduce transfer trauma by allowing certain routine medical services to be provided within a standard licensed facility by qualified staff;
- clarifies roles of various staff, for example, it defines "manager";
- increases core training requirements for administrators and managers;
- increases continuing education hours;
- creates a competency based exam for both core training and limited mental health training;
- streamlines pre-service and in-service training requirements for staff;
- deletes outdated portions of the rule as a result of prior statutory changes involving background screening and licensing procedures; and,
- deletes text that is wholly duplicative of existing statutory language.

The following is a short summary of specific rule revisions:

Rule Chapter 58A-5, Assisted Living Facilities

58A-5.0131 Definitions

- Added definition of "Agency Field Office" – clarification of terminology used in the rule.
- Clarified definition of "direct care staff" – condense terminology and eliminate confusion regarding who precisely are "supervisors" of facilities, especially with regard to training requirements, etc.
- Added definition of "manager" – Negotiated Rulemaking Committee (NRC) work product; needed to clarify the roles and responsibilities of a manager in an ALF relative to the administrator.

- Deleted the definition of "major incident" – NRC work product, intended to reduce overburdensome regulation; since this is duplicative of adverse incident reporting requirements.
- Added definition for "staff in regular contact" to provide clarity for the streamlined training guidelines specified in Rule 58A-5.0191, F.A.C. This terminology is used in the ADRD training language in s. 429.178, F.S.

58A-5.014 Licensing and Change of Ownership

- Removed portions of rule section which were wholly duplicative of Part II, Chapter 408 and Rule Chapter 59A-35, F.A.C., and associated agency forms which are incorporated by rule. Additionally, with the revisions to Chapter 429, there no longer were laws to be implemented for much of this rule.

58A-5.015 License Renewal and Conditional Licenses

- Repealed in its entirety, with the exception of two provisions which have been consolidated into Rule 58A-5.014 (Conditional License and OSS Resident Determination).

58A-5.016 License Requirements

- Clarifying language throughout, language duplicative of statutory language was deleted.
- (6) Changed Medicaid "Waiver" terminology in recognition of Medicaid managed care
- (8) Third Party Services was moved from Rule 58A-5.016 and added to Rule 58A-5.0181(7) (Admission Procedures), so that all sections relating to third party services will now be located in one section of rule.

58A-5.0181 Admission Procedures, Appropriateness of Placement and Continued Residency Criteria

- (1)(p) - Aging in place initiative & NRC recommendation which provides a standard licensed facility with the ability to retain a resident requiring assistance with portable oxygen, routine colostomy care, and anti-embolism stockings/hosiery as long as appropriate staff is available to provide such services.
- (4) Continued Residency – NRC work product addressing issues specific to hospice –- Specifies that the interdisciplinary care plan must delineate the services which will be provided by either the facility or the hospice staff.

58A-5.0182 Resident Care Standards

- (6) - Corrected terminology; provided correct naming conventions.
- (6)(g) – removing duplicative language; clarifying intent of language through rewrite.
- (7) – third party services added from Rule 58A-5.016 (licensure application).
- (8)(a)2. Elopement Standards – clarified intent through revisions.

58A-5.0185 Medication Practices

- (3) ("Assistance with Self Administration) – rearranging rule for clarity
- (3)(b) – clarifying that reading aloud medication labels in a resident's presence is included as part of assistance with self-administration of medication.
- Corrected rule citing references.

58A-5.0186 Do Not Resuscitate Orders (DNROs)

- NRC work product – clarifying the correct Dept of Health form and process for facility management of DNRO documentation.

58A-5.019 Staffing Standards

- (1) Administrators – revisions to the statutory and rule references governing administrators, revision of grandfathering language that no longer has effect, clarification that core training and the core test requirements must be met (goes along with new training rule, 58A-5.0191)
- (1)(b) – initiative to ease burdensome regulation; understanding that, especially for smaller facilities, the death of an administrator (or situations of that sort) is an extenuating circumstance; permits the agency to temporarily approve management of a facility by an individual who is 21, has a high school diploma or GED, has completed background screening, but has not completed core training and testing, so long as such individual completes (or is making strides to complete) the necessary training and testing requirements to become an administrator within 90 days.
- (1)(c) and (d) – NRC recommendations and work product clarifying the structural arrangement of administrators and managers of facilities; provides that managers of facilities larger than 16 beds must satisfy the same qualifications as administrators under (1), and that managers may not serve as a manager of more than a single facility and may not simultaneously serve as an administrator of any other facility.
- (2)(a) Staff – NRC reviewed communicable diseases/TB testing both in rule and on Form 1823, and in looking at these issues determined that the rule should explicitly include references to TB testing for staff.
    - The rule also now requires that staff having, or suspected of having, a communicable disease must obtain a statement from a health care provider indicating that they are no longer a transmission risk, rather than permitting the administrator to "determine that such condition no longer exists".
    - Miscellaneous cleanup intended to clarify time frames for the health care provider documentation.
- Added (2)(f) referencing statutory background screening provisions for staff, thereby eliminating the need for (3).
- (3)(a)2 –Staffing Standards - NRC recommendation clarifying flexible staffing standards for independent living residents. Coincides with 58A-5.024(3)(o) (Resident Records; meals for independent living residents)
- (3)(a)5 – clarifying language; added (a) and (b) First Aid/CPR staffing provisions which formerly were embedded in 58A-5.0191 (Training). These provisions more directly related to staffing, rather than specifying staff training requirements.
- (3)(a)6 – 21 years of age to conform to administrator/manager qualifications under (1).
- (3)(a)7 – adding "grounds" maintenance to more fully clarify who is and is not counted for staffing standards.

58A-5.0191 Administrator, Manager, and Staff Training Requirements.

This section is substantially reworded, although the bulk of the substance of what was formerly 58A-5.0191 remains, just in a more coherently-structured manner. Did not add requirements other than those proposed by the Gov. ALF Workgroup and the NRC. Intent was to clarify and streamline this training rubric in a way that makes it more accessible and understandable by each class of facility staff – administrators/managers, direct care staff, and all other facility staff (with clarifications regarding additional training required of facilities/staff holding certain specialty licenses). Makes use of the definitional changes proposed in 58A-5.0131 ("staff in regular contact"); streamlines 30-day window for most training.

Each section of the new rule is organized in a similar manner by classification of the facility staff then within each section as applicable is initial training, specialty license training, continuing education, and any outlier training:

- Training for All Facility Staff,
  - One-time HIV/AIDs training
  - Elopement
  - Do Not Resuscitate Orders
- Training for Administrators and Managers
  - Initial training
    - core training – 40 hours (Gov's ALF Workgroup, increased from 26 hours)
    - core competency test
  - Initial Specialty License training
    - ECC
    - LMH
  - Continuing Education ("CE")
    - Limitation on providers qualified to offer CE training
    - 18 hours (increased from 12) – Gov's ALF Workgroup
    - ECC CE
    - LMH CE
    - Food service CE
- Training for Staff Interacting with Residents (direct care staff and staff in regular contact)
  - Pre-service (infection control, universal precautions, sanitation procedures – exemptions are provided for licensed staff) 1-hour
  - In-service – 5 total hours within 30 days with some exemptions
  - Specialty License training
    - ECC (within 30 days)
    - LMH (within 6 months of initial license or 30 days of existing license)
  - Continuing Education
    - 3 hours of LMH
- Additional Training for Administrators, Managers, and Staff
  - ADRD
    - Incidental contact – general information w/in 3 mos
    - Direct care staff and staff in regular contact – 4 hours initial w/in 3 mos (Level 1 training, provides for exemptions for certain individuals).
    - Direct care staff – add'l 4 ours w/in 9 mos (Level II training).
    - Continuing Education – direct care staff and administrators/managers must have 4 hours annually.
  - Assistance with Self-Administered Medication
    - For unlicensed persons –increased from 4 to 6 hours (NRC recommendation)
    - Substance of rule remained the same – topic areas, who is allowed to provide training.
    - Continuing Education – 2 hours annually.
  - Food Service
    - Staff who prepare or serve food – 1 hour in-service within 30 days.
    - Continuing Education – if the food services designee or manager (and not the administrator or manager of the facility), then 2 hours annually
- Training Documentation and Monitoring
  - Requirements for training certificates and documentation
  - Do not have to repeat the initial or one-time training upon change of employment.
  - Agency and department retain ability to monitor training.

- Moved the substance of ADRD training/curriculum approval provision into its own new section of rule (58A-5.0194).

58A-5.020 Food Service Standards

- Exempted certain classes of individuals from the module training.
- Clarified that, in addition to this training, individuals "designated" by a facility administrator to be responsible for total food services and the day-to-day supervision of food services staff, those designees are not subject to staff in-service training but must nonetheless comply with food service continuing education requirements imposed by 58A-5.0191.
- (2) – NRC recommendation to correct/specify the entities providing dietary guidelines; removes dietary allowance specifications from rule.

58A-5.021 Fiscal Standards

- Removed portions of rule section which were wholly duplicative of Part II, Chapter 408, F.S., and Rule Chapter 59A-35, F.A.C., remaining portions were consolidated.

58A-5.023 Physical Plant Standards

- General clean-up, clarification, and correction of citations.

58A-5.024 Records

- Clarifies that records must be readily available for inspection (NRC recommendation).
- (1)(d) Deletes references to major incident reporting as those incidents are subsumed within adverse incident reporting.
- (3)(p) Clarifies reduced record keeping for independent living residents residing in ALF licensed beds.

58A-5.0241 Adverse Incident Report
58A-5.0242 Liability Claim Report

- Revises rule to reference new online reporting requirements.

58A-5.025 Resident Contracts
58A-5.026 Emergency Management
58A-5.029 Limited Mental Health

- General clarification, updating of terminology, deletion of duplicative text.

58A-5.030 Extended Congregate Care Services

- General clarification, updating of terminology, deletion of duplicative text.
- (5) Admission and Continued Residency – NRC work product addressing issues specific to hospice –- Specifies that the interdisciplinary care plan must delineate the services to be provided by either the facility or the hospice staff.

58A-5.031 Limited Nursing Services

- General clarification, updating of terminology, deletion of duplicative text, correction of citations.

58A-5.033 Administrative Enforcement

- Removed portions of rule section which were wholly duplicative of Part II, Chapter 408, F.S., and Rule Chapter 59A-35, F.A.C., remaining portions were consolidated.

58A-5.035 Waivers

- General clarification, updating of terminology, deletion of duplicative text.

Florida Assisted Living Workgroup, Phase II Recommendations

November 26, 2012

Final Report of the Assisted Living Workgroup

On January 31, 2012 Governor Rick Scott directed the Agency to go forward with Phase II of the Assisted Living Workgroup (AL Workgroup) to continue the examination of issues related to assisted living facilities (ALF). Phase I of the AL Workgroup made recommendations to the Governor and Legislature to improve the monitoring of safety in ALFs. Phase I took place between August 8, 2011 and November 8, 2011, and a report of initial (Phase I) recommendations was issues in November 2011.

In the 2011 report, the AL Workgroup recommended that a Phase II workgroup be appointed to continue to address assisted living policy and regulation in a comprehensive manner. Phase II Assisted Living Workgroup meetings were held on June 25th in Jacksonville, July 27th in Fort Lauderdale, September 10th in Orlando and October 3rd through the 5th in Tallahassee as well as two conference calls that took place on August 31st and September 21st. The AL Workgroup heard testimony and presentations from a wide spectrum of the stakeholders, including: assisted living resident advocates, operators, owners, administrators, state agency staff, managed care organizations, and community mental health centers.

The workgroup included the State Long-Term Care Ombudsman, assisted living facility representative, advocates, health care association representatives, policy experts as well as Senator Rene Garcia and Representative Matt Hudson. Dr. Larry Polivka, Director and Scholar in Residence at the Claude Pepper Foundation, served as Chairman of the workgroup and Agency Secretary Elizabeth Dudek and representatives from the Governor's Office participated in each meeting. State agency leadership participation included representatives from each Agency involved in assisted living facility oversight.

Phase II of the AL Workgroup was designed to utilize the information and recommendations gathered during Phase I and develop recommendations for Legislative proposals for the 2013 Legislative session.

Dr. Larry Polivka, Chair, identified three major priorities of the Phase II Workgroup:

- Identification and discussion of mental health related assisted living issues.
- Evaluation and discussion of issues raised during Phase I relating to organizational infrastructure for regulation.
- Evaluation and discussion of issues related to administrative qualifications, licensure, resident admission/discharge, staffing, resident rights and safety issues.

Throughout Phase II, twenty-one public comments were heard and eleven state agency presentations were made. Additionally, due to the amount of public testimony and potential mental health recommendations, the AL workgroup dedicated two full days to mental health issues, October 4-5, 2012. Prior to that meeting, an Assisted Living Facility/Limited Mental Health and Community Mental Health Center Summit conference call was held September 21, 2012 and a follow-up Summit was held in Tallahassee October 3, 2012. Workgroup member Bob Sharpe, President and CEO, Florida Council for

Community Mental Health, chaired the Summit and presented specific recommendations from the Summit to the Al Workgroup for consideration at the October 4-5, 2012 meeting.

All of the written resources used by the workgroup along with the minutes for the meetings and the Phase I Final Report & Recommendations are available to view at http://ahca.myflorida.com/SCHS/CommiteesCouncils/ALWG/index.shtml.

WORKGROUP MEMBERSHIP AND PARTICIPATION

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

Larry Polivka, PhD., Chair, The Pepper Center Florida State University
Senator Rene Garcia, The Florida Senate
Representative Matt Hudson, The Florida House of Representatives
Larry Sherberg, Florida Assisted Living Association
Steven P. Schrunk, Florida Health Care Association
Charles Paulk, Florida Life Care Residents Association (FLiCRA)
Jack McRay, AARP-Florida
Jim Crochet, Long Term Care Ombudsman
Bob Sharpe, Florida Council for Community Mental Health
Scott Selis, Esq., The Florida Bar, Elder Law Section
Brian Robare, The Villa at Carpenters
Roxana Solano, Villa Serena I-V
Michael Bay, Eastside Care, Inc.
Martha Lenderman, Lenderman and Associates
Luis E. Collazo, MSW, Palm Breeze ALF
Darlene Arbeit, LeadingAge Florida

The Office of the Governor was represented by Danielle Scoggins and Michael Joos.

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

Elizabeth Dudek, Secretary, Agency for Health Care Administration
Molly McKinstry, Deputy Secretary for Health Quality Assurance, Agency for Health Care Administration
Polly Weaver, Bureau Chief, Field Operations, Agency for Health Care Administration
Anne Avery, Operations and Management Consultant, Bureau of Field Operations, Agency for Health Care Administration
Darcy Abbott, Bureau of Medicaid Services, Agency for Health Care Administration
Carol Barr Platt, AHCA Administrator, Managed Behavioral Health, Legislative Analysis & Special Projects Unit, Bureau of Managed Health Care, Agency for Health Care Administration
David Oropallo, Bureau Chief, Health Facility Regulation, Agency for Health Care Administration
Shaddrick Haston, Esq., Assisted Living Unit Manager, Agency for Health Care Administration
Susan Kaempfer, Operations and Management Consultant Manager, Assisted Living Unit, Agency for Health Care Administration
Marisol Novak, Government Operations Specialist, Bureau of Health Facility Regulation, Agency for Health Care Administration

Charles Corley, Secretary, Department of Elder Affairs
Susan Rice, Assistant General Counsel, Department of Elder Affairs
Jackie Beck, Bureau Chief, Mental Health Services, Department of Children and Families
Robert Anderson, Director Adult Protective Services, Department of Children and Families
Cynthia Holland, Bureau Chief, Substance Abuse and Mental Health Services, Department of Children and Families
Mary Beth Vickers, Division Director, Children Medical Services, Department of Health
Robin Eychaner, Environmental Supervisor II, Bureau of Environmental Health, Department of Health
James Varnado, Director, Medicaid Fraud Control Unit, Attorney General's Office
David Bundy, Chief Assistant Attorney General, Medicaid Fraud Control Unit, Office of the Attorney General
Captain Chuck Jordan, Medicaid Fraud Control Unit—Central Florida Region, Office of the Attorney General
Captain William Avery, Medicaid Fraud Control Unit, Office of the Attorney General
Captain David Brockmeier, Medicaid Fraud Control Unit, Office of the Attorney General
George Cooper, State Fire Marshall, Department of Financial Services
Fred Chaplin, Regional Supervisor, Bureau of Fire Prevention, Department of Financial Services
Tom Rice, Operations Review Specialist, Agency for Persons with Disabilities
Gerry Driscoll, South East Region Manager, Agency for Persons with Disabilities

EXECUTIVE SUMMARY

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

The changing landscape of long-term care with the expected implementation of Medicaid managed care statewide will further strengthen and evolve the role of ALFs. In addition, Phase II of the AL Workgroup delved into the expanding role of ALFs providing residential services to the limited mental health population. The need for clear roles and responsibilities for provision of services to all categories of residents within ALFs is evident, and will help to provide more efficient and effective care to these residents

This report and the recommendations contained herein, if passed into law, would increase some regulations and continue Florida's tradition of providing the home-like characteristics that have allowed for such growth. These recommendations will also address the growing limited mental health community residing in ALFs with resident's safety and security ensured. Going forward, the Agency for Health Care Administration must continue diligent cooperation with other agencies, provider representatives, advocates, families and individuals to reduce regulation in areas that are overly burdensome while implementing further safeguards and regulations that will protect the residents of ALFs in the ever-evolving health care landscape.

ASSISTED LIVING WORKGROUP RECOMMENDATIONS

The Assisted Living Workgroup, Phase II, compiled a series of recommendations based on public meetings and member input. Although not all issues had the full support of each member, Phase II recommendations did receive approval by a majority of members.

Based on Phase II deliberations, the following recommendations were made:

Utilize Current Regulations

1. Utilize existing regulations to evict unethical or incompetent providers from the system. Recognize that most ALF residents are currently being well taken care of under the current regulatory environment. Do not undermine a social model of care that works.

2. Evaluate the ALF enforcement process beyond a punitive approach. Although the punitive approach is necessary for chronically poor performing facilities, it is not the best way to elevate quality across the ALF community. Examine the Wisconsin model for ALF regulation which is similar to the AHCA abbreviated survey with the addition of a consultative/collaborative regulatory model.

3. Maintain current law that fines will only be imposed for low-level citations if uncorrected, to focus penalties on poor performers without adverse impact on competent providers.

4. Work with long-term managed care plans, once selected by AHCA, to promote the number and use of ALF beds through reimbursement and other incentives, so that the plans increasingly serve as appropriate diversions to nursing home care as well as serving those on waiting lists for nursing home care.

Licensure Revisions

5. Enable a public record exemption for AHCA complaints. Complaints filed with AHCA are currently not protected from disclosure. Consider adding confidentiality to AHCA complaints equivalent to that of the Ombudsman.

6. Allow assisted living facilities to use bulk over-the-counter medications.

7. Amend Chapter 429, F.S., to authorize the use of a floating license for facilities that have a standard, LNS or ECC license.

8. Amend Chapter 429, F.S., to allow Assisted Living Facilities to use the acronym ALF on business cards and other forms of advertising rather than having to spell out Assisted Living Facility.

9. Make technical changes to Chapter 429.14 specific to administrative penalties by changing deficiencies to violations.

10. Include a volunteer representative from another licensed ALF in an AHCA ALF survey team, provided that the ALF being surveyed agrees to the presence of the volunteer representative. A volunteer representative must comply with confidentiality statutes or regulations applicable to the survey team.

Multiple Regulators

11. Form a workgroup of all agencies involved in ALF regulation and stakeholder groups to develop a new organizational structure streamlining the regulatory process. Designate AHCA as the lead agency for all regulatory activities in the interim.

12. Improve coordination between the various federal, state and local agencies with any role in long-term care facilities oversight, especially ALFs. This includes AHCA, the Long Term Care Ombudsman Program, local fire authorities, local health departments, DCF, DOEA, local law enforcement and the AG's Office.

13. Clearly define and formalize Agency responsibilities and lines of communication, coordination and cooperation between agencies with oversight/regulatory through inter-agency agreements.

14. Allow AHCA discretion to use DCF Adult Protective Services findings and pursue sanctions for verified abuse and neglect findings in a facility.

15. Evaluate the ability to determine Level of Care at the time a person is initially added to the wait list as well as allow a person who meets nursing home level of care to receive Medicaid at the ICP level while awaiting long-term care services. AHCA should work with DOEA on this evaluation.

16. Develop a strategy with the State Fire Marshal, DOEA and AHCA to deliver a proposal to address life safety plans and fire sprinkler systems for ALFs with communities with municipal water supply access issues.

17. Develop a strategy with the State Fire Marshal, DOEA and AHCA to deliver a proposal addressing locked unit requirement within facilities.

18. Authorize use of DCF Adult Protective Services finding and investigations in employment matters. As it currently stands, s. 415.107 (8), F.S., states that "information in the Central Abuse Hotline may not be used for employment screening." The current statutory construct allows for the verified perpetrators of abuse, neglect or financial exploitation to continue working with vulnerable populations as long as none of those cases subsequently result in prosecution and conviction. Allowing ALFs (and other providers) to use the information from the abuse registry to screen out such employees during the hiring process would necessitate a change in this law. This change would require DCF to offer due process hearings for perpetrators prior to the closure of all abuse investigations with verified indicators.

19. Modify existing administrative rules so that any licensee, direct service provider, volunteer or any other person working in a residential facility who is an alleged named perpetrator in an active protective investigation of abuse, neglect or exploitation of a vulnerable adult under

Chapter 415, F.S., or abuse, abandonment or neglect of a child under part II of Chapter 39, F.S., and upon reasonable suspicion by an DCF investigator, are prohibited from working directly with residents or being alone with residents until the investigation is closed. The only exception to this prohibition would be if the alleged perpetrator is under the constant visual supervision of other persons working in the facility who are not also alleged named perpetrators in the same investigation. This provision would only be applicable in situations where the licensee has been made aware of the investigation.

20. Work together within state agencies to minimize audit and documentation regulatory requirements on community mental health agencies and ALFs by at least 30 percent to provide for better patient coordination and outcomes.

21. Improve the accessibility of transportation services for ALF residents by working with the Florida Transportation Commission, DCF and AHCA.

Administrator Qualifications

22. Develop protocols for administrator mentorship programs by the provider community and ALF associations for ALFs with no Class I or II violations in the past two years.

23. Create a professional board with regulatory responsibility for assisted living facility administrators.

24. Require assisted living administrators to hold certification by a non-profit third-party credentialing organization. This certification is to be in lieu of licensing administrators.

Information and Reporting

25. Require AHCA to investigate the types of technology currently available for cost effective methods of collection, reporting and analyzing client information and allow facilities to select the type of technology most appropriate to each individual facility—including the availability of swipe or scan handheld devices. The fiscal impact of the equipment, software and staff time must be considerations.

26. Require AHCA to examine the "Dashboard" technology used by DCF in measuring the outcomes of Community Based Care agencies serving dependent children as some aspects of this oversight may be applicable to long-term care settings.

27. Amend Chapter 429, F.S., to consolidate the adverse incident report from two reports into one final report. This final report will be filed within 15 business days of the occurrence of the adverse incident, except in cases of death or elopement.

28. Establish through pilot projects the development of consultative health quality initiatives in Florida. The pilot projects should include criteria for quality improvement plans and a means of measuring progress towards implementation of quality improvement plans. These pilot projects should include data collection requirements regarding resident satisfaction, quality of care indicators and implementation of best practices into the hands of frontline caregivers.

29. AHCA should conduct a cost of care study that would establish cost of care to meet all the requirements associated with the care of a resident in a licensed LMH ALF, a standard licensed facility, a licensed LNS and ECC facility.

Resident Rights and Safety

30. Hold state and local hospitals accountable for discharge planning that matches individual needs and desires to an appropriate and available setting that best integrates individuals into the community. Modify Chapter 395, F.S., to require hospital document consideration of an individual's choices in discharge placements. Address hospitals that do not consider the individual's preferences and community integration in discharge planning.

31. Establish a hospital discharge protocol to an ALF that should include, at a minimum: 3 days of medication if the resident is being discharged during a non-business day, a completed 1823, insurance information, prescriptions, diagnosis, prognosis and discharge orders.

32. Enact legislation that provides ALF residents a formal appeal process for disputed discharge.

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

34. Increase the amount and quality of activities made available to ALF residents.

35. Evaluate expectations for quality of life and care in an ALF. Focus cannot be limited to physical health and safety—it must extend to other quality of life factors, including staff that are kind and focused of the individual wants/needs of each resident.

36. Amend Chapter 429, F.S., to include proposed language that will increase the provision an ALF may provide for the safekeeping of a resident's personal property and funds from $200 to $500. This is more in line with today's economy.

Consumer Information

37. Develop an independent Medicaid consumer choice counseling hotline for patients, their families or medical professionals to access information on making informed decisions about appropriate ALF placement. This single point of contact could provide options depending on managed care options. This will be operated by a third party to eliminate the possibility of referrals to facilities motivated for reasons other than resident needs.

Mental Health

38. Require the ALF's administrator, or designee, who acts to have a resident involuntary examined pursuant to Chapter 394, F.S., to document in the resident record the steps taken to prevent the

Baker Act within five business days after the initiation of the Baker Act. The presence of the documentation within the timeframe permitted shall be sufficient to satisfy the requirement.

39. Increase state funding to limited mental health facilities prior to imposing fee increases by state and local agencies.

40. Increase funding for personal needs allowance for ALF residents and provide cost of living increases for ALF residents receiving OSS funds.

41. Convene a summit to collaborate on issues to provide better care to residents of ALFs who have a mental illness with ALF operators and Community Mental Health Centers.

42. Allow DCF to provide more intense services for ALF residents with mental illness.

43. Improve case management services and advocacy for residents by offering residents choice of case managers and living arrangements.

44. Prohibit targeted case management from being provided by an assisted living facility.

45. Increase the monitoring of case managers.

46. Conduct a study to explore the methods of enhancing care for persons with severe and persistent mental illness in ALFs.

47. Develop methods for reducing the LMH ALF resident-to-staff case management ratios for community mental health agencies.

48. Work together to develop a crisis avoidance system for ALFs and ALF residents with the ALF providers, community mental health agencies and managed care organizations.

49. Increase the availability, use and responsiveness of emergency interventions, including but not limited to, mobile crisis services.

50. Clarify roles and responsibilities of LMH ALFs and make appropriate changes with AHCA, DOEA, DCF and any other appropriate agencies.

Additional Policy Issues

51. Support legislation to form an ALF Policy Council to continue to address issues identified by the workgroup. The ALF Policy Council should meet on a permanent, on-going basis.

52. Additional funds should be appropriated by the legislature for assistive care services and other budget categories that support the cost of care for residents of assisted living facilities.

53. Address the issue of tort reform in assisted living facilities through legislation.

Recommendations from ALF Workgroup for 2013 Legislation

I. The Assisted Living Workgroup met from August 2011 to October 2012 (7 meetings), produced two Reports (Phase I and Phase 2) with about 125 recommendations.

II. This reflects, I think, the gap between assisted living growth and change and our current regulatory framework.

III. I've always been very sensitive to regulatory over reach in assisted living and opposed the imposition of a NH like regulatory framework in assisted living and national regulatory legislation similar to NH regulation since the 1980s. And I've supported increasing Assisted Living Facilities capacity to allow aging in place (admission and retention of more impaired residents)--since the ECC License in 1990/91. But, I've also long felt that we (policymakers, advocates, media) should monitor the growth (huge since 1992) and changes in assisted living (residents and services) from a public policy perspective, including regulation. As more impaired residents live in assisted living and age in place we need to ensure that the regulatory framework continues to be effective--responsive to resident needs for an adequate quality of care and life.

IV. I think I shared this perspective with other members of the Assisted Living Workgroup, all of whom were very conscientious and thoughtful in all workgroup deliberations and the development of final recommendations. It was an honor to be able to work with them.

V. Many Phase I recommendations were included in 1012 ALF legislation (2 senate bills—most of the higher priority recommendations were in both bills and other were in one or the other bill). I hope these recommendations are also included in any 2013 legislation.

VI. I have identified the following recommendations from the Phase I Report for priority attention in the development of 2013 Legislation. I did not include any from the 24 training recommendations, several of which were addressed in the DOEA negotiated rule for assisted living. I am inclined to defer to AHCA, DOEA and others in identifying the other training recommendations that should be included in any 2013 Legislation.

ALF Administrator Qualifications

1. Raise standards to become an ALF administrator including:

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

- A bachelor's degree in a field other than in health care from an accredited college and one year experience working in an ALF or,
- At least two years experience working in a health care related field having direct contact with one or more of the client groups or,
- A valid nursing home administrator's license, or
- A valid registered nurse license, or
- Grandfather existing administrators with certain training and experience, and no Class I or Class II deficiencies in their past.

Surveys and Inspections

2. Modify survey frequency. Inspect facilities with a problematic regulatory history, as defined in statue, more frequently than once every two years. Require more frequent and extensive inspections of those facilities that have recurring or observed deficiencies.

3. Allow AHCA to approve accreditation for facilities that have undergone accredititation or certification by a nationally recognized body such as CARF might be helpful to reduce the number and frequency of on-site surveys. Any deemed status must be based on a nationally recognized accreditation body or upon a documentation history of high performance without serious or repeated citations.

4. Require a specific number of lead surveyors in each area office to specialize on ALF inspections and be dedicated to ALF inspections only.

5. Require dedicated AHCA staff to monitor surveyors and the field work to ensure consistency in inspections, citing deficiencies, and enforcement throughout the state.

6. Assess AHCA inspection forms. Create a workgroup that includes Ombudsman members and stakeholders to assess AHCA inspection forms to assure they adequately assess ALF compliance with the law, resident protection, and meeting resident needs.

7. Require dedicated AHCA staff to focus on assisted living facilities including one position to monitor state-wide issues and lead surveyors in each field office.

Licensure

8. Prohibit an administrator or property owner associated with an ALF with a regulatory record that would qualify for license revocation or denial, from future affiliation with an ALF. Align with the requirements in s. 408.815 that allow mitigation. This provision would require disclosure of property ownership.

Resident Discharge

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

10. Mandate that social workers and discharge planners provide a completed AHCA 1823 Form to the assisted living facility administrator to ensure appropriateness of the resident's admission.

ALF Information and Reporting

11. Require minimal online data submission to the Agency on a quarterly basis. ALFs currently submit data to the agency in a variety of online applications including adverse incident reporting, monthly liability claim reporting and participation in the Emergency Status System (over 85% of ALF have online accounts). ALF data submission to the Agency should include:
    Number of residents (census)
    Number of residents requiring specialty license services: Limited Nursing Services (LNS), Limited Mental Health (LMH), Extended Congregate Care (ECC)
    Number of residents on Optional State Supplementation (OSS)
    Number of Medicaid recipients whose care is funded through Medicaid by type of waiver

Enforcement

12. Require AHCA to assess certain administrative penalties such as increasing sanctions for recurrence of serious deficiencies affecting resident' health, safety, or welfare or failure to pay fine.

13. Require a mandatory moratorium for serious violations (Class I or II), when an ALF fails to correct all outstanding deficiencies and reach full compliance at the time of a follow up visit or by the mandatory correction date.

14. Authorize AHCA to cite violations for falsification of information. Current laws authorize licensure action for falsification of a license application [s. 408.815(1)(a) F.S] or authorize criminal penalties for falsification of records (s. 429.49, F.S.), but do not address licensure violations for other falsified documentation submitted to AHCA.

Resident Advocacy

15. An employee or volunteer of the Office of Long Term Care Ombudsman shall be required to report, with the resident's consent, all instances of resident retaliation exercising rights guarantee pursuant to s. 429.28, F.S., the resident bill of rights. The Agency is required to impose a sanction for this violation regardless of the deficiency classification. The Agency shall not be required to reinvestigate the incident if the Office of the LTCOC provides a certification that this was an investigation by the Office and the incident was confirmed.

16. Ensure volunteers have the right to visit licensed programs at any time for purposes of monitoring as well as for complaint resolution. All observations and findings should be submitted to AHCA and acted on in an expedited manner.

17. Create an independent statewide ALF Council made up of residents, ombudsmen, and families (at least 2/3 of the membership), in addition to one member from each respective trade association, to meet periodically.

Mental Health

18. Require a Limited Mental Health (LMH) license for ALFs with any mental health residents. The current definition of LMH license is an ALF that serves three or more mentally ill or disabled residents must obtain a limited mental health (LMH) specialty license. Change the definition to require an ALF that serves one or more mental health residents as defined in statute to obtain a limited mental health specialty license. For the purposes of assisted living licensure, a mental health resident is defined as an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives optional state supplementation (OSS). This definition is limited as there may be other assisted living facility residents with sever and persistent mental illness who have a case manager but do not meet this specific definition.

Multiple Regulators

19. Require in law that AHCA staff and other agencies involved in ALF's report knowledge or suspicion of any resident abuse, neglect or exploitation to the central DCF abuse hotline.

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

Phase II Recommendations

21. Establish an ALF Policy Review Council with broad representation from AHCA, DCF, DOEA and ADP, from the ALF industry, ALF residents and family members, aging and disabled adults, mental health and developmentally disabled advocates and other policy experts. The council should have 15-20 members appointed by the Governor for terms of two and three years and meet at least three times a year. Several other high priority ALF Workgroup recommendations could be among the first issues addressed by the Council including the following:

    - Evaluate the ALF enforcement process beyond a punitive approach. Although the punitive approach is necessary for chronically poor performing facilities, it is not the best way to elevate quality across the ALF community. Examine the Wisconsin model for ALF regulation which is similar to the AHCA abbreviated survey with the addition of a consultative/collaborative regulatory model.
    - Amend Chapter 429, F.S., to authorize the use of a floating license for facilities that have a standard, LNS or ECC license.

- Authorize use of DCF Adult Protective Services finding and investigations in employment matters. As it currently stands, s. 415.107 (8), F.S., states that "information in the Central Abuse Hotline may not be used for employment screening." The current statutory construct allows for the verified perpetrators of abuse, neglect or financial exploitation to continue working with vulnerable populations as long as none of those cases subsequently result in prosecution and conviction. Allowing ALFs (and other providers) to use the information from the abuse registry to screen out such employees during the hiring process would necessitate a change in this law. This change would require DCF to offer due process hearings for perpetrators prior to the closure of all abuse investigations with verified indicators.
- Develop methods for reducing the LMH ALF resident-to-staff case management ratios for community mental health agencies.
- Work together to develop a crisis avoidance system for ALFs and ALF residents with the ALF providers, community mental health agencies and managed care organizations.
- Increase the availability, use and responsiveness of emergency interventions, including but not limited to, mobile crisis services.

Assisted living is a rapidly growing and evolving part of the long-term care system and is expected to play an increasingly important role as Florida moves towards reducing its reliance on nursing homes and maintaining more care recipients in the community. As this occurs assisted living is likely to become a bigger part of the long-term care system than nursing home care and to serve a more impaired and care dependent population it does today. These trends should be carefully monitored and the state's capacity to respond effectively to changes should be enhanced. A Policy Review Council with a broadly representative membership should be an effective vehicle for this enhancement.

Other high priorities from the Phase II Report of the Workgroup include the following:

22. Include a volunteer representative from another licensed ALF in an AHCA ALF survey team, provided that the ALF being surveyed agrees to the presence of the volunteer representative. A volunteer representative must comply with confidentiality statutes or regulations applicable to the survey team.

23. Form a workgroup of all agencies involved in ALF regulation and stakeholder groups to develop a new organizational structure streamlining the regulatory process. Designate AHCA as the lead agency for all regulatory activities in the interim.

24. Allow AHCA discretion to use DCF Adult Protective Services findings and pursue sanctions for verified abuse and neglect findings in a facility.

25. Evaluate the ability to determine Level of Care at the time a person is initially added to the wait list as well as allow a person who meets nursing home level of care to receive Medicaid at the ICP level while awaiting long-term care services. AHCA should work with DOEA on this evaluation.

ALF Administrator Qualifications

In addition to administrator qualifications recommended in the Workgroup Phase I Report, the state should:

26. Improve the accessibility of transportation services for ALF residents by working with the Florida Transportation Commission, DCF and AHCA.

ALF Information and Reporting

In addition to the information and reporting recommendations in the Workgroup Phase I Report, the state should:

27. Require AHCA to investigate the types of technology currently available for cost effective methods of collection, reporting and analyzing client information and allow facilities to select the type of technology most appropriate to each individual facility—including the availability of swipe or scan handheld devices. The fiscal impact of the equipment, software and staff time must be considerations.

28. Establish through pilot projects the development of consultative health quality initiatives in Florida. The pilot projects should include criteria for quality improvement plans and a means of measuring progress towards implementation of quality improvement plans. These pilot projects should include data collection requirements regarding resident satisfaction, quality of care indicators and implementation of best practices into the hands of frontline caregivers.

29. AHCA should conduct a cost of care study that would establish cost of care to meet all the requirements associated with the care of a resident in a licensed LMH ALF, a standard licensed facility, a licensed LNS and ECC facility.

Resident Admission, Quality of Life, Discharge, Safety and Rights

30. Hold state and local hospitals accountable for discharge planning that matches individual needs and desires to an appropriate and available setting that best integrates individuals into the community. Modify Chapter 395, F.S., to require hospital document consideration of an individual's choices in discharge placements. Address hospitals that do not consider the individual's preferences and community integration in discharge planning.

The Phase I report included a recommendation to:
"Reduce the resident discharge notice from 45 to 30 days and provide an option for the resident to appeal a decision within 10 days. The entire appeal process should take no longer than 45 days."

This recommendation was reinforced by two Phase II recommendations:

31. Establish a hospital discharge protocol to an ALF that should include, at a minimum: 3 days of medication if the resident is being discharged during a non-business day, a completed 1823, insurance information, prescriptions, diagnosis, prognosis and discharge orders.

32. Enact legislation that provides ALF residents a formal appeal process for disputed discharge.

Consumer Information

33. Develop an independent Medicaid consumer choice counseling hotline for patients, their families or medical professionals to access information on making informed decisions about appropriate ALF placement. This single point of contact could provide options depending on managed care options. This will be operated by a third party to eliminate the possibility of referrals to facilities motivated for reasons other than resident needs.

Mental Health

34. Require the ALF's administrator, or designee, who acts to have a resident involuntary examined pursuant to Chapter 394, F.S., to document in the resident record the steps taken to prevent the Baker Act within five business days after the initiation of the Baker Act. The presence of the documentation within the timeframe permitted shall be sufficient to satisfy the requirement.

35. Improve case management services and advocacy for residents by offering residents choice of case managers and living arrangements.

36. Prohibit targeted case management from being provided by an assisted living facility.

37. Increase the monitoring of case managers.

38. Clarify roles and responsibilities of LMH ALFs and make appropriate changes through a collaborative process including AHCA, DOEA, DCF and any other appropriate agencies.

The Phase I recommendation to require a Limited Mental Health License for ALFs with any mental health residents (one or more) should not be lost sight of.

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

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

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

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

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

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

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

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

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

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

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

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

Tragedies revealed

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

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

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

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

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

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

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

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

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

without doctors' orders.

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

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

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

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

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

Failure to protect

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

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

For example:

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

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

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

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

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

penalties are routinely decreased, delayed or dropped altogether.

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

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

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

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

Both facilities are still licensed by AHCA.

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

Reluctant to punish

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

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

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

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

Eventually, someone died.

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

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

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

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

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

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

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

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

Homes of horror

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

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

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

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

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

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

once every two years.

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

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

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

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

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

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

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

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

Cases skyrocket

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For Rosalie Manor, it was a longer battle.

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

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

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

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

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

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

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

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

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

Administrator charged

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

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

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

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

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

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

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

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

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

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

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

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

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

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

facility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

investigations — concealing key evidence. None was charged.

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

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

The wrong drugs

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

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

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

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

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

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

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

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

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

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

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

the caretakers refused to dial 911, records state.

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

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

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

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

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

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

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

Fatal mistakes

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

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

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

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

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

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

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

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

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

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

The end came after the 11th fall.

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

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

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

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

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

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

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

Baseball-size sore

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

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

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

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

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

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

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

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

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

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

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

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

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

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

with no autopsy.

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

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

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

No red flags

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

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

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

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

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

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

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

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

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

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

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

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

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

Miami Herald staff writer Jared Goyette contributed to this report.

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Part III | Inspectors find violations at Lauderhill ALFs

By Laura Figueroa
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More than a dozen inspectors, representing state and local agencies, conducted an unusual round of surprise inspections at several Lauderhill assisted living facilities Thursday. Their target: the blighted Cannon Point community, known to many as "ALF Row."

On Thursday, inspectors found unsanitary conditions at three of the facilities that house elderly and mental health patients. Among the findings: A live mouse stuck to a glue trap. A drawer lined with mouse droppings. Roaches scurrying around the kitchen.

Orchestrated by the State Attorney General's Medicaid Fraud Unit, the inspections come two weeks after the Herald's investigative series "Neglected to Death" detailed sweeping breakdowns in the state's oversight of ALFs leaving thousands of people to fend for themselves in dangerous conditions. The Herald found that dozens of people died from abuse and neglect at the hands of caretakers over the past decade, but few were ever held accountable.

"They should have been out here a long time ago," said Daniel Reiter, a volunteer inspector with the Florida Department of Elders Affairs Ombudsman Program, which is manned by state certified volunteers. As an ombudsman for the state, Reiter can investigate complaints, but his office has no authority to leverage punishments.

Reiter said different state agencies, such as the Agency for Health Care Administration, which oversees the state's 2,850 ALFs, has the ability to enforce penalties.

"These residents are neglected, exploited, abused, locked in, locked out and no one seems to care," Reiter said.

The Attorney General's office, noting the surprise element of the inspections, declined to comment on what prompted the two-day sweep that continues Friday, or which specific facilities were up for review.

"Generally speaking we do not let the facilities know ahead of time that they are going to be the subject of an inspection," said Jennifer Krell Davis, spokeswoman for the State Attorney General Pam Bondi's office.

Surprise factor or not, many of the ALFs inspected on Thursday are no stranger to scrutiny from state and city inspectors.

Positioned in the heart of Lauderhill, Cannon Point has the largest concentration of ALFs in the state, drawing police and rescue calls around the clock to respond to emergencies, including fights, mental health breakdowns and drug deals. Since 2005, police and rescue calls to the facility have totaled 13, 250 — roughly one call every four hours, according to an analysis of 911 calls.

Early Thursday, at Loving Care of Lauderhill, 5607 NW 27th Court, residents on sat in a gated courtyard smoking cigarettes and lounging, unphased by the fleet of state and Lauderhill police and fire rescue cars pulling up to the facility.

Many welcomed the opportunity to talk to state inspectors, even if their interactions were brief.

Resident Alonza Jones, 47, has lived at the facility since March, and said inspectors asked him how he was feeling and whether he liked the ALF's food.

"You would figure if they were with the state they would spend more time with us," Jones said. "Maybe they don't want us to get too noisy."

Jones said he had no issues with his treatment at Loving Care, he just wished they organized more activities for the residents.

"We get bored," he said between puffs of a cigarette.

Ilene Lasher, 57, said she told inspectors she "liked" her digs at Loving Care, with one exception.

"They have mental health drugs and they give it to people who sometimes don't need it," Lasher said.

When reviewing the facility's medical rolls, Reiter, with the ombudsman's office, said several residents were checked off for receiving medicine ahead of the date they were suppose to receive it.

Since 2003, Loving Care of Lauderhill has been issued 57 citations from the Agency of Healthcare Administration, including violations for not administering medications properly and overall problems with the facility's upkeep from plumbing problems to faulty locks. Loving Care has also been sanctioned with close to $11,000 in fines according to state records.

Facility administrator Angela Changoor declined to comment for this article.

What made Thursday's surprise inspections so unusual was the number of ALFs visited. Typically, inspections happen at one facility, but for the agencies to plan to

sweep through six ALFs over two days is highly extraordinary. Each detailed inspection take about three hours.

Reiter said its up to the state and respective agencies to enforce the different violations found.

Thursday's check is expected to result in fines for the three facilities investigated, but those sanctions must first be approved by the state agency that oversees health care facilities.

It's unlikely that any of the ALFs will be shut down, but Reiter said he hoped the surprise sweep would send a message to the facility administrators.

"We want them to clean these places up, follow the rules," Reiter said. "The residents deserve that."

WLRN-Miami Herald reporter Kenny Malone contributed to this report.

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Lawmakers pushed to slash state oversight of Assisted Living Facilities

By Michael Sallah, Rob Barry and Carol Marbin-Miller
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When Sedrek Singleton, a career criminal with a violent past, checked into Nueva Vida assisted living facility, caretakers at the cluster of cottages in Miami-Dade never took steps to protect other residents.

They never had to.

Months after moving in, the 30-year-old man flew into a rampage, beating his roommate to death with a brick — nearly tearing off the disabled man's ear — before bolting from his new home.

The brutal assault came just weeks after Florida lawmakers rejected a bill that would have put the burden squarely on ALF owners to safeguard people in their homes when accepting residents with criminal histories.

But the defeat in 2008 to bring more protections to vulnerable residents was just the beginning.

Over the next three years, lawmakers rejected sweeping plans to toughen Florida's ALF law — often at the urging of industry leaders — while stripping away enforcement powers that left hundreds of residents to fend for themselves in dangerous conditions.

While frail residents were dying of abuse and neglect in ALFs across the state — nearly one a month — lawmakers pushed three dozen pieces of legislation since 2007 to cut crucial protections that had been in place for a generation.

The changes in Florida's ALF law created even more gaps in a state enforcement system that was already failing to investigate dangerous practices and shut down the worst offenders.

For example:

• Lawmakers said state regulators no longer have to report abuses and deaths to the Legislature, instead allowing them to keep the cases secret.

• Even as homes were caught breaking the law — including caregivers beating

residents, doping them with powerful tranquilizers and locking them in closets — lawmakers rejected a plan to crack down on rogue operators.

• Though abuse cases have risen over the past five years, lawmakers blocked efforts to heighten checks on bad homes — including inspections every 15 months — saying they were too expensive.

• As the state was finding hundreds of people languishing without proper care, lawmakers stripped the authority of inspectors to call doctors and get them removed — leaving the decision to ALF operators.

The moves to change the state's historic ALF law — one of the oldest in the country — came as abuse and neglect cases were rising in ALFs.

Led by Florida's largest industry group, a dozen lawmakers stepped forward in the past five years to create 36 pieces of legislation to remove regulations — including parts of the Residents' Bill of Rights that guarantees safety and protection to vulnerable adults.

The effort peaked this year, with legislators pressing 23 bills, including a plan by Sen. Rene Garcia — a powerful Hialeah Republican who chairs the Senate's health committee — to overhaul ALF law.

The 37-year-old lawmaker, whose district includes more than 100 ALFs — including some of the most heavily fined homes in Miami-Dade — pushed to cut back penalties against caretakers and reduce the state's power to close troubled homes.

Garcia said he was simply pressing for changes raised by industry leaders who were working with the state's chief regulator — Agency for Health Care Administration. "This was just the beginning of a long process," he told The Miami Herald. "You file a bill. Some things stay, some things don't. "

But a Herald investigation found Garcia's proposal would have stripped critical enforcement tools from a state system that has allowed dozens of the worst facilities to stay open.

Ironically, the push to slash regulations started with an effort to bring about reforms.

The gruesome discovery of Ron Larsen, 85, who was ignored by caregivers in Manatee County as a cancerous tumor engulfed his face prompted GOP Sen. Ronda Storms of Valrico to push for the most sweeping changes in the ALF law in three decades.

But her effort to increase inspections, criminal background checks and penalties on bad homes in 2008 was not only defeated, it backfired, triggering the most intense effort in state history to cut back on oversight.

Over the next three years, key lawmakers, with the support of the Florida Assisted Living Association, introduced major legislation to strip regulations in place since the 1980s.

Just months after the Storms bill was rejected, FALA named Hugh Gibson — the House sponsor who ended up killing the measure — its legislator of the year before a packed audience at an industry convention in St. Augustine.

"It was like a snowball," said Don Hering, former chair of the state ombudsman council, which opposed many of the industry's proposals. "There was no way we could compete with these people. It's the money and the staying power."

While industry leaders were pouring hundreds of thousands into the coffers of key lawmakers — more than $215,000 since 2007 — the number of new bills affecting ALFs rose every year, records show.

In one of the first significant acts, the Legislature gave up its right in 2009 to see what was taking place in the homes. No longer were regulators required to provide lawmakers the number of adverse incidents like deaths and injuries — information that can show dangerous trends.

Co-sponsored by Sen. Don Gaetz, the law also ended the state's power to bring in medical teams to decide whether sick residents should be removed from homes failing to provide enough care, leaving the decision to ALF operators.

Over the next two years, hundreds of residents were found languishing in homes unable to provide for their needs, nearly twice the rate than before the protection was cut, The Herald found.

In one facility alone, three people died, including an elderly resident who fell 24 times and was hospitalized nine times for head wounds, broken ribs and two fractured hips.

A second resident, 82-year-old Charlene Webb, suffered fatal burns after falling for the fifth time on the floor and urinating on a power strip, causing electrical surges to rip through her body.

At no point during the residents' stay at the Pasco County home did caregivers note they were in danger before they died. Karen Lucas, a company spokeswoman, said Emeritus at La Case Grande has since taken steps to resolve the problems, including increasing staff and training.

Gaetz said he was unaware of issues created by his bill and could not recall the portion that stripped the state's right to call in medical teams. "I just don't remember," said the GOP lawmaker from Destin, adding that AHCA had a major role in reviewing the language.

AHCA spokeswoman Shelisha Coleman said the agency rarely turned to the practice of calling doctors when residents were in danger, instead placing the burden on ALF

owners.

While lawmakers were making the changes, another trend was under way that left residents at risk: AHCA was slashing investigations of serious incidents — including deaths and abuse — by nearly 90 percent through most of the last decade.

While the agency was struggling to perform what were once routine duties, it agreed to numerous cuts by lawmakers, saying it supported "streamlining regulation" and reducing paperwork, according to annual reports.

AHCA told lawmakers the costs of supporting Storms' bill — one of the few to crack down on bad homes — would run $2.6 million a year and force the agency to hire 46 new people.

The agency also said new rules forcing homes to buy heart-saving devices known as defibrillators would trigger an "increase [in] the workload of AHCA staff," because ALF workers would have trouble running the machines.

"They said nothing about saving lives," said Brian Lee, past director of the state's ombudsman program who supported putting the devices in ALFs.

While a struggle emerged between industry groups and elderly advocates, a dangerous pattern was unfolding in ALFs across the state: Residents were dying at the hands of their caregivers.

At least 70 residents died from causes including starvation, gangrene, scalding burns and overdoses of powerful narcotics. And those are just the known cases: More than 200 others died under questionable circumstances, but the records are sealed under state law — even the names withheld.

Despite the deaths, lawmakers took another step to remove a key enforcement tool: the automatic shutdown of homes caught repeatedly putting residents in mortal danger.

The bid by Garcia, the Hialeah lawmaker, to strip the state's power to revoke the licenses of homes with two or more Class I violations — breaches often found in death cases — was one of the many proposed cuts he pushed in his bill this year. In addition, it would have stripped the state's power to impose additional fines when regulators catch workers breaking the law -- a key enforcement tool to crack down on bad homes.

Championed by industry leaders, the plan called for regulating homes in a "less restrictive way," including allowing the state to cut back on mandatory inspections.

The bill would have removed a key protection from the Residents Bill of Rights that allowed residents to step forward to report wrongdoing in the homes to state agents without fear of retaliation by ALF owners.

"It was damning legislation as far as residents are concerned," said Brian Lee. "I didn't see one thing that actually helped residents. It was for the industry."

Garcia, who received $8,100 from industry contributions, said he didn't favor removing the protections from residents, adding that much of the legislation was started by FALA.

He also said he was unaware of language in the bill to slash the state's authority to revoke licenses of homes caught repeating severe violations. "I just don't recall that," he said. "FALA came to me with this massive deregulation bill. We went back and forth, but my intent was to help [the industry and AHCA] create its own chapter" of enforcement.

At one point, lawmaker Michelle Rehwinkel Vasilinda said she was struck by the furious pace of the proposals, but after carefully reading a bill that tried to stop the state from providing lists of troubled ALFs to the public, she drew a line.

"This is where the rubber hits the road," said the Democratic House member from Tallahassee. "I wasn't going to vote for that."

The bill, co-sponsored by Daphne Campbell, a Miami-Dade Democrat who owned group homes until she lost her state funding when several vulnerable residents died in one of her facilities, ultimately passed, but was vetoed by Gov. Rick Scott.

Another bill would have removed the power of the state ombudsman to make yearly visits to ALFs with a checklist to make sure homes were safe for residents.

Supporters of that bill, including House sponsor Matt Hudson, argued the group was just duplicating work already being done by state regulators: AHCA.

But The Herald found that was not the case: AHCA was actually cutting back on inspections of homes — down by 33 percent in the past five years — at the same time the ombudsman program was turning up more cases of abuse and neglect than any time in the program's history.

Hudson, a Naples Republican who received more than $5,000 in industry contributions, said he believes in "less government," and if AHCA was not enforcing the law, that's the issue that needs to be addressed.

While several bills appeared to be headed for passage this year, at least 16 were put on hold, including Garcia's and most of Hudson's, after a Herald investigation in May revealed sweeping breakdowns in ALFs — with lawmakers deciding to wait until next year to resurrect the bills.

One legislator, Mike Fasano of New Port Richey, said the momentum created during the legislative session was a part of a larger culture pervading the capital this year. "The governor and lawmakers were all pushing to deregulate the professions."

The Republican senator said one of his own bills — the requirement that homes carry the life-saving heart devices — was attacked by fellow lawmakers who tried to repeal the law this year in two separate bills. "It's outrageous," he said. "I shake my head in disbelief. The cost is minimal to what the cost of a life is."

Miami Herald staff writer Laura Figueroa contributed to this report.

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic ALF Workshop

Bill Number _____ *(if applicable)*

Name Brian Lee

Amendment Barcode _____ *(if applicable)*

Job Title Executive Director

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Speaking: ☐ For ☐ Against ☑ Information

Representing Families for Better Care

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic ALFs

Bill Number _____ *(if applicable)*

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Representing AARP

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic ALF

Bill Number _____ *(if applicable)*

Name Neal McGarry

Amendment Barcode _____ *(if applicable)*

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Representing Florida Certification Board

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/2013
Meeting Date

Topic Assisted Living

Bill Number _____ *(if applicable)*

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Amendment Barcode _____ *(if applicable)*

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Speaking: ☐ For ☐ Against ☑ Information

Representing Florida Assisted Living Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/2013
Meeting Date

Topic A L F's

Bill Number _____ *(if applicable)*

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Representing JUSTICE-2-JESUS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/20/11)

OPPAGA and Auditor General Reviews of the Department of Children and Families' Independent Living Program

Presentation to the Senate Committee on Children, Families, and Elder Affairs

January 15, 2013

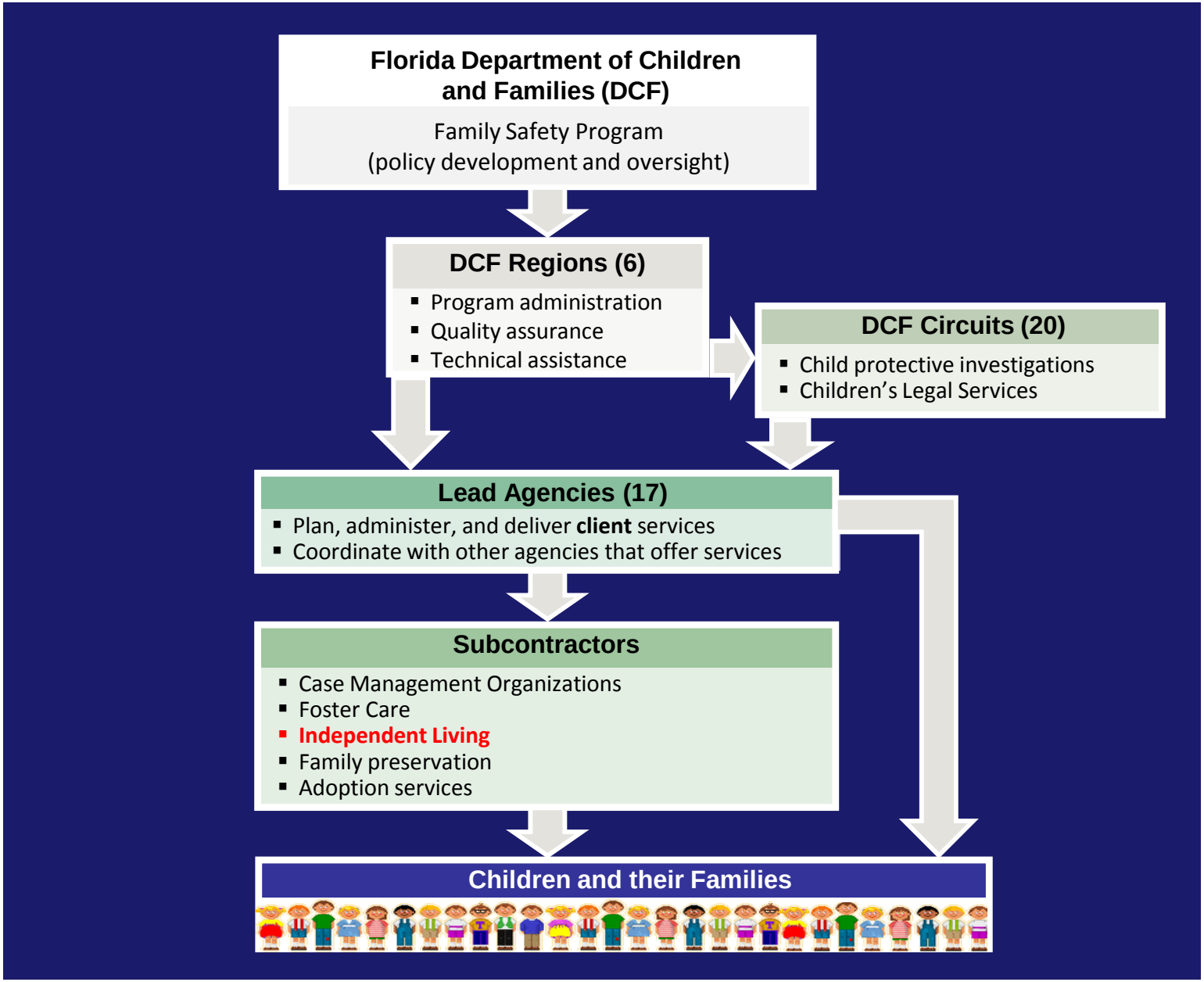
Jennifer Johnson
Staff Director, OPPAGA

Jane H. Flowers, CPA
Audit Manager, Auditor General

Independent Living

- Services and financial assistance for older children in foster care and young adults who exit foster care at age 18 to make the transition to self-sufficiency as adults
  - Section 409.1451, *Florida Statutes*
  - 1999 Federal Chafee Foster Care Independence Act (Public Law 106-169)
- Administered by the Department of Children and Families and community-based care (CBC) lead agencies

Florida's Child Welfare System



Independent Living

- The independent living program serves
  - Children ages 13 to 17 currently in foster care
  - Young adults ages 18 to 22 formerly in foster care who have “aged out” or who were adopted or placed by the court with an approved guardian after reaching the age of 16
    - Young adults seeking post-secondary education
    - Young adults in high school or seeking GED

Independent Living Services

Ages	Service	Description
13-17 years old	Pre-Independent Living (13-15 years old)	Life skills training, educational field trips, conferences, etc.
	Life Skills (15-17 years old)	Banking and budgeting skills, educational support, employment training, etc.
	Subsidized Independent Living (16-17 years old)	Living arrangements that allow an adolescent to live independently
18-22 years old	Aftercare Support	Services to assist living independently, including: tutoring, life skills classes, counseling, etc.
	Transitional Support	Short-term services that may include: employment, housing, counseling, etc.
	Road to Independence Scholarship	Financial assistance for youth to receive the training needed to achieve independence.

Independent Living

- Fiscal Year 2011-12
  - $49.0 million expenditures
- As of July 2012
  - 4,433 children eligible for services
  - 2,132 young adults receiving financial assistance

Program Oversight

	Department	CBC Lead Agencies
Contract Management	• Oversees vendor day-to-day performance • Approves deliverables and invoices • Serves as contact between department and vendors	• Oversees vendor day-to-day performance • Approves deliverables and invoices
Contract Monitoring	Assesses vendors compliance with • laws, • rules, • policies, and • contract provisions through on-site or desk reviews	Assesses subcontract vendors compliance with • contract terms (which typically include laws, rules, and policies) through periodic reviews
Quality Assurance		Conducts quarterly reviews of internal or subcontracted case management services to evaluate service quality

Oversight of Independent Living Youth Age 13-17 Years

Activity (Parties Involved)	Purpose	Frequency
Face-to-face Meeting (case manager, child, and caregiver)	Discuss with caregiver the case plan progress and the child's progress, development, health, and education	Every 30 days
Staffings (case manager, child, caregiver, guardian ad litem, attorney, independent living provider, and relatives)	Review education goals, work goals, progress in life skills	Annual for clients age 13-14 years Every six months for clients age 15-17 years
Judicial Review (case manager, child, and independent living provider)	Update court on the client's progress toward attaining independent living skills	Every 6 months

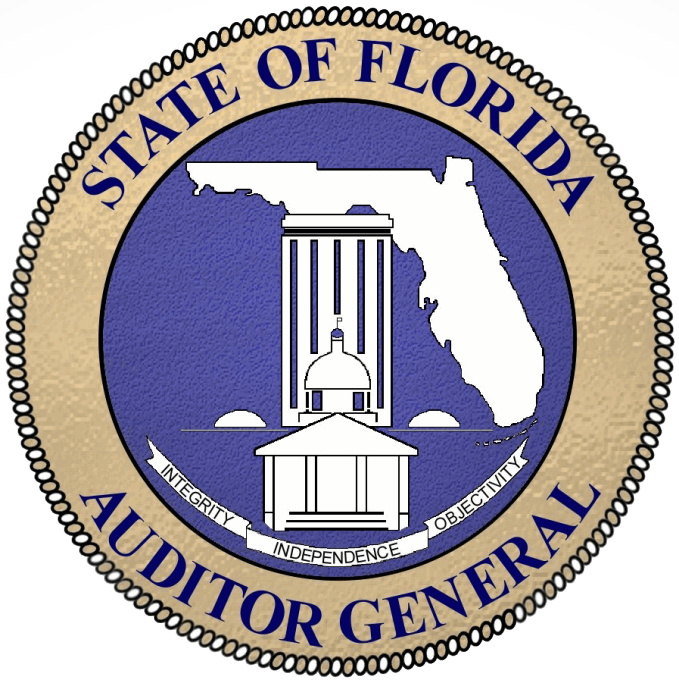
Limited Oversight of Young Adults Age 18-22 Years

- Program shift from providing services to providing financial assistance
  - Independent Living Specialists determine living and educational needs
  - Young adults receive stipend directly and have full discretion over spending
  - FY 2011-12 Road to Independence Stipend expenditures $29.4 million

Limited Oversight of Young Adults Age 18-22 Years

(continued)

- Lead agencies have limited authority to oversee how young adults use the money
  - Annual meeting to update needs assessment to determine award amount
  - No routine interaction with case managers and dependency courts
  - Only terminate funds if young adults reach educational goals, do not maintain progress, or are no longer enrolled



Independent Living Transition Services Program

Report No. 2011-176

Background

- **Audit Objectives:**
  - Obtain an understanding of Department of Children and Families internal controls relevant to the Independent Living Transition Services (ILTS) Program.
  - Determine program compliance with governing laws, rules, and Department policy.
- Follow-up of report No. 2011-176 is currently underway.
- Similar findings were disclosed in report No. 2005-119 issued February 2005.

Road to Independence Award Needs Assessment

Finding No. 1: Actual living and educational expenses were not required to be utilized as a basis for determining the amounts of the Road to Independence awards made to clients who were high school students. The Department set the cost at the statutory maximum annual award amount which is based on the Federal minimum wage.

For clients who were post-secondary students, we found instances in which required documentation was not provided or did not fully support the amount awarded. Specific instances included lack of documentation of application for grants and scholarships and to support the living and educational needs amount reported.

Appropriate Progress

Finding No. 2: Young adults receiving Road to Independence awards are required to complete the number of hours considered full time by the educational institution to maintain appropriate progress. Department rules and guidelines did not specifically address the types of documentation that would be sufficient to demonstrate appropriate progress by students in GED programs.

Transitional, Aftercare Support, and Road to Independence Payments

Finding No. 3: In some instances young adults received payments for one service type from multiple programs. While payments for more than one service type are allowed, we found multiple payments for the same service, specifically housing assistance. Additionally:

- Documentation was not always provided evidencing assessment of need for Aftercare Support assistance.
- We noted inappropriate use of Transitional Support funds for achieving an educational goal.
- Payments were erroneously coded. Instances were noted where Aftercare Support payments were charged to Transitional Support and where Transitional Support payments were incorrectly charged to Road to Independence.
- Payments were made to ineligible individuals.

Transitional, Aftercare Support, and Road to Independence Payments

Finding No. 4: We noted instances where young adults did not meet Program eligibility requirements, including instances in which the maximum age limitation was exceeded.

Finding No. 5: Our analysis disclosed that payments were made in excess of established spending caps. We noted that the maximum amounts were exceeded for Subsidized Independent Living and Road to Independence payments.

Adolescent Case Management

Finding No. 6: Documentation to support the required number of services worker contacts for adolescents in Subsidized Independent Living was not always provided. Additionally, the required staffings, assessments, and judicial reviews were not always documented or timely provided.

Finding No. 7: Specific required tasks for adolescents' staffings, assessments, and case plans were not always documented. We also identified instances in which the assessment was not completed timely.

Program Administration

Finding No. 8: The Department did not require the community-based care lead agencies to fully utilize the functionality of the Florida Safe Families Network (FSFN) specific to the ILTS Program, although system capabilities were available. We noted instances where ILTS data was not reported in FSFN or was incomplete.

Finding No. 9: We noted instances where Department monitoring efforts did not lead to timely resolution of identified problems. Exhibit B of our report summarizes Department monitoring efforts.

Performance and Outcomes

- Prior OPPAGA reports highlighted the need to track services and report outcomes
  - OPPAGA recommended that DCF track the number of 13- to 17-year old youth served by the program and the services provided
  - OPPAGA recommended that DCF require lead agencies to report data on outcomes measures

Performance and Outcomes

(continued)

- To address federal and state requirements, DCF implemented two surveys to capture data on services and outcomes
  - My Services Review Survey captures information on services for youth (age 13 to 17)
  - National Youth in Transition Database Survey captures data and tracks outcomes on young adults (age 17 to 22)
  - Lead agencies are entering data into the Florida Safe Families Network database

My Services Survey Data
Foster Care Children Ages 13-17
Spring 2012

Education	
Foster parents review report cards	76%
Caseworker reviews report cards	69%
Has Education and Career Path Plan	35%
Changed schools at least once during school year	47%

Normalcy	
Can spend time with friends without adult supervision	65%
Can spend the night with friends	45%
Receives a personal allowance each week	53%
Have a driver's license (age 16-17 only)	3%

Health and Dental Care	
Receiving needed medical care	86%
Saw a dentist in last year	86%
Eye exam in last year	68%

Juvenile Justice System Involvement	
Arrested in the past 12 months	28%
Currently on probation or under DJJ supervision	22%

Florida Nation Youth in Transition Survey Data of Young Adults Ages 18-22

Spring 2012

Education	
Completed Grade 12 or GED	57%
Completed post-secondary education	7%

Employment	
Any job—full-time, part-time, temporary, seasonal	19%

Health and Dental Care	
Has health insurance coverage	86%
Received dental services in last year	39%

Housing and Transportation	
Safe housing	92%
Experienced homelessness	28%
Reliable means of transportation to school and/or work	80%
Have a driver's license	47%

Criminal Justice System Involvement	
Arrested in past 12 months	40%

Performance and Outcomes

(continued)

- DCF requires the lead agencies to report on five outcome measures included in the contracts
- DCF reported that it would use FY 2011-12 data to set standards for the FY 2012-13 contract

Contract Measures

Percentage of youth who have aged out of care completing high school or GED by 20 years of age

Percentage of youth who completed high school or GED and are involved in post secondary education

Percentage of youth age 18 and over receiving Independent Living services who have a job (including joining the military)

Percentage of young adults in safe housing

Percentage of 17-year-old youth in licensed out of home care who had a transition plan signed by the youth and filed with the court

Questions?

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The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

RESEARCH MEMORANDUM

The Department of Children and Families' Independent Living Program

January 11, 2012

Summary

At the request of the Florida Legislature, OPPAGA reviewed the Department of Children and Families' (DCF) Independent Living Program to assess contract management and monitoring. The department has established a new system to track youth services and outcomes. In addition, the department and the lead agencies each now have systems in place to monitor the Independent Living Program. The department and lead agencies continue to address problems as they are identified through their respective monitoring systems.

Background

The state's child welfare system provides services to care for and protect abused and neglected children. Florida outsources most of its child welfare system through contracts with private, not-for-profit corporations called community-based care lead agencies. There are currently 19 lead agencies providing a continuum of child welfare services, including independent living transition services.

The Independent Living Program provides an array of transition services to adolescents and young adults. As provided by s. 409.1451, *Florida Statutes*, the program's goals are to assist older children in foster care and young adults formerly in foster care to obtain the life skills and education necessary to become self-sufficient, live independently, and maintain employment. All foster youth 13- to 17-years-old and some former foster youth 18- to 22-years-old are eligible for services.[1] (Appendix A describes the six components of the Independent Living Program.)

Some lead agencies provide direct independent living program services, while others outsource these functions. Of the 19 lead agencies, 9 manage the program themselves and 10 subcontract this responsibility to a local service provider. Each lead agency has an independent living coordinator (either in-house or with a subcontracted provider) who is responsible for overseeing the program's daily operations. Independent living coordinators ensure the timely completion of transition plans, assign clients to independent living specialists, and verify that the court has the documents necessary to conduct judicial reviews.

[1] Florida statutes define three types of services available to young adults that exit foster care at 18 years of age. Eligibility varies by the type of service, as described in s. 409.1451(5), *F. S.*

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For Fiscal Year 2011-12, the Legislature appropriated $30.2 million to the Independent Living Program ($18.8 million from general revenue and $11.4 million from federal and state trust funds). While the appropriation for the Independent Living Program has remained constant since Fiscal Year 2009-10, expenditures rose to $52.3 million in Fiscal Year 2010-11. Lead agencies use a combination of other appropriated funds and their general revenue carry-forward funds to cover the difference between the appropriation and expenditures for independent living clients.[2] The majority of expended funds (67%) were used to support young adults in the Road to Independence component of the Independent Living Program.[3]

Previous reports by OPPAGA noted problems with the program's lack of information and accountability. In 2010, OPPAGA reported that the department could not determine which of the 13- to 17-year-olds entitled to independent living services by statute actually received such services because it was not requiring the lead agencies to enter this information into its data system. The department also was not routinely monitoring whether lead agencies met minimum contract standards for services and had not met statutory requirements to establish program outcome measures. These concerns led to the request that we review the program's management and monitoring systems to ensure that such problems are being adequately addressed.

The department has established a system to track youth services and outcomes

In a March 2010 report, OPPAGA recommended that the department require lead agencies to report independent living services provided to foster youth in its data system so as to improve program management.[4] Since that time, the department and lead agencies have begun collecting data and the department now requires lead agencies to enter it into the Florida Safe Families Network database. Also, the department's contracts with the lead agencies require them to report on five outcome measures. The department has not been able to obtain information from the Department of Education on foster youths' educational progress.

The department and lead agencies are now collecting youth service and outcome data. In response to federal and state reporting requirements, the department has implemented two new survey instruments to capture data on services and outcomes. These enhancements allow the department to track and report the number of 13- to 17-year-olds in foster care that receive independent living services and the services they received. The department is also tracking outcome data on its 17- to 22-year-old independent living clients. The additional data will enable the department to correlate outcomes for young adults with the independent living services they received as adolescents. (See Appendix B.)

The department now requires lead agencies to submit service and outcome information through the department's Florida Safe Families Network database. Two key sources for the information in the database pertain to a federal foster care requirement.

- **My Services Review Survey.** The department's My Services Review survey captures information on the independent living services children ages 13 to 17 receive as well as information in areas such as educational services, medical services, life skills, and engagement in normal teen activities.

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[2] Section 409.1671(8), *F.S.*, allows community-based lead agencies to carry forward documented unexpended state funds from one fiscal year to the next.

[3] The Road to Independence Program provides financial assistance to help former foster care youth to receive the educational and vocational training needed to achieve independence.

[4] *DCF Has Improved Some Aspects of Independent Living Program Oversight; Other Long-Standing Problems Remain*, OPPAGA Report No. 10-30, March 2010.

- **National Youth in Transition Database (NYTD) Survey.** Established under the federal Foster Care Independence Act of 1999 (P.L. 106-169), the NYTD survey captures data for young adults 17- to 22-years old and tracks outcomes that include educational attainment, employment, welfare dependency, homelessness, non-marital childbirth, incarceration, and high-risk behaviors. The state is required to provide this information to this federal database.

Exhibit 1 provides selected outcome results by age group from these data sources.

Exhibit 1
DCF Collects Survey Data for Adolescents and Young Adults

Survey Question/Item		Fiscal Year 2010-11 Results
Adolescents Ages 13 to 17	Youth changed schools during school year	38%
	Youth received dental services in the last six months	85%
	Youth completed standardized life skills assessment	75%
	Education and Career Path Plan filed with the court	32%
	Youth has a life skills training plan and helped develop this plan	66%
	Youth has signed his independent living transition plan (age 17)	56%
	Youth has a bank account (age 17)	32%
	Youth has a driver's license or permit (age 17)	19%
	Youth know the skills to get employment (age 17)	70%
	Youth know housing options in their area (age 17)	73%
	Youth have developed a budget for life after foster care (age 17)	60%
Young Adults Ages 18 to 22	Young adult has safe, stable housing	90%safe/60%stable
	Young adult received dental services in last year	40%
	Young adult lives in own place or with roommates, friends, or dormitory	61%
	Young adult has a reliable means of transportation to school or work	73%
	Young adult has birth certificate	27%
	Young adult actively involved in development of independent living plan	74%
	Young adult with a part-time or full-time job	18%
	Young adult has a bank account	64%
	Young adult has a driver's license	15%
	Young adult has Medicaid coverage	69%
	Young adult has a high school diploma or GED	54%
	Young adult has a Social Security Card	29%

Source: Department of Children and Families.

To meet federal Foster Care Independence Act requirements, in November 2011, the department submitted its first full year's worth of data to the U.S. Administration for Children and Families. The U.S. Administration for Children and Families can impose a financial penalty of between 1% and 5% of the state's annual allotment if the state does not comply with data reporting requirements.[5] To ensure that data are complete and timely, the department has informed lead agencies that they will share financial penalties with DCF; those lead agencies that fail to meet data submission standards established by the federal government will lose a percentage of their federal independent living funds based upon the standard(s) not met. As of September 2011, when the most recent data was collected,

[5] The size of the penalty depends on the standard not met: 2.5% for non-compliance with file submission standards, 1.25% for noncompliance with the error-free data standard, 1.25% for noncompliance with the outcome universe standard, 0.5% for non-compliance with the youth in foster care participation rate standard, and 0.5% for non-compliance with the discharged youth participation rate standard.

the database only contained information on 42.8% of the youth ages 13 to 17 eligible to receive Independent Living services.[6]

The department also has established outcome measures in its contracts for the Independent Living Program. Previous OPPAGA reports found that the department had included contract performance measures for the Independent Living Program in lead agency contracts but did not require the lead agencies to collect or report data for these measures, so the measures could not be used to gauge lead agency performance.[7] The department now specifies five independent living performance measures for the youth ages 17 to 22 in the lead agency contracts. (See Exhibit 2.) Per the federal requirements to report outcome and service data, non-compliant lead agencies may be subject to the financial penalties discussed above. Fiscal Year 2011-12 data will be the basis for performance standards to be included in the Fiscal Year 2012-13 contracts.

Exhibit 2
The Department Incorporated Five Independent Living Outcome Measures in Lead Agency Contracts[1]

Independent Living Outcome Measures
1. Percentage of youth who have aged out of care completing high school or GED by 20 years of age
2. Percentage of youth who completed high school or GED and are involved in postsecondary education
3. Percentage of youth age 18 and over receiving Independent Living services who have a job (including joining the military)
4. Percentage of 17-year-old youth in licensed out of home care that had a transition plan signed by the youth and filed with the court.
5. Percentage of young adults in safe housing

[1] Data sources for these outcomes are the National Youth in Transition Database and the Florida Safe Families Network Database.

Source: Department of Children and Families.

The department has been unable to obtain information on educational progress from the Florida Department of Education. DCF is not able to obtain client-level data from the Florida Department of Education (DOE) to track educational progress for the children in its care. While the department has a data sharing agreement with DOE that allows it to obtain aggregate information on a number of educational outcomes related to children currently in care, the department cannot obtain client-level data to enhance its tracking of educational progress or outcomes.

The Federal Educational Rights and Privacy Act (FERPA) establishes guidelines under which DOE may share educational information with individuals or entities other than a parent or a student. In Florida, the Department of Education's interpretation of this legislation limits DCF's access to client-level data without the written consent of each foster parent. The department reports that data sharing discussions with DOE are ongoing and it will continue to obtain aggregate educational data. Lead agency managers we interviewed also noted the difficulty in obtaining educational information concerning the children in their care, although this appears to vary across school districts.

Both the department and the lead agencies monitor the Independent Living Program

The department monitors all lead agency activities, including the Independent Living Program, in three ways: contract management, contract monitoring, and quality assurance. In turn, the lead agencies monitor their staff and subcontractors through contract management and monitoring and quality

[6] In March 2011, OPPAGA reported that the department's Florida Safe Families Network data system only contained information on 25% of the 13- to 17-year-old youth in licensed foster care who were eligible for independent living services (*DCF Has Improved Some Aspects of Independent Living Program Oversight; Other Long-Standing Problems Remain*, OPPAGA Report No. 10-30).

[7] *DCF Has Improved Some Aspects of Independent Living Program Oversight; Other Long-Standing Problems Remain*, OPPAGA Report No. 10-30, March 2010; *Improved Fiscal and Quality Oversight Is Needed for the Independent Living Program*, OPPAGA Report No. 07-11, February 2007.

assurance activities. The lead agencies and subcontracted providers also directly monitor program youth; however, the majority of these efforts are related to the 13- to 17-year-olds, as the lead agencies are limited in their ability to monitor the 18- to 22-year olds.

The department and lead agencies have several similar oversight efforts, although DCF recently modified its activities. The department oversees lead agencies in three ways: contract management, contract monitoring, and quality assurance, as described in Exhibit 3. In turn, lead agencies supervise their staff and subcontractors using contract management and monitoring systems that are similar to the department's, as well as through additional quality assurance activities.

Beginning in Fiscal Year 2011-12, DCF modified its statewide quality assurance program; it no longer participates in quality assurance reviews of the lead agencies and instead places primary responsibility for these efforts with the lead agencies.[8] As directed by the department, the lead agencies use standardized quality assurance tools and submit quarterly quality assurance review rating data into the department's secure quality assurance portal. With this information, the department can summarize results across all the lead agencies and report statewide quality assurance information. The department requires lead agencies to participate in its statewide quality assurance program to fulfill the federal requirement for each state to have a quality assurance and improvement system in order to receive federal child welfare funding.

Exhibit 3
DCF and Lead Agencies Have Three Contract Oversight Systems

Oversight System	Department Responsibilities	Lead Agency Responsibilities
Contract Management	▪ Provide day-to-day oversight of vendor performance and review and approve deliverables and invoices[1] ▪ Serve as the primary contact for information transmitted to vendors	▪ Provide day-to-day oversight of vendor performance and review and approve deliverables and invoices
Contract Monitoring	▪ Assess whether vendors comply with federal and state laws, rules, policies, and contract provisions by conducting on-site or desk reviews[2]	▪ Ensure that subcontractors comply with the terms of their contracts by conducting periodic reviews[3, 4]
Quality Assurance	▪ Conduct reviews of child protective investigations and special reviews, as requested	▪ Conduct quarterly reviews of internal or subcontracted case management services to evaluate the quality of services provided to children and their families

[1] DCF contract managers determine which aspects of a vendor's Independent Living Program are assessed by contract monitors.

[2] The frequency of contract monitoring is determined by an annual risk assessment performed by the Contract Oversight Unit per s. 402.7305(4)(a), *F.S.* However, the department is limited to conducting administrative monitoring once every three years for vendors that are accredited by a national accreditation organization, pursuant to s. 402.7306(1), *F.S.*

[3] The department must approve all lead agency subcontract monitoring policies and procedures.

[4] Lead agencies, like the department, are limited to conducting administrative monitoring to once every three years for subcontracted vendors that are accredited by a national accreditation organization, pursuant to s. 402.7306(1), *F.S.*

Source: Department of Children and Families.

Lead agencies also provide direct client oversight for adolescents 13- to 17-years-old; however, such oversight decreases as clients reach age 18. Statutes and rules mandate three processes to ensure the provision of independent living services to adolescents 13- to 17-years-old.

[8] The department's modifications to the quality assurance program for lead agencies reflects a priority to refocus on its child protective investigations system and to re-deploy its limited quality assurance staff to ensure the quality of investigations.

- Dependency case managers must conduct face-to-face meetings monthly with children on their caseload. These meetings allow the case manager to ensure the child is experiencing and learning skills, e.g., grocery shopping, cooking, ironing, laundry.[9] Results of these visits and the independent living services provided to the child must be recorded in the Florida Safe Families Network data system.
- Required independent living multi-disciplinary staffings review the child's independent living plan and the child's progress.[10] The frequency of these meetings varies based on the adolescent's age. Lead agency managers reported these meetings often include the child, the foster parent or residential group care provider, the independent living specialist, the dependency case manager, and school personnel. These staffings must be documented in the Florida Safe Families Network.
- Every six months, lead agencies must provide the court with information for required judicial review. These reviews compare the adolescent's independent needs assessment against his independent living and education plans to determine progress.[11]

However, when adolescents turn age 18, the focus of the program shifts from providing services to providing limited financial assistance in the form of a monthly stipend. The stipend supports youth who are completing their training and education, helping ensure that they will be self-sufficient. The amount of oversight the lead agencies have after age 18 is significantly restricted. These young adults are no longer under the jurisdiction of the dependency court and therefore routine judicial reviews of the youth's progress are no longer held.[12] Before age 18, these youth had monthly case manager meetings and semi-annual interdisciplinary case staffings that are required for adolescents in foster care. After their 18th birthday, they no longer have a dependency case manager to routinely monitor their educational progress or progress in establishing a self-sufficient life. Instead, young adults determine the frequency of meetings with the independent living specialist, which can be as infrequently as once a year. Specialists use the annual meeting to determine young adults' continued eligibility for financial support and conduct a financial assessment determining the level of this support.

Financial support for young adults pursuing educational or vocational training is intended to cover their living and educational needs and must be paid directly to the young adult. Lead agencies may only terminate these awards when young adults attain their educational goal (i.e., high school, GED, or post-secondary degree); do not maintain appropriate educational progress; are no longer enrolled in an educational program; or are no longer a resident of Florida. Young adults whose financial support is terminated have the right to appeal this decision and continue to receive financial support during the appeals process.

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[9] Rule 65C-30.007, *F.A.C.*, requires the services worker to make face-to-face contact with children under supervision and living in Florida no less frequently than every thirty days.

[10] Rule 65C-28.009(5)(f), *F.A.C.*, requires annual staffing for children in foster care who are 13- to 14-years-old. Rule 65C-28009(6)(f), *F.A.C.*, mandates staffings every six months for each child in licensed out-of-home care who is 15 but is not yet 18.

[11] Rule 65C-30.013(2), *F.A.C.*

[12] Section 39.013(2), *F. S,* allows the youth to petition the court for continued jurisdiction until the 19th birthday for the purpose of determining whether appropriate aftercare support, Road-to-Independence Program, transitional support, mental health, and developmental disability services, to the extent otherwise authorized by law, have been provided to the formerly dependent child who was in the legal custody of the department immediately before his or her 18th birthday. The court may also retain jurisdiction in cases where there has been a petition for special immigrant juvenile status.

The Department and lead agencies are addressing problems identified through monitoring and oversight

Through their monitoring and oversight activities, the department and lead agencies are identifying and addressing problems with the Independent Living Program. The most common type of problem the department uncovered during Fiscal Year 2010-11 was inadequate or untimely casework for adolescents. The department's reviews identified 12 lead agencies with such issues. These file reviews found 17-year-olds who did not have documentation of an independent living staffing in time for the special judicial review. In addition, a 2011 quality assurance review by the lead agencies found that case managers failed to regularly monitor adolescents' progress in developing the life skills necessary to transition into adulthood. Only 67% of cases reviewed contained documentation that necessary and required activities were occurring for adolescents, with a low of 43% in the Suncoast Region to a high of 86% in the Southeast and Southern regions. Another significant issue identified was ineligible young adults receiving services. The department found five lead agencies that had ineligible clients receiving independent living services. Examples included clients not eligible because they did not meet full-time education enrollment standards, they did not spend at least six months in foster care prior to reaching their 18th birthday, and they exceeded the maximum benefit period for transitional support services.

To address these issues, department officials have required 10 lead agencies to develop corrective action plans to resolve problems that they identified related to 13- to 17-year-olds. In addition, the department required 5 of these 10 lead agencies to make corrective action plans for independent living services provided to 18- to 22-year-olds. Steps taken by lead agencies in these plans include running daily reports to capture youth not yet referred for services; having supervisors verify that case plans include education and career paths based on the interests and abilities of each child; and having supervisors ensure that independent living case plans will be submitted to the court for the special judicial review that occurs within 90 days after a child in foster care turns 17 years of age. To ensure that the lead agencies fulfill their corrective actions, the plans detail the individuals responsible for each task and the date the department's contract manager will review the agency's progress.

The lead agencies also have taken some steps to address these issues. These actions include requiring subcontracted providers to submit weekly performance reviews of case management services and monthly data reports on key independent living indicators. The lead agencies conduct activities to check their subcontractors' performance and ensure that the subcontractors are providing proper services to these youth. They also conduct reviews of random cases to ensure that case managers are meeting the milestones set by federal and state statutes; a limited number of lead agencies conduct annual monitoring reviews of subcontractors.[13]

[13] An OPPAGA review of 17 of the 19 lead agency monitoring policies revealed that only five lead agencies have a policy to annually review independent living subcontractors.

Appendix A

The department contracts with community-based care lead agencies to provide child protective services, including independent living services, in the state's 67 counties. The Independent Living Program includes six categories of services that are provided to foster youth and former foster youth, depending on the age of the youth, as described in Table A-1.

Table A-1
Florida's Independent Living Program Has Six Components

Service	Eligibility	Description
Pre-independent living services	All 13- to 15-year-olds in foster care.	The following services may be included. • Life skills training • Educational field trips • Conferences
Life skills services	All 15- to 17-year-olds in foster care.	The following services may be included. • Banking and budgeting sills • Interview skills • Parenting skills • Time management and organizational skills • Educational support • Employment training • Counseling
Subsidized independent living services	Some 16- to 17-year-olds identified by community-based care lead agencies as being able to live independently.	Living arrangements that allow an adolescent to live independently of the daily care and supervision of an adult.
Aftercare support services	Young adults ages 18 to 22 who have been in foster care, meet certain conditions, and are determined eligible by a lead agency. Temporary assistance is provided to prevent homelessness. The amount provided is based upon funds available.	Services to assist young adults who were formerly in foster care to continue to develop the skills and abilities necessary for independent living. The following services may be included. • Mentoring and tutoring • Mental health services and substance abuse counseling • Life skills classes, including credit management and preventive health activities • Parenting classes • Job and career skills training • Financial literacy skills training • Temporary financial assistance
Transitional support services	Young adults ages 18 to 22 who have been in foster care and demonstrate that the services are critical to their efforts to develop a personal support system and achieve self-sufficiency.	The following short-term services may be included. • Financial • Housing • Counseling • Employment • Education • Mental health • Disability support services
Road to Independence Scholarship	Young adults ages 18 to 22 who meet one of the following criteria: (1) earned a high school diploma or its equivalent and has been admitted to full-time enrollment in an eligible postsecondary institution; (2) enrolled full-time in an accredited high school; or (3) enrolled full-time in an accredited adult education program designed to provide a high school diploma or its equivalent.	Financial assistance to help former foster care youth to receive the educational and vocational training needed to achieve independence. The amount of the award based on the living and education needs of the young adult and may be up to, but shall not exceed, the amount the student would have been eligible to earn working 40 hours a week at a job paying the federal minimum wage.

Source: Section 409.1451, *F.S.*

Appendix B

In February 2011, the department began collecting data for the National Youth in Transition Database (NYTD). The department now can provide information on adolescents in foster care receiving independent living services and the types of services provided. Table B-1 provides the percentage of 13- to 17-year-old adolescents receiving specific services.

Table B-1
The Florida Safe Families Network Records Information on Services Received by Foster Care Youth

Independent Living Service Category	Percentage of 13- to 17-Year-Olds Receiving Service
Academic Support	12.5%
Post-Secondary Educational Support	2.2%
Career Preparation	9.6%
Employment Programs and Vocational Training	10.0%
Budget and Financial Management	20.9%
Housing Education and Home Management Training	16.1%
Health Education and Risk Prevention	22.4%
Family Support and Healthy Marriage Education	4.0%
Mentoring	1.9%
Supervised Independent Living	4.5%
Room and Board Financial Assistance	4.8%
Education Financial Assistance	32.2%
Other Financial Assistance	1.0%

Source: Department of Children and Families National Youth in Transition Database.

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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

March 2010 **Report No. 10-30**

DCF Has Improved Some Aspects of Independent Living Program Oversight; Other Long-Standing Problems Remain

at a glance

The Department of Children and Families has improved its fiscal oversight of lead agency Independent Living expenditures for young adults age 18 and older to help ensure that federal funds for this age group are spent in compliance with federal law. The department also has broadened its contract monitoring and quality assurance systems to better address key elements of the Independent Living Program.

However, the department continues to lack an effective mechanism to track whether 13- to 17-year-old youth receive services as directed by law. The department also is not routinely monitoring whether lead agencies meet minimum contract standards for services and has not met statutory requirements to establish program outcome measures.

Scope

In accordance with state law, this progress report informs the Legislature of actions taken by the Department of Children and Families (DCF) in response to a 2007 OPPAGA report.[1, 2] This report presents our assessment of the extent to which the department has addressed the findings and recommendations included in our report.

Background

As provided by s. 409.1451, *Florida Statutes*, the Independent Living Program provides services and financial assistance to prepare current and former foster youth to live independently. Long stays in foster care can hamper a youth's transition to adulthood, as most young adults learn the skills needed to live independently while they are growing up with their families.

The department contracts with community-based care lead agencies to provide child protective services, including independent living services, in the state's 67 counties. All 13- to 17-year-old foster youth and some 18- to 22-year-old former foster youth are eligible for services. The program provides six categories of services.

- All 13- to 14-year-old foster youth are eligible to receive **pre-independent living** services which include life skills training, educational field trips, and conferences.
- All 15- to 17-year-old foster youth are eligible to receive **life skills services** which include banking and budgeting skills, educational support, and employment training.

[1] Section 11.51(6), *F.S.*

[2] *Improved Fiscal and Quality Oversight Is Needed for the Independent Living Program,* OPPAGA Report No. 07-11, February 2007.

- Some 16- and 17-year-old youth who demonstrate self-sufficiency skills may be chosen to participate in the **Subsidized Independent Living program**. This program allows youth to live independently of the daily care and supervision of an adult.
- **Road to Independence scholarships** provide eligible 18- to 22-year-old young adults with financial assistance up to $1,256 per month for educational and vocational training.[3]
- **Aftercare services** provide services to eligible 18- to 22-year-old young adults so that they can continue to develop the skills and abilities necessary for independent living including tutoring, counseling, and skills training.
- **Transition services** provide eligible 18- to 22-year-old young adults with short-term services including financial, housing, counseling, and employment.

As shown in Exhibit 1, there were 4,055 youth aged 13 to 17 eligible to receive pre-independent living and life skills services as of June 30, 2009. However, as discussed later in this report, the department and lead agencies lack information on the extent to which youth in this age group receive services. Of the young adults age 18 and older, 4,333 received Road to Independence program, aftercare, and transition services.

For Fiscal Year 2009-10, the Legislature appropriated $35.3 million to the Independent Living Program. This includes $9 million in federal funds from the John H. Chafee Foster Care Independence program and Education and Training Voucher funds, and $26 million in general revenue.

Exhibit 1
Limited Data Available on 13- to 17-Year-Old Youth; 4,333 Young Adults Received Services in Fiscal Year 2008-09

Independent Living Services for 13- to 17- Year-Old Youth	Number Served	Number Eligible
Pre-Independent Living (ages 13-14)	Not Available	1,101
Life Skills (ages 15-17)	Not Available	2,954
Subsidized Independent Living (ages 16-17)	246	2,205
Total	**Not Available**	**4,055**[1]
Independent Living Services for 18- to 22- Year-Old Young Adults	**Number Served**	**Number Eligible**[2]
Road to Independence	3,004[3]	5,729
Transition	1,722	5,298
Aftercare	985	5,735
Total	**4,333**[4]	**Not Available**

[1] The total number of youth eligible is an unduplicated count as of June 30, 2009.
[2] The numbers of former foster youth age 18 and over eligible for each service are estimated based on the number of youth who aged out of foster care between 2004 and 2009 and the eligibility criteria for each service. Young adults may be eligible for more than one type of service.
[3] In June 2009, approximately 45% of Road to Independence program recipients received the full stipend award of $1,135 per month.
[4] The total number of young adults age 18 and over served is an unduplicated count of former foster youth receiving independent living services. Some young adults received more than one type of service during Fiscal Year 2008-09.
Source: Department of Children and Families.

At the direction of the Legislature, OPPAGA reviewed the Independent Living Program in 2007 and concluded that DCF needed to improve its fiscal oversight to ensure that program resources were used as intended and in compliance with state and federal guidelines. DCF also lacked the information necessary to ensure lead agencies provided statutorily mandated services to 13- to 17-year-old youth in foster care.

[3] In July 2009, the department increased the maximum monthly payment from $1,135 to $1,256 due to an increase in the federal minimum wage.

Current Status

The department has implemented our 2007 recommendations to better oversee Independent Living Program expenditures for young adults age 18 and over and better ensure that state and federal funds for this age group are spent in compliance with federal law. In addition, the department has implemented our recommendations to broaden the scope of its contract monitoring and quality assurance systems.

However, the department continues to lack an effective mechanism to track whether 13- to 17-year-old youth receive services. The department also does not routinely monitor whether lead agencies meet standards for independent living services, and it has not established an effective mechanism to hold lead agencies accountable for program outcomes.

DCF has improved fiscal oversight of the Independent Living program

The department provided lead agencies with guidance on program budgetary requirements and recently began to more routinely monitor whether lead agencies exceed federal spending limits. The department also created a fiscal monitoring unit to track and analyze lead agency expenditures.

The department has provided lead agencies with guidance on state and federal budgetary requirements for the Independent Living Program. Our 2007 report noted that some lead agencies had not used all of their available federal Education and Training Voucher funds and had charged eligible expenditures to other funding sources, and we recommended that DCF provide more guidance to lead agencies on proper use of program funds.

Consistent with our recommendation, DCF has adopted a manual for lead agency budget staff that provides budgetary guidelines for state and federal program funds and serves as a guide for coding payments correctly within the department's data system. Lead agencies have subsequently expended all federal Education and Training Voucher funds received since Federal Fiscal Year 2006-07 and have reduced the frequency of coding violations for voucher funds.[4]

The department has recently implemented a process to more routinely monitor federal per-client spending limits for Education and Training Voucher funds. Our prior report noted that the department lacked the capability to determine whether lead agencies exceeded federal Education and Training Voucher fund limits; some data indicated that more than half of the lead agencies had exceeded per-client spending limits. To ensure that funds are spent appropriately, we recommended that the department better track the amount and fund sources lead agencies use for payments to young adults.

To address this problem, DCF began to monitor Education and Training Voucher funds by analyzing Integrated Child Welfare Services Information System data on a monthly basis. When DCF staff identified problems, they sent a notice to contract managers requesting that the lead agencies that had overspent these funds take corrective actions.

However, DCF administrators reported that the department did not perform this routine oversight between October 2007 and January 2010 due to staffing limitations. During the period when this monitoring was not done, lead agencies exceeded limits for voucher fund payments for 8% of the young adults who received these funds. Specifically, lead agencies exceeded the $6,250 annual per-

[4] Coding violations have decreased from 96 in Fiscal Year 2007-08 to 36 for Fiscal Year 2008-09.

young adult federal cap for Education and Training Vouchers for 132 of the 1,590 young adults who received these funds between July 2007 and June 2009.

The department has established a fiscal monitoring unit to track and analyze lead agency expenditures. Our prior report noted that several lead agencies had not spent their allocation of state and federal independent living funds for Fiscal Year 2005-06. We also noted that DCF had not required lead agencies to submit finalized invoices detailing expenditure information prior to receiving contract payments, and it was unable to determine how the lead agencies used general revenue funds.

In October 2008, the department created a fiscal monitoring unit to determine whether lead agencies use proper funding sources for various child welfare services.[5] The department now requires lead agencies to submit invoices and actual expenditure reports for all programs within 20 days of the end of each month. Lead agencies must reconcile their invoices with data in the department's Integrated Child Welfare Services Information System in order to receive funding from DCF for the next month.[6] The fiscal monitoring unit uses lead agencies' monthly expenditure reports and program performance indicators to compile quarterly fiscal indicators reports. DCF circuit administrators review these reports with the lead agencies and then notify the monitoring units of any problems that need additional follow-up.

DCF has enhanced its quality assurance and contract monitoring

The department has broadened the scope of its quality assurance and contract monitoring reviews to better address key elements of the Independent Living Program.

The department has implemented a new quality assurance system. Our prior report noted that DCF's quality assurance data tools focused on compliance rather than the quality of services provided to foster children, and did not address key elements of the Independent Living Program. In July 2008, the department replaced its compliance-focused quality assurance system with a Regional Quality Management System. In the new system, staff conduct quarterly quality assurance reviews of a sample of case files for each lead agency using a statewide core set of 70 quality assurance standards.[7] Unlike the previous system, the new system includes four standards that assess quality of independent living services, including whether youth receive needed services and discuss their educational goals with their case manager. DCF and the lead agencies used this system to complete reviews for each quarter in Fiscal Year 2008-09 and the second quarter of Fiscal Year 2009-10.[8]

DCF has also conducted a series of special quality assurance program reviews at the request of an advocacy group. DCF published its initial special review in December 2009 which focused on management of services for 18- to 22-year-old

[5] For more information on the fiscal monitoring unit, see *DCF Improves Contract Oversight of Lead Agencies; Fiscal, Quality, and Performance Assessment Are Undergoing Change*, OPPAGA Report No. 08-39, June 2008.

[6] Lead agencies receive funding in 12 monthly increments.

[7] Lead agency staff review 25 cases each quarter; the lead agency reviews 17 and the department and lead agency staff conduct a side-by-side review on the remaining 8 cases. In Fiscal Year 2008-09, DCF examined two standards for the program, and the department added two additional standards in Fiscal Year 2009-10.

[8] The department did not complete a quality assurance review for the first quarter of Fiscal Year 2009-10 because it used its quality assurance staff to assist in the Report on the Gabriel Myers Workgroup.

young adults.[9] DCF will conduct two additional reviews that will focus on whether 17-year-old youth in out-of-home care are prepared to exit foster care and the quality of pre-independent living services assessments and services provided to 13- to 16-year-old youth.

The department has broadened the scope of its contract monitoring reviews. We previously reported that the department's contract monitoring tools did not examine key program elements and were limited to assessing whether lead agencies accurately determined eligibility for Road to Independence program recipients age 18 and older. Specifically, the monitoring tools did not address whether young adults receiving aftercare and transition services met eligibility requirements for those services or whether lead agencies complied with federal and state requirements for services provided to 13- to 17-year-old youth.

In response to our recommendation, the department has broadened the scope of these reviews to include new assessments of the Independent Living Program. Specifically, the department established six monitoring tools that assess whether lead agencies comply with statutes and rules when providing services, three tools that assess services for 13- to 17-year-old youth, and three tools that assess lead agency compliance with requirements for young adults over 18.

DCF continues to lack information about the adequacy and quality of lead agency independent living programs

DCF's data system continues to lack accurate information on independent living services provided to 13- to 17-year-old youth. DCF does not require lead agencies to report on these services, and it is not monitoring whether lead agencies meet minimum contract standards for the services. DCF also has not established outcome measures for the program as required by law.

DCF's data system lacks accurate information on the services provided to 13- to 17-year-old youth. Florida statutes require the department and lead agencies to provide an array of independent living services for 13- to-17-year-old foster youth. Our prior report noted that DCF could not determine whether foster youth were receiving these services due to limitations in its own and lead agencies' data systems. While DCF's data system could identify the number of 13- to 17-year-old youth in licensed foster care who were eligible for independent living services, the system could not track the number of youth who received these services or what services were provided.

DCF has not sufficiently addressed this problem. Although DCF added data fields to its case management system in August 2009 to enable lead agencies to enter data on independent living services provided to each foster youth, it has not required lead agencies to use these data fields. In practice, lead agencies typically do not enter data on youth that could be used to determine the number served and the types of services they receive. As a result, in February 2010, the department's data system only contained information on 25% of the 13- to 17-year-old youth in licensed foster care who were eligible for independent living services.

Research shows that teaching independent living skills to foster youth at an early age can lead to more effective results over time. Accordingly, it is important for DCF to collect reliable information on whether lead agencies are addressing the needs of eligible 13- to 17-year-old foster youth.[10]

[9] The report provides six recommendations, including a recommendation for the department to establish core requirements in the lead agencies' contracts for the program's structure and service delivery.

[10] A November 2009 interim report by the Florida Senate's

DCF has not established an effective mechanism to ensure that lead agencies meet minimum contract standards for independent living services. The 2006 Legislature required DCF via proviso language to incorporate minimum independent living standards into lead agency contracts by July 1, 2007, as recommended in a 2004 OPPAGA report.[11] Further, the Legislature directed the agency to begin monitoring lead agency performance in accordance with these requirements by Fiscal Year 2008-09. These standards cover a comprehensive array of services including life skills, housing, education, and employment. The standards are intended to better ensure that foster youth receive the services they need to become self sufficient and that services are consistently delivered throughout the state. However our 2007 report noted that the DCF had made little progress in developing these standards.

DCF has incorporated minimum standards into lead agency contracts. However, it does not routinely assess whether lead agency services meet the standards. The department's December 2009 special quality assurance review of the program concluded that DCF needed to more frequently scrutinize the level and quality of program services. The report also found wide variations in lead agencies' processes for providing services to youth and young adults and recommended that DCF set contract requirements for program service delivery.

DCF has collected information on program services, but has not established program outcome measures as required by law. The 2002 Legislature required DCF to develop outcome measures for independent living services.[12] Our prior report noted that the department had not finalized such measures, although it was working with the Department of Education to obtain data related to youth with a high school diploma or GED and young adults enrolled in postsecondary education.

The department still has not established such measures, although it is collecting information on the independent living services received by foster youth. While DCF contracts require lead agencies to meet contractually specified performance outcomes for other child welfare services, it has not yet established contractual outcome standards for the Independent Living Program. Such standards could cover critical program goals such as the percentage of youth served who graduate from high school. DCF managers report that it has formed a workgroup that includes department and lead agency staff that is developing outcome measures for the independent living program. DCF plans to incorporate outcome measures related to the Independent Living Program into lead agency contracts effective July 1, 2010.

The department and lead agencies conduct an annual survey of youth, young adults, and case workers that could be used to track performance towards some key independent living goals. These surveys include questions on housing arrangements, educational goals, and employment status for youth. Beginning in October 2010, the department will also participate in a federally required survey to gather information for the National Youth in Transition Database; this effort will collect information on youth who are in or who have aged out of foster care and the services they

Committee on Children, Families, and Elder Affairs found that although attention to the needs of 13- to 17-year-old youth has increased significantly over the past decade, the services intended to help prepare them to live independently upon aging out of the system appear to remain limited and fragmented. The report found that concerns continue to be raised as to whether all eligible youth are being served, and whether the direction and oversight of community-based care lead agencies and providers are sufficient to ensure that the goals of the program are being met.

[11] *Independent Living Minimum Standards Recommended for Children in Foster Care*, OPPAGA Report No. 04-78, November 2004.

[12] Chapter 2002-19, *Laws of Florida*.

receive. The department must begin reporting this data in May 2011. The department should use these data as well as data from external sources such as the Agency for Workforce Innovation's employment information to develop an effective mechanism to assess the extent to which the Independent Living Program is meeting its statutory goals to prepare foster youth for productive adult lives.

The Florida Legislature

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REPORT NO. 2011-176
APRIL 2011

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

INDEPENDENT LIVING TRANSITION SERVICES PROGRAM

Operational Audit

STATE OF FLORIDA
AUDITOR GENERAL
DAVID W. MARTIN, CPA

SECRETARY OF THE DEPARTMENT OF CHILDREN AND FAMILY SERVICES

The Department of Children and Family Services is created by Section 20.19, Florida Statutes. The head of the Department is the Secretary who is appointed by the Governor subject to confirmation by the Senate. During the period of our audit, the following individuals served as Secretary:

George Sheldon	From September 2008 to January 2011
Robert Butterworth	From January 2007 to August 2008

The audit team leader was Samantha Colbert, CPA, and the audit was supervised by Mary Stewart, CPA. Please address inquiries regarding this report to Jane Flowers, CPA, Audit Manager, by e-mail at janeflowers@aud.state.fl.us or by telephone at (850) 487-9136.

This report and other reports prepared by the Auditor General can be obtained on our Web site at www.myflorida.com/audgen; by telephone at (850) 487-9175; or by mail at G74 Claude Pepper Building, 111 West Madison Street, Tallahassee, Florida 32399-1450.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Independent Living Transition Services Program

SUMMARY

This operational audit of the Department of Children and Family Services (Department) focused on the Department's administration of the Independent Living Transition Services (ILTS) Program. Our audit disclosed the following:

YOUNG ADULT SERVICES

Finding No. 1: The Department and community-based care (CBC) lead agencies did not require that actual living and educational expenses be utilized as a basis for determining the amounts of the Road to Independence (RTI) awards made to clients who were high school students. Additionally, for clients who were post-secondary students, the Department and CBCs were unable to provide documentation supporting the appropriateness of the amounts of the RTI awards.

Finding No. 2: Department rules and guidelines did not specifically address the type of documentation that would be sufficient to demonstrate appropriate progress by students in GED programs.

Finding No. 3: The Department and CBCs made payments for Aftercare Support Services to young adults in the same month during which the young adult received both RTI and Transitional Support Services payments. These payments in total were sometimes significant in amount, and in some cases, made to meet the same identified need. In addition, the Department and CBCs did not always ensure that only eligible young adults received Aftercare and Transitional Support Services and that the payments for Aftercare and Transitional Support Services were documented by applications and properly coded.

Finding No. 4: Federal funds totaling $641,913 from the Chafee Foster Care Independence (Chafee) Program and Chafee Education and Training Vouchers (ETV) Program were paid to ineligible young adults. In addition, administrative and support services costs were not properly allocated to State General Revenue and Chafee Program funds. CBCs also did not properly code payments for young adult services to the correct funding source.

SPENDING CAPS

Finding No. 5: ETV Program, RTI, and Subsidized Independent Living (SIL) payments were made to young adults and adolescents in excess of established spending caps.

ADOLESCENT SERVICES

Finding No. 6: Specific to adolescents in SIL, the Department and CBCs were unable to provide documentation to support the required number of services worker visitations. In addition, the Department and applicable CBCs were unable to provide documentation showing that staffings, assessments, and judicial reviews had been completed.

Finding No. 7: The Department and CBCs did not properly conduct or provide supporting documentation showing that staffings, assessments, and case plans for adolescents ages 13 to 17 had been completed.

ILTS PROGRAM ADMINISTRATION

Finding No. 8: The Department did not require CBCs to fully utilize the functionality of the Florida Safe Families Network specific to the ILTS Program.

Finding No. 9: Department monitoring efforts were not sufficient to ensure ILTS Program compliance.

BACKGROUND

State law[1] requires the Department to outsource the provision of foster care and related services Statewide by contracting with community-based care (CBC) lead agencies. As of August 2010, the Department had entered into contracts totaling $3 billion with 21 lead agencies.

The Independent Living Transition Services (ILTS) Program is one of the programs administered by the CBC lead agencies. The purpose of the ILTS Program is to assist older children in foster care and young adults, who become ineligible for foster care at age 18, with obtaining life skills and education to make the transition to independent living and employment, to have a quality of life appropriate for their age, and to assume personal responsibility for becoming self-sufficient adults. According to Department accounting records, the Department expended approximately $38.5 million and $51.9 million in the 2008-09 and 2009-10 fiscal years, respectively, for the ILTS Program. Included in these amounts were administrative and support services expenditures totaling approximately $8.8 million and $10.7 million in the 2008-09 and 2009-10 fiscal years, respectively. Administrative and support services costs consisted of salaries and expenses for staff providing case coordination and support services to youth and qualifying young adults. The Department funds the services primarily from the Chafee Foster Care Independence (Chafee) Program grant, the Chafee Education and Training Vouchers (ETV) Program grant, and State General Revenue.

The ILTS Program assists two age groups. Adolescents in foster care aged 13 to 18 are eligible to receive services under the Pre-Independent Living, Life Skills, and Subsidized Independent Living (SIL) Programs, hereafter cumulatively referred to as Adolescent Services, and financial assistance payments under the SIL Program. Young adults (ages 18 to 23) who were formerly in foster care may receive Young Adult (YA) Services that include financial assistance payments under the Aftercare Support, Road-to-Independence (RTI) Award, and Transitional Support Programs. Table 1 details the administrative and support services costs, as well as the YA and SIL payments and client counts, by funding source and service type for the 2008-09 and 2009-10 fiscal years for the ILTS Program. Additionally, **EXHIBIT A** of this report describes the various Program services and provides demographic information.

[1] Section 409.1671, Florida Statutes.

Table 1

ILTS Program Expenditures and Client Count for the 2008-09 and 2009-10 Fiscal Years

ILTS Program Expenditures			Client Count	
Service Type	**2008-09**	**2009-10**	**2008-09**	**2009-10**
Administrative and Support Services Expenditures [a]	$ 8,834,560	$ 10,738,650	N/A	N/A
Financial Assistance Payments:				
SIL	833,921	737,457	246	157
Aftercare Support	1,056,033	877,447	985	911
Transitional Support	4,349,971	4,265,864	1,722	1,671
RTI Awards	23,390,750	35,260,681	3,004	3,698
Totals	**$38,465,235**	**$51,880,099**	**5,957**	**6,437**
Funding Source	**2008-09**	**2009-10**		
ETV Program	$ 2,587,411	$ 2,396,966		
Chafee Program	7,208,194	6,645,620		
State General Revenue	28,669,630	42,837,513		
Totals	**$38,465,235**	**$51,880,099**		

Source: Department records.

[a] Because the Pre-Independent Living and Life Skills Services do not provide for direct payments to adolescents, ILTS Program expenditures for adolescents receiving those services are included within Administrative and Support Services expenditures.

The Department established rules[2] for the ILTS Program, while the CBCs were to provide the services. The CBCs were responsible for planning, administering, and coordinating the delivery of client services, ensuring compliance with State laws and Federal regulations (including eligibility determination), compensating service providers, and administering financial assistance payments to clients.

The Department monitored the activities of the ILTS Program through CBC contract monitoring, fiscal monitoring, quality assurance monitoring, special reviews, and surveys of participating adolescents and young adults. Specifically:

- The Department's Contract Oversight Unit (COU) monitored the CBCs based on a scope identified by the contract manager. Depending on the scope, tools were utilized specific to the topics identified. During the 2009-10 fiscal year, 18 CBCs were monitored for compliance with one or more components of the ILTS Program standards. Effective July 1, 2010, COU monitoring will be limited to once a year, and administrative monitoring will be limited to once every 3 years if the CBC is accredited.[3]
- The Department was to perform fiscal monitoring on a continual basis through a review of CBC monthly expenditure reports, CBC policies and procedures, subcontractor monitoring reports prepared by the CBCs, and available Florida Safe Families Network (FSFN) data. In addition, on-site fiscal monitoring was performed for all CBCs at least once during the period July 2008 through June 2010.[4] The fiscal monitoring performed was not specifically focused on ILTS Program expenditures.
- Department staff, along with CBC staff, performed quality assurance monitoring. Twenty-five cases related to youths in foster care were reviewed from each CBC each quarter through a three-step process. In this

[2] Department Rules, Chapters 65C-31 and 65C-28, Florida Administrative Code. Additionally, Chapter 2010-158, Laws of Florida, effective July 1, 2010, authorized the Department to begin rule-making procedures to govern the payments and conditions related to payments for services to youth or young adults provided under Florida law.

[3] Section 2, Chapter 2010-158, Laws of Florida. Accreditation can be obtained through the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Children and Family Services.

[4] Fiscal monitoring was outsourced until December 2009 for Our Kids of Miami-Dade/Monroe, Inc. and ChildNet, Inc.

process, the CBCs reviewed 17 cases and then a side-by-side review was conducted for the remaining 8 cases. Finally, the quality assurance staff performed an in-depth review of 2 cases. The quality assurance review report published in October 2009 for the 2008-09 fiscal year included two standards specific to Adolescent Services: pre-independent living assessments and case plans. For the two standards, the reports disclosed a 73 percent and 84 percent compliance rate, respectively. The report for the 2009-10 fiscal year was released in November 2010 and included four standards specific to Adolescent Services: pre-independent living assessments, development of educational and career paths, opportunities to participate in life skills activities, and monitoring progress through regular staffings.[5] For these four standards, the reports disclosed compliance rates between 76 and 78 percent.

- At the conclusion of our audit field work, the Department was in the process of conducting the final phase of a three-phase special review addressing inequities and inconsistencies in ILTS Program service delivery throughout the State. The first phase, released in December 2009, focused on process management for Aftercare Support, Transitional Support, and RTI Services. The second phase, released in June 2010, focused on a review of randomly selected adolescents in foster care who had reached their 17th birthday to assess service delivery in preparing the adolescents for independence. The third phase, expected to be completed by January 2011, will include randomly selected case file reviews and interviews with children in foster care who are ages 13 through 16 to assess pre-independent living assessments and services.
- The Department utilized an ILTS Program Critical Checklist to obtain data directly from adolescents and young adults related to a variety of aspects of the ILTS Program. The checklist was an annual survey designed for adolescents ages 13 through 17 in licensed out-of home care, and young adults ages 18 through 22 receiving RTI, Transitional Support, or Aftercare Support Services. The 2009 survey compiled results from over 6,500 participants and reported on various elements including life skills, housing, education, employment, health, corrections or juvenile justice, case plan, and Aftercare Support and Transitional Support Services. Future checklists will be utilized to comply with Federal reporting requirements.

FINDINGS AND RECOMMENDATIONS

Young Adult Services

Young adults (ages 18 to 23) who were formerly in foster care are eligible for YA Services, including RTI, Transitional Support, and Aftercare Support. Department records show payments totaling approximately $28.8 million and $40.4 million made to young adults in the 2008-09 and 2009-10 fiscal years, respectively.

Finding No. 1: RTI Award Needs Assessments

RTI is to be provided to eligible young adults, who are enrolled full-time in high school, GED programs, or post-secondary educational institutions, to pay for living and educational expenses. State law[6] requires the CBCs to determine the RTI award amount based on an assessment of the living and educational needs of the young adult. State law also requires that in determining the amount of the RTI award, consideration be given to all income, including other grants, scholarships, waivers, earnings, and other income, that may be received by the young adult. Additionally, State law[7] requires that CBCs assist young adults in applying for other grants and scholarships for which they may qualify. To assist the CBCs in completing the needs assessment for eligible young adults, the Department established rules, issued guidelines, and developed assessment documents for use by the CBCs.

Our examination of the assessment documents disclosed that the high school and post-secondary needs assessments developed by the Department appropriately provided for a consideration of all income in the calculation of RTI

[5] A staffing is a meeting between the Independent Living service provider, the child, and any other individuals significant to and familiar with the child, the purpose of which is to develop plans for meeting the identified needs of the child.
[6] Section 409.1451(5)(b)4., Florida Statutes.
[7] Section 409.1451(5)(b)3., Florida Statutes.

award amounts. Additionally, for post-secondary students, the needs assessment process also appropriately took into consideration living and educational expenses (cost of attendance)[8] and educational scholarships. However, the process for high school students did not require that the living and educational expenses of the young adult be individually determined and included in the calculation of the award amount. Instead, the Department set the cost of attendance for young adults in high school at the statutory maximum annual award amount of $13,614 until July 2009, when it was increased to $15,068.[9]

In response to our audit inquiry, Department staff indicated that, after review of the calculations of the costs of attendance for high school students, the Department determined that the overall costs of daily living would generally exceed the statutory maximum; therefore, the maximum allowed by State law would be the most appropriate amount to use in all cases. Absent a cost-of-living calculation for each young adult, the Department cannot demonstrate why the maximum allowable amount would be a better indicator of the living and educational needs of a young adult than a budget prepared by a high school student based on actual expenses.

Additionally, our examination of needs assessments for 24 post-secondary students disclosed instances in which required documentation was not provided or did not fully support the amount awarded. Specifically, we noted:

- For 8 students, the CBCs were unable to provide documentation evidencing that the young adults had applied for grants and scholarships for one or more academic years and no such amounts were considered in the determination of the RTI scholarship amount. For 7 of the students, we were able to obtain financial aid information from the applicable public institution and determined that grants or scholarships had been awarded to 4 students in amounts per student ranging from $1,000 to $4,875. The failure to include these amounts in the calculation of the RTI Scholarship amount resulted in overpayments to 2 students totaling $536 and $3,250.
- For 7 students, the CBCs were unable to provide documentation to support the living and educational needs (cost of attendance) amount reported on the assessments. Additionally, for 5 of the 7 students, it was not evident that the CBCs properly considered tuition and fee waivers when determining the award amount. For all 7 students, we obtained the costs of attendance from the applicable institutions and recalculated the monthly awards, including exemptions for tuition and fee waivers. Our recalculation disclosed that, for 4 students, the monthly award was overstated from $71 to $541 and resulted in overpayments during the period July 2008 through February 2010 ranging from $71 to $4,871.

In most instances, there was no evidence that a supervisory review of the needs assessment was conducted and, as a result, errors and omissions in the needs assessments and related documentation were not subject to timely detection. The failure to maintain adequate documentation limits the assurance that the award is calculated correctly. Additionally, the failure to accurately determine the cost of attendance and to consider any tuition and fee waivers or Federal scholarships increases the likelihood that the award amount will exceed the amount authorized.

Recommendation: We recommend that the Department reconsider the needs assessment process for high school students and provide for an estimate of living and educational needs for each student. We also recommend that for post-secondary students, the Department take steps to ensure that needs assessments are accurately completed and properly supported.

[8] The cost of attendance is the "student budget" as determined by the educational institution, less any tuition and fee waivers.

[9] The statutory maximum amount was computed based on the Federal minimum wage which increased on July 24, 2009. Department rules further required that the maximum monthly award amount not exceed $1,134.46 prior to July 2009 and $1,255.70 thereafter.

Finding No. 2: Appropriate Progress

State law[10] requires young adults receiving RTI awards to complete the full-time equivalent credit hours on an annual basis as defined by the educational institution and to maintain appropriate progress. Department rules required the CBCs to maintain documentation of the young adult's progress as well as an annual evaluation of the young adult's compliance with the education requirement. The young adult was required to provide documentation of enrollment and of progress made in their course of study[11] and the CBCs were to complete the evaluations during the renewal process.

Department rules and guidelines did not specifically address the type of documentation that would be sufficient to demonstrate appropriate progress, other than obtaining progress reports or documenting contacts with educational institutions. Our interviews conducted during site visits to seven CBCs disclosed that, while the determination of appropriate progress for young adults in high school or post-secondary institutions can be readily evidenced by obtaining report cards or semester grades, the determination of appropriate progress was less evident for GED programs. Management at the seven CBCs indicated that they use various means to document proof of progress, including contacting the applicable GED program, obtaining monthly progress reports and attendance sheets, and relying on periodic test results, such as the test of adult basic education (TABE). Several CBC staff suggested that they needed clarification from the Department to ensure that proof of appropriate progress was consistently documented for young adults in GED programs.

Recommendation: We recommend that the Department establish rules or guidelines outlining accountability measures related to providing attendance and proof of appropriate progress for young adults in GED programs.

Finding No. 3: Transitional and Aftercare Support Services

In addition to RTI awards, State law[12] also makes funding available for Aftercare Support and Transitional Services to assist young adults to continue to develop the skills and abilities necessary for independent living. **EXHIBIT A** contains descriptions of the specific eligibility requirements for these programs.

Aftercare Support may include, for example, services relating to mentoring, job training, and temporary financial assistance for housing, food, or utilities. Department rules[13] required eligible young adults to complete an application for financial assistance. The application was designed to allow an assessment of the specific financial needs of the young adult and requested information related to the feasibility of agreements with community providers to waive fees, assistance of relatives, and other such options.

Transitional Support may consist of services, including financial assistance, critical to the young adult's efforts to achieve self-sufficiency and develop a personal support system. State law and Department rules[14] required young adults requesting Transitional Support to submit an application and prepare a transition plan designed to identify specific needs as well as tasks to be completed or maintained in order to achieve self-sufficiency. Since Transitional Support Services were by definition short-term in nature, CBCs were required to review the transition plan and, when

[10] Section 409.1451(5)(b)6.i., Florida Statutes.
[11] Department Rule, 65C-31.004(5)(e), Florida Administrative Code.
[12] Section 409.1451(5)(a) and (c), Florida Statutes.
[13] Department Rule 65C-31.003, Florida Administrative Code.
[14] Section 409.1451(5)(c)1., Florida Statutes, and Department Rule 65C-31.005(5), Florida Administrative Code.

the young adult intended to re-apply for services, make adjustments to the plan a minimum of once every 3 months according to the young adult's needs.

As shown in Table 1, for the 2008-09 and 2009-10 fiscal years, Aftercare and Transitional Support expenditures totaled approximately $1.9 million and $8.6 million, respectively. We examined case file documentation related to Aftercare Support financial assistance payments totaling $65,436 made to 17 young adults from July 2008 through January 2010. We also examined case file documentation related to Transitional Support payments totaling $178,761 made to 20 young adults from July 2008 through February 2010. Our tests disclosed the need for Department guidance regarding allowable uses of Aftercare and Transitional Support, as well as some payment errors:

- Young adults sometimes received payments for one service type from multiple programs and monthly amounts that, in some instances, were excessive. The Department's rules did not require CBCs to document why a young adult would need to receive simultaneous ILTS Program component payments relative to the same service. Specifically, Aftercare Support financial assistance payments were made to 10 of the 17 young adults during the same months that the young adults received RTI award moneys or Transitional Support payments. While payments for more than one service type are allowed, our examination of the supporting documentation provided indicated that the payments were for the same service, specifically housing assistance. Upon further analysis of all recorded ILTS Program payments made to young adults from July 2009 through February 2010, we identified 61 instances in which young adults received payments for Aftercare Support, Transitional Support, and RTI ranging in total from $638 to $6,267, and averaging $2,788 within the same month. We also identified 933 instances in which the young adult received payments for Aftercare Support and either RTI or Transitional Support within the same month. Absent a policy to consider all sources of ILTS payments, payments may exceed need.
- The CBCs were unable to provide the Aftercare Support cash assistance application, or other documentation evidencing their assessment of need, for 86 payments totaling $10,129 made to 10 of the 17 young adults. In some instances, CBC staff indicated that they did not require an application because they did not realize applications were needed, for example, for bus tickets or gift cards. After examining additional documentation provided upon audit inquiry, we determined that 80 of the payments, ranging from $22 to $1,858, were for services such as rent, utilities, food, gift cards, and bus tickets. However, the applicable CBCs were unable to provide documentation detailing the purpose for 6 payments totaling $702. Absent a completed application, the purpose or the appropriateness of the payment may not be clearly demonstrated.
- A CBC, using Transitional Support funds, awarded an educational incentive payment of $3,000 each to 2 young adults for achieving an educational goal. It was not clear to us that the payments for such a purpose were authorized, and upon our inquiry, Department staff agreed the payments were not an appropriate use of Transitional Support funds.
- Payments to 7 young adults were erroneously coded. Specifically, Aftercare Support payments totaling $12,744 made to 2 young adults were incorrectly charged to Transitional Support Services and Transitional Support payments totaling $81,028 made to 5 young adults were incorrectly charged to RTI Services. Coding errors limit the Department's ability to control and accurately report the amount of funds expended by service type.
- In two instances, ineligible young adults received payments during the period July 2008 through January 2010 that totaled $32,085. These individuals were ineligible because they had left foster care prior to age 18.

Recommendation: We recommend that the Department establish clear guidelines for CBC use regarding when it is appropriate for a young adult to receive both Transitional and Aftercare Support Services based on the situation of the young adult. In addition, we recommend that the Department ensure that payments to young adults are properly coded and that sufficient documentation, including applications, is completed and maintained in the case files.

Finding No. 4: Federal Grant Funding

Young Adult Services are funded from State General Revenue funds and Federal grants, including the Chafee Program and ETV Program. Both Federal programs are formula grants whereby each state receives an allotment based on its foster care ratio.[15] Table 1 provides a breakdown of the YA expenditures by funding source for the 2008-09 and 2009-10 fiscal years.

Program Eligibility

To receive YA Services under the Chafee and ETV Programs, individuals must meet and maintain the eligibility requirements set forth in Federal regulations, State law, and Department rules, including age limitations and school enrollment. Our analysis of Chafee and ETV Program payments made to young adults during the period July 2008 through February 2010, disclosed instances in which the young adult did not meet the Program eligibility requirements. Specifically,

- Chafee Program payments totaling $621,043 were made to 234 young adults who exceeded the maximum age limitation. Department staff indicated that they did not monitor CBC compliance with the age limitation during this period.
- ETV Program payments totaling $20,870 were erroneously made to 3 young adults who were enrolled in high school or a GED program, rather than an institution of higher education, as required. Subsequent to our audit inquiry, the payments for 2 of these young adults were reclassified to an appropriate funding source.

Program Funding Source

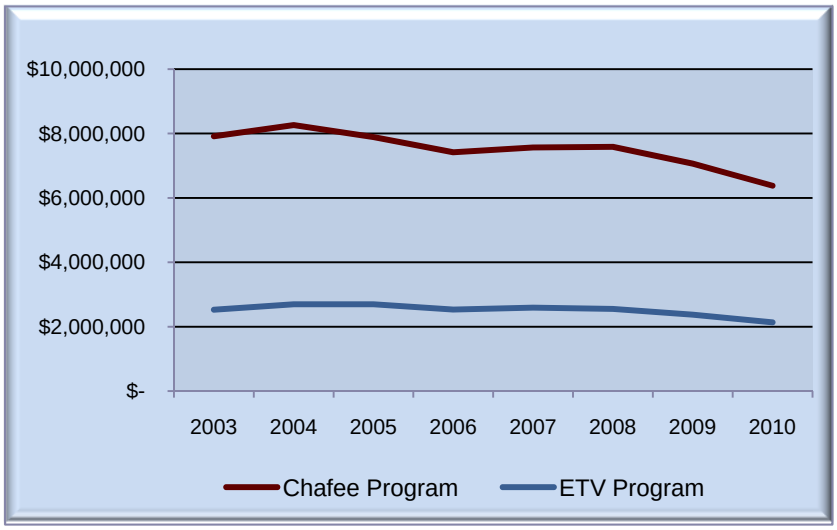
To maximize available funding and ensure compliance with Federal regulations, Department rules[16] required the CBCs to determine the most appropriate funding source. Additionally, ETV Program funds were to be used for eligible students as the first option.

Historically, Florida has spent its entire annual Chafee Program allotment and, since 2006, has spent its annual allotment for the ETV Program as well. As indicated in Chart 1, Federal grant awards have decreased due to reductions in Florida's foster care ratio, thereby increasing the reliance on General Revenue funds. Although Florida has fully maximized funding from the Chafee and ETV Programs, proper coding of YA Services payments as to source is critical to accurately reflect the usage of Federal funding and General Revenue.

[15] The foster care ratio is calculated by dividing the number of children in a state's foster care program by the total number of children in foster care in all states for the most recent fiscal year.
[16] Department Rule 65C-31.002(5), Florida Administrative Code.

Chart 1

Chafee and ETV Programs Grant Awards by Federal Grant Award Year



Source: Department records.

We examined the case files for 63 young adults who received RTI (43 young adults) or Transitional Support (20 young adults) payments totaling $865,576 during the period July 2008 through February 2010 to determine whether the payments were coded to the most appropriate funding source. Our tests disclosed that payments were not always coded to the most appropriate funding source. For example, for 10 young adults, the CBC coded RTI or Transitional Support payments totaling $142,234 to State General Revenue funds even though approximately $72,290 should have been coded to the ETV or Chafee Programs.

Program Administrative and Support Services Cost Allocation

In addition to funding for YA Services, administrative and support services costs for the delivery of ILTS Program Services were also funded either by State General Revenue funds or by Federal funds received through the Chafee Program grant depending on the eligibility of the individual served. Administrative and Support Services costs include salaries and expenses for staff providing case coordination and support services.

According to staff at seven CBCs, typically, the allocation between State General Revenue funds and the Chafee Program grant was based on the number of young adults who met the eligibility criteria for the Chafee Program compared to the number of young adults who did not. Our review of accounting records maintained by those seven CBCs disclosed two CBCs that did not properly allocate administrative and support services costs. In both instances, all administrative and support services costs were allocated to the Chafee Program and, as a result, administrative and support services costs for young adults not eligible for the Chafee Program were incorrectly charged to the Chafee Program grant. Department staff indicated that they did not monitor each CBC's allocation of ILTS Program administrative and support services costs.

Recommendation: We recommend that the Department enhance its monitoring procedures to ensure that payments to young adults are in compliance with Federal requirements and that administrative and support services costs allocated to the Chafee Program relate to Program-eligible young adults. In addition, we recommend that the Department take steps to ensure that the CBCs properly record ILTS Program payments.

Spending Caps

Finding No. 5: ETV Program, RTI Award, and SIL Program Spending Caps

Federal ETV Program requirements limit the ETV portion of the RTI award amount to the lesser of $5,000 annually or the cost of attendance established by the applicable educational institution. Since the State is reimbursed for 80 percent of the amount of the young adult's RTI award, the Department established an annual ETV Program award limit of $6,250. Our analysis of ETV Program payments totaling $10,870,924 made to 2,523 young adults during the period July 2008 through February 2010, disclosed that 314 young adults received ETV Program payments in excess of the annual spending cap, in amounts ranging from $1 to $4,525 and averaging $1,277. Department staff indicated that an annual evaluation of the ETV Program spending cap was completed for the 2008-09 fiscal year and that staff then notified the CBCs to reclassify the funds exceeding Federal limitations to either Chafee or General Revenue sources. As of February 2011, no evaluation for the 2009-10 fiscal year had been completed.

In addition, as described in finding No. 1, Department rules limited the amount of the monthly RTI award to $1,135 until August 2009 when the award limit was increased to $1,256. Department rules also applied the same award limits to SIL subsidy payments. During the period July 2008 through February 2010, Department records indicated that 52,018 RTI payments totaling approximately $46 million and 1,834 SIL payments totaling approximately $1.3 million were made to adolescents and young adults. Our analysis of RTI and SIL subsidy payments for the same period disclosed 2,887 instances in which the young adult's or adolescent's monthly RTI or SIL payment exceeded the maximum allowed amount. Specifically, our analysis disclosed:

- A total of 79 SIL payments in excess of the monthly spending cap ranging in amount from $1 to $1,269 and totaling approximately $37,386 were made to 71 adolescents.
- A total of 2,808 RTI payments in excess of the monthly spending cap ranging in amount from $5 to $3,741 and totaling approximately $1,165,000 were made to 984 young adults.

While Department rules provide for a maximum monthly award amount, Department management indicated that, in practice, the RTI and SIL spending cap limit had been considered on an annual basis. To determine whether spending cap limits had been exceeded on an annual basis, we performed an analysis of the total RTI and SIL payments made to young adults during the 2008-09 fiscal year. Our analysis disclosed 113 instances ranging in amount from $4 to $5,235 and totaling approximately $128,000 in which the young adult received more than the maximum annual RTI award, but no instances where the annual spending cap for SIL adolescents was exceeded.

Department staff indicated that, as of February 2011, no comprehensive monitoring of ETV Program, RTI, and SIL spending caps had been conducted for the 2009-10 fiscal year. Absent monitoring of the spending caps, the Department had limited assurance that the amount of ETV Program funds used to pay young adult RTI awards did not exceed the Federal limitation and the RTI and SIL payments did not exceed the amount authorized in Department rules.

Recommendation: We recommend that the Department perform monitoring to ensure Department payments to young adults do not exceed the annual ETV Program spending limit. Additionally, to ensure compliance with Department rules, we recommend that the Department establish procedures to monitor the RTI and SIL spending caps on a monthly basis.

Adolescent Services

The ILTS Program, available to adolescents ages 13 to age 18 who are in the custody of the Department, consists of Pre-Independent Living, Life Skills, and SIL Services. While in the custody of the Department, adolescents receiving Program services remain subject to the requirements of case plans and judicial reviews until permanency is established. To develop plans for meeting the adolescents' identified needs, independent living staffings, assessments, and contacts were to be made periodically.

Finding No. 6: SIL Case Management

State law[17] describes SIL Services as living arrangements that allow a teen, aged 16 or 17, to live independently of the daily care and supervision of an adult in a setting that is not required to be licensed. The teen must have been adjudicated dependent, resided in licensed out-of home care for at least 6 months prior to entering SIL, and be able to demonstrate independent living skills as determined by the Department. Department rules[18] require the teen to either be employed part-time or involved in extra-curricular activities, have sufficient savings for move-in costs, be enrolled full-time in an educational program, have made adequate progress in his or her educational program, have been evaluated through an assessment of skills, have exhibited responsible behavior, and have CBC approval.

Additionally, while a teen was in an SIL living arrangement, services workers[19] were required to have contact with the teen at intervals of twice a week for the first 3 months. At least one contact a week was required to be in the teen's residence. After 3 months, the number of contacts could be reduced to no fewer than one a month in the teen's residence.

Our test of case files for 41 teens in the SIL Program during the period July 2008 through February 2010, disclosed:

- For 21 teens, the CBC was unable to provide documentation that the services worker contacted the teen at least twice a week during the first 3 months. During the 3-month period, approximately 24 visits were required for each teen. The actual number of visits ranged from 2 to 16, with 11 teens having fewer than 6 visits, 9 teens having between 6 and 15, and one teen having 16 visits.
- Subsequent to the first 3 months, for 5 teens, the CBC was unable to provide documentation that the services worker contacted the teen at least once a month in the teen's residence.

In addition to the contact requirements, services workers were also required to ensure that staffings, assessments, and judicial reviews were conducted at mandatory intervals. Upon reaching age 18, when the teen is emancipated from the Department, Department rules[20] required written documentation of the teen's preparation for independence and plan for transition to adulthood. Our test of the case files for 33 teens disclosed that staffings, assessments, and judicial reviews for teens approaching age 18 were not always documented or timely provided as shown in Table 2.

[17] Sections 409.1451(4)(c)1. and 2., Florida Statutes.
[18] Department Rule 65C-28.009(7)(c), Florida Administrative Code.
[19] A services worker is an individual who is accountable for service delivery regarding safety, permanency, and well-being for a caseload of children and families under supervision, and includes an individual assigned to assist young adults who are receiving Independent Living services.
[20] Department Rule 65C-28.009(9)(a) and (b), Florida Administrative Code.

Table 2

SIL Case Management
Summary of Audit Test Results

Task	Date Required	Number Examined	Number of Tasks Not Documented	Number of Tasks Not Conducted Timely
Independent Living Assessment	Month following 17th birthday	33	-	2
Staffing	30 days prior to special judicial review	32	3	1
Special Judicial Review Hearing	90 days after 17th birthday	32	3	1
Special Judicial Review	Month that begins the 6-month period before 18th birthday	32	1	-

Periodic visitations, staffings, and judicial review hearings enable Department and CBC staff to monitor the teens and measure whether they are making progress in the transition to adulthood. The failure of the services worker to perform and document these tasks may jeopardize a teen's progress and safety in the SIL placement setting.

Recommendation: We recommend that the Department disseminate guidance and provide training to CBCs regarding the performance and documentation of SIL Program tasks.

Finding No. 7: Adolescent Case Management Tasks

To assist in a successful transition into adulthood, the Department provides adolescents in foster care transition to independence services through the ILTS Program. Adolescents aged 13 and 14 are to be referred for Pre-Independent Living Services including, but not limited to, life skills training, educational field trips, and conferences. Adolescents aged 15 through 17 are to be referred for Life Skills Services including, but not limited to, training to develop banking, budgeting, interviewing, parenting, time management, and organizational skills; educational support; employment training; and counseling. To document and monitor an adolescent's progression, State law and Department rules[21] set forth specific tasks to be performed by services workers for adolescents. These tasks included referrals, staffings, assessments, and case plans. Specifically:

- Staffings for adolescents aged 13 and 14 were required annually and once every 6 months for adolescents aged 15, 16, and 17.[22] Staffings were to address topics such as educational and work goals, life skills needed, the SIL Program, the RTI Award Program, permanency arrangements, and plans for living arrangements after age 18.
- Assessments for adolescents were required at ages 13, 15, and 17. Assessments were to help determine the training and services needed for an adolescent to begin learning life skills, to measure life skills development and determine each adolescent's strengths and needs, and to determine the adolescent's skills and ability to live independently and become self-sufficient. Assessment tools most commonly used were either the Casey Life Skills Assessment or Daniel Memorial Institute Assessment. For every needed skill, the CBC was required to document who was to help the adolescent develop that skill and the time frame in which the adolescent would receive the training.
- Case plans were required for adolescents in foster care who had reached 13 years of age. The case plan was to be reviewed at each judicial hearing and a goal was required to be identified of either attending a 4-year college or university, a community college, or a military academy; receiving a 2-year post-secondary degree;

[21] Section 409.1451, Florida Statutes, and Department Rule 65C-28.009, Florida Administrative Code.
[22] Department Rule 65C-28.009(5)(f) and (6)(f), Florida Administrative Code.

attaining a post-secondary career, technical certificate, or credential; or beginning immediate employment or enlisting in the military.

As shown in Table 3, our examination of staffings, assessments, and case plans for adolescents disclosed that related tasks were not always documented.

Table 3

Adolescent Case Management
Summary of Audit Test Results

	Number Examined	Element Not Documented
Required Elements in Staffings		
Needed Life Skills	39	28
Progress Toward Developing Life Skills	39	28
Educational and Work Goals	39	9
Staffing Not Provided	9	
Required Elements in Assessments		
Counselor Discussed Results With Youth	10	9
Responsibility Assigned to Individual to Assist Youth With Life Skills	18	18
Time Frame in Which Life Skills Training Will be Received Specified	18	18
Assessment Not Provided	1	
Required Elements in Case Plan		
Educational and Career Path, Post-Secondary Goal, Core Courses and Electives Needed, and Grade Point Average Necessary to Achieve Goals	8	6
Case Plan Not Provided	12	

Absent the completion of case management tasks, there was no clear evidence that needed skills were identified, a plan had been developed to determine how and by whom needed skills would be provided, or progress toward ensuring independence and self-sufficiency had been measured. In addition to the results in Table 3, we identified 15 instances in which the assessment was not completed timely, with the assessments ranging from 16 to 378 days late, and 1 instance in which the staffing was completed 6 months past the due date.

Recommendation: We recommend that the Department take steps to ensure that required staffings, assessments, and case plans are properly and timely conducted and documented.

ILTS Program Administration

Finding No. 8: Florida Safe Families Network

Florida Safe Families Network (FSFN) is a Department system that has been used to document and integrate various aspects of child welfare case practice and service delivery, including intake and investigation, assessment and case planning, financial management, resource and provider management, and service delivery tracking. In August 2009, FSFN released a module with additional capabilities to allow for the reporting of ILTS Program data, both financial and support. Using the module, services workers are able to create an ILTS Program page for each client that would include data related to all ILTS Program Services.

According to Department management, although system capabilities were available, CBCs were not required to utilize FSFN to report ILTS Program data. Through interviews conducted during our site visits at seven CBCs, staff at six of the CBCs indicated that they did not utilize the FSFN ILTS Program capabilities. Alternatively, they maintained documentation through the use of internal databases or purchased software packages. Our analysis of the ILTS Program data in FSFN for 30 adolescents ages 13 through 17 disclosed that, for 17 adolescents, the services worker had not created an ILTS Program page. For the remaining 13 adolescents for whom an ILTS Program page had been created, data relating to the adolescents was incomplete.

CBC use of FSFN to report ILTS Program data would enable the Department to more closely track and monitor the work and efforts made by the CBCs toward assisting adolescents in becoming able to live independently as adults. Additionally, for program evaluation purposes, FSFN, if fully utilized by the CBCs, could provide a complete history of each adolescent's progress while involved in the ILTS Program.

Recommendation: We recommend that the Department consider requiring the CBCs to fully utilize FSFN's functionality related to the ILTS Program.

Finding No. 9: ILTS Program Monitoring

EXHIBIT B summarizes the COU monitoring performed, the services for which areas of noncompliance were reported, and whether the CBC was issued a corrective action plan specific to an ILTS Program deficiency. Although the Department utilized many monitoring techniques and had established a robust monitoring process, the monitoring efforts did not lead to timely resolution of identified problems. For example:

- COU monitoring during the 2008-09 fiscal year at one CBC identified eight areas of noncompliance related to the Pre-Independent Living Program. Monitoring during the 2009-10 fiscal year identified six areas of noncompliance, five of which were also identified in the 2008-09 fiscal year. The areas of continuing noncompliance included:
  - A lack of documentation showing that an ILTS Program referral was made.
  - Untimely referrals.
  - Assessments not completed.
  - Untimely assessments.
  - Assessments lacking documentation showing who was to be responsible for helping the child develop skills and the timeframe to receive training.
- COU monitoring during the 2008-09 fiscal year at one CBC identified nine areas of noncompliance related to the Life Skills Program. Monitoring during the 2009-10 fiscal year identified four areas of noncompliance, all of which were also identified in the 2008-09 fiscal year. The areas of continuing noncompliance included:
  - Assessments not completed.
  - Untimely assessments.
  - A youth that did not have a required special judicial review hearing.
  - A lack of documentation showing that a youth who received a special judicial review hearing was provided notice of the right to petition the court for continuing jurisdiction for one year after the youth's 18th birthday, along with information on how to obtain access to the court.

Upon identification of a CBC that fails to demonstrate satisfactory progress in addressing areas of noncompliance, the Department can implement its Progressive Intervention and Program Improvement process. According to

Department staff, no progressive intervention actions had been taken related to ILTS Program deficiencies as of January 2011. The process begins with a required action to correct performance deficiencies within a prescribed amount of time and, if the CBC continues to fail to demonstrate satisfactory progress, the Department is to establish a Management Peer Review Team to conduct an assessment and evaluation to determine the cause of the unacceptable performance. The final stage includes penalties, receivership, reprocurement of a service, or reprocurement of the CBC's contract.

Recommendation: We recommend that, in addition to the corrective action plans utilized during COU monitoring, the Department consider utilizing the Progressive Intervention and Program Improvement process to address continued CBC noncompliance in ILTS Program areas.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit from January 2010 through October 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This operational audit focused on the Department's operation and management of the Independent Living Transition Services Program. The overall objectives of the audit were:

- To evaluate the effectiveness of established internal controls in achieving management's control objectives in the categories of compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To evaluate management's performance in achieving compliance with controlling laws, administrative rules, and other guidelines; the economic, efficient, and effective operation of State government; the relevance and reliability of records and reports; and the safeguarding of assets.
- To identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.
- To evaluate the Department's compliance with the ILTS Program laws and rules that are included in Section 409.1451, Florida Statutes, and Department Rule 65C-31, Florida Administrative Code, related to eligibility and funding.

In conducting our audit we:

- Obtained an understanding of the Department's FSFN IT general and application controls, assessed the risks of those controls, evaluated whether selected general and application IT controls were in place, and tested the effectiveness of the controls.
- Determined the extent of the Department's efforts to comply with the Chafee National Youth in Transition Database requirements.
- Determined the extent of the fields available in FSFN to capture Independent Living data.
- Obtained an understanding of the Department's monitoring processes related to the ILTS Program.

- Obtained an understanding of each community-based care organization's methodologies for providing Independent Living services to youth, including whether services are subcontracted, how services are monitored, the types of services offered to youth, and the costs of services.
- For seven selected CBCs:[23]
  - Interviewed CBC management during site visits conducted during the period April 2010 through June 2010.
  - Obtained an understanding of the CBC controls related to the ILTS Program including determining and documenting eligibility and the disbursement of Program funds.
  - Obtained an understanding of the types of costs included in the CBC's general ledger specific to the ILTS Program.
  - Evaluated the administrative and support services costs related to the ILTS Program and determined the allowability of costs.
  - Obtained an understanding of the CBC's monitoring process related to any subcontracted Independent Living service providers.
- Examined case file documentation for 20 adolescents who were eligible for Pre-Independent Living Services during the period July 2008 through February 2010, to determine compliance with governing laws, rules, and Department policy.
- Examined case file documentation for 10 adolescents who were eligible for Life Skills Services during the period July 2008 through February 2010, to determine compliance with governing laws, rules, and Department policy.
- Examined case file documentation for 41 teens who received approximately $334,810 in Subsidized Independent Living Services financial assistance payments during the period July 2008 through February 2010, to determine compliance with governing laws, rules, and Department policy.
- Examined case file documentation for 17 young adults who received approximately $65,436 in Aftercare Support Services financial assistance payments during the period July 2008 through January 2010, to determine compliance with governing laws, rules, and Department policy.
- Examined case file documentation for 20 young adults who received approximately $178,761 in Transitional Support Services financial assistance payments during the period July 2008 through February 2010, to determine compliance with governing laws, rules, and Department policy.
- Examined case file documentation for 43 young adults who received approximately $686,815 in Road to Independence financial assistance payments during the period July 2008 through February 2010, to determine compliance with governing laws, rules, and Department policy.
- Performed analytical procedures related to Chafee Education and Training Vouchers Program spending caps and other statutory limitations for all payments during the period July 2008 through February 2010.
- Performed analytical procedures related to Chafee Foster Care Independence Program age limitations for all payments during the period July 2008 through February 2010.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe those matters requiring corrective actions.

[23] Big Bend Community Based Care, Inc. (East); ChildNet, Inc.; Our Kids of Miami-Dade/Monroe, Inc.; Family Services of Metro-Orlando, Inc.; Kids Central, Inc.; Heartland For Children; and Hillsborough Kids, Inc.

AUTHORITY

Section 11.45, Florida Statutes, requires that the Auditor General conduct an operational audit of each State agency on a biennial basis. Pursuant to the provisions of Section 11.45, Florida Statutes, I have directed that this report be prepared to present the results of our operational audit.

David W. Martin, CPA
Auditor General

MANAGEMENT'S RESPONSE

In a response letter dated April 8, 2011, the Secretary of the Department concurred with our audit findings and recommendations. The Secretary's response is included as **EXHIBIT C**.

EXHIBIT A
INDEPENDENT LIVING TRANSITION SERVICES PROGRAM
DESCRIPTION OF PROGRAM COMPONENTS AND TYPES OF SERVICES PROVIDED

Program Components and Types of Services	Examples of Specific Services Provided	Age Group Served	Foster Care Status	Initial Request for Services by	Academic Requirements	Ongoing Determination Basis	Spending Caps	Funding Source
Pre-Independent Living	Life skills training, educational field trips, and conferences.	13 to 15	In custody of Department. [a]	N/A	N/A	Annual staffing.	N/A	N/A [c]
Life Skills	Independent living skills training, including training to develop banking and budgeting skills, interviewing skills, parenting skills, and time management or organizational skills, educational support, employment training, and counseling.	15 to 18	In custody of Department. [a]	N/A	N/A	Staffing every 6 months.	N/A	N/A [c]
Subsidized Independent Living (SIL)	Financial assistance for living arrangements that allow the child to live independently of the daily care and supervision of an adult.	16 to 18	In custody of Department for at least 6 months prior to entering SIL, with a goal of either adoption, long-term licensed care, or independent living. [a]	N/A	Full-time educational program making adequate progress.	Continue to demonstrate independent living skills.	N/A	Chafee Program and State.
Aftercare Support	Housing, electric, water, gas, sewer service, food, mentoring, tutoring, mental health services, substance abuse counseling, life skills classes, parenting classes, job and career skills training, counselor consultations, temporary financial assistance, and financial literacy skills training.	18 to 23 [b]	Leave foster care at age 18.	Prior to age 23.	N/A	N/A	N/A	Chafee Program and State.
Transitional Support	Financial, housing, counseling, employment, education, mental health, disability, and other services.	18 to 23 [b]	Be or have been in the legal and/or physical custody of Department at age 18 and spent at least 6 months in foster care before age 18. [a]	Prior to age 23.	N/A	Transition plan completed every 3 months. [b]	N/A [b]	ETV and Chafee Programs and State.
Road to Independence (RTI) Awards	Financial educational assistance.	18 to 23	In licensed foster care or in SIL at age 18 or currently living in licensed foster care or SIL or, after reaching age 16, adopted from foster care or placed with a court-approved dependency guardian and spent a minimum of 6 months in foster care immediately preceding such placement or adoption and spent at least 6 months in foster care before age 18.	Prior to age 21.	Full-time enrollment in post-secondary, high school, or GED program.	Annual renewal, maintain adequate progress.	Prior to July 2009, $1,134 per month. $1,255 per month thereafter.	ETV and Chafee Programs and State.

[a] In custody of the Department refers to foster care placements.

[b] Additional requirements exist if the young adult's benefits are paid from the ETV and/or Chafee Programs.

[c] Funding included in amounts provided for Administrative and Support Services.

Sources: Department Rules 65C-28.009 and 65C-31, Florida Administrative Code, and Section 409.1451, Florida Statutes.

EXHIBIT B
SUMMARY OF CONTRACT OVERSIGHT UNIT (COU) MONITORING FINDINGS

CBC Lead Agency	COU Monitoring Dates	Pre-Independent Living	Life Skills	Subsidized Independent Living	Aftercare Support	Transitional Support	Road to Independence	Corrective Action Plan Required
Families First Network of Lakeview	06/12/2009	CD	CD				CD	Yes
	05/28/2010					CD		Yes
Big Bend Community Based Care, Inc. (East and West)	03/05/2009	CD	CD	CD	CD		CD	Yes
	03/24/2010	CD	CD	CD			CD	Yes
Partnership for Strong Families, Inc.	05/17/2009	CD	CD	CD			CD	Yes
	03/26/2010	CD	CD					Yes
Family Support Services of North Florida, Inc.	05/13/2009	CD	CD	CD		CD	CD	Yes
	05/03/2010	CD	CD	CD	CD		CD	Yes
Community Partnership for Children, Inc.	02/24/2009	CD	CD	CD		CD	CD	Yes
	01/07/2010	CD						No
St. Johns County Board of County Commissioners	11/25/2008	CD	CD	CD				Yes
	02/19/2010	CD	CD			CD		Yes
Kids First of Florida, Inc.	10/21/2008	CD	CD					Yes
	02/02/2010	CD	CD			CD	CD	Yes
Sarasota Family YMCA, Inc.	03/09/2009	CD	CD		CD	CD	CD	Yes
	02/10/2010	The ILTS Program was not monitored.						
Eckerd Community Alternatives	07/21/2009	CD	CD				CD	Yes
	06/29/2010	CD	CD			CD	CD	Yes
Hillsborough Kids, Inc.	04/24/2009	CD	CD				CD	Yes
	03/02/2010	The ILTS Program was not monitored.						
Children's Network of Southwest Florida, Inc.	06/08/2009	CD	CD			CD	CD	Yes
	06/29/2010	CD	CD	CD	CD	CD	CD	Yes
Community Based Care of Seminole, Inc.	04/15/2009	CD	CD			CD		No
	04/23/2010	CD	CD					No
Community Based Care of Brevard, Inc.	03/31/2009	CD	CD					Yes
	02/19/2010	CD	CD					Yes
Family Services of Metro-Orlando, Inc.	06/02/2009	CD	CD	CD		CD	CD	No
	06/18/2010		CD	CD			CD	Yes
Kids Central, Inc.	06/16/2009	CD	CD	CD		CD	CD	Yes
	05/06/2010	CD						No
Heartland for Children, Inc.	11/25/2008	CD	CD	CD	CD	CD	CD	Yes
	03/24/2010	CD	CD			CD	CD	Yes
United for Families, Inc.	06/11/2009	CD	CD			CD	CD	Yes
	05/04/2010	CD	CD					No
Child and Family Connections, Inc.	05/08/2009	CD			CD		CD	Yes
	01/07/2010	CD	CD		CD	CD	CD	Yes
ChildNet, Inc.	Monitoring performed by contracted monitors.							
Our Kids of Miami-Dade/Monroe, Inc.								

Note: A "CD" indicates that compliance deficiencies related to the provision of services were identified in the applicable monitoring report. The lack of deficiencies in a report may be due to: 1) the COU not monitoring the specified service, 2) the CBC not participating in the specified service, or 3) the COU not identifying any deficiencies.

Source: Department monitoring reports.

EXHIBIT C
MANAGEMENT'S RESPONSE

State of Florida
Department of Children and Families

Rick Scott
Governor

David E. Wilkins
Secretary

April 8, 2011

Mr. David W. Martin, CPA
Auditor General
State of Florida
G74 Claude Pepper Building
111 West Madison Street
Tallahassee, Florida 32399-1450

Dear Mr. Martin:

Thank you for your March 3, 2011 letter providing preliminary and tentative audit findings and recommendations of the audit of the Department's Independent Living Transition Services Program.

Attached is the Department's response to the findings and recommendations. As you may be aware, there is proposed legislation to redesign the Independent Living Transition Services Program, Senate Bill 1902 and House Bill 1241. If adopted, the Department will revamp all components of the Independent Living Transition Services Program.

If you or your staff have any questions, please contact Jamie Self, Ed.D., Director of the Office of Family Safety, at 850-488-8762.

We appreciate the opportunity to respond and look forward to continued collaboration with your office.

Sincerely,

David E. Wilkins
Secretary

Attachment

EXHIBIT C
MANAGEMENT'S RESPONSE (CONTINUED)

RESPONSE TO OFFICE OF AUDITOR GENERAL
PRELIMINARY AND TENTATIVE AUDIT FINDINGS ON
OPERATIONAL AUDIT OF
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
INDEPENDENT LIVING TRANSITION SERVICES PROGRAM

Finding No. 1: RTI Award Needs Assessments

Recommendation No. 1: We recommend that the Department reconsider the needs assessment process for high school students and provide for an estimate of living and educational needs for each student. We also recommend that for post-secondary students, the Department take steps to ensure that needs assessments are accurately completed and properly supported.

Department Response: The Department concurs. The high school needs assessment process should be re-evaluated to accurately reflect the cost of living and educational needs for the student. In addition, steps have already begun to ensure that the post secondary needs assessments are accurately completed and properly supported.

The Department's Statewide Automated Child Welfare Information System, Florida Safe Families Network (FSFN), provides the capacity to scan and store digital documents related to active casework. Policy and guidance will be provided to the community-based care lead agencies of the requirement to scan all needs assessments along with corresponding backup documentation into FSFN and store in the File Cabinet linked to the specific young adult.

Finding No. 2: Appropriate Progress

Recommendation No. 2: We recommend that the Department establish rules or guidelines outlining accountability measures related to providing attendance and proof of appropriate progress for young adults in GED programs.

Department Response: The Department concurs. Emergency rules developed for Chapter 65C-31, Florida Administrative Code (F.A.C.), Services to Young Adults Formerly in the Custody of the Department, became effective in September 2010. A modification to administrative rule 65C-31.004, F.A.C., Road to Independence Scholarship, requiring Road to Independence recipients enrolled in a GED program to take the full battery of GED tests every six months, was submitted to the Joint Administrative Procedures Committee (JAPC). This change provided the Community-Based Care lead agencies (CBCs) a way to measure appropriate progress for the GED program. However, the JAPC informed the Department that a statutory change is required to promulgate a rule addressing this issue. JAPC cited §409.1451(5)(b), Florida Statutes, "satisfactory progress as defined by the educational institution." Thus, we were unable to amend the language in the proposed permanent rule for 65C-31.004, F.A.C.

EXHIBIT C
MANAGEMENT'S RESPONSE (CONTINUED)

RESPONSE TO OFFICE OF AUDITOR GENERAL
PRELIMINARY AND TENTATIVE AUDIT FINDINGS ON
OPERATIONAL AUDIT OF
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
INDEPENDENT LIVING TRANSITION SERVICES PROGRAM

Finding No. 3: Transitional and Aftercare Support Services

Recommendation No. 3: We recommend that the Department establish clear guidelines for CBC use regarding when it is appropriate for a young adult to receive both Transitional and Aftercare Support Services based on the situation of the young adult. In addition, we recommend that the Department ensure that payments to young adults are properly coded and that sufficient documentation, including applications, is completed and maintained in the case files.

Department Response: The Department concurs. Establishment of clear guidelines is needed for local use when a young adult is seeking monetary benefits through the three Independent Living Transition Services Program service types. The guidance should also address protocol for the three service types to ensure proper application with documentation, as well as appropriate coding in FSFN.

In July 2007, an Independent Living Payment Guide and Code Definitions Guidebook was provided to each CBC lead agency. The guidebook gives detailed information on coding for each service type, in each available situation. In addition, the guidebook provides a complete and comprehensive definition of the expenditures allowed for each service type, as well as the eligibility and age limitation (for funding source purposes) for each service type. For example, the Road to Independence Program has different coding requirements for a young adult attending high school rather than post secondary education; the guidebook provides further clarification of available codes within each of these variations to allow for Chafee's funding restriction of age.

Although §409.1451(5), Florida Statutes, allows for a young adult to receive all three service types at the same time, the young adult should not be requesting the same need for all service types within the same time period. The Department will update the guidebook to assist the CBCs in evaluating applications when a young adult is requesting multiple service types to ensure each application is not duplicative of the need being requested within a specified time period, as well as including the requirement of scanning documents into FSFN.

Finding No. 4: Federal Grant Funding

Recommendation No. 4: We recommend that the Department enhance its monitoring procedures to ensure that payments to young adults are in compliance with Federal requirements and that administrative and support services costs allocated to the Chafee Program relate to Program-eligible young adults. In addition, we recommend that the Department take steps to ensure that the CBCs properly record ILTS Program payments.

Department Response: The Department concurs. Payments made to clients who exceeded the maximum age limitation for the Chafee program were improperly coded. As pointed out in the audit report, recoding these clients would have no impact on the amount of Chafee grant

EXHIBIT C
MANAGEMENT'S RESPONSE (CONTINUED)

RESPONSE TO OFFICE OF AUDITOR GENERAL
PRELIMINARY AND TENTATIVE AUDIT FINDINGS ON
OPERATIONAL AUDIT OF
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
INDEPENDENT LIVING TRANSITION SERVICES PROGRAM

drawn by the Department, as expenditures far exceed the grant available. The CBC lead agencies reported spending $29.2 million in state fiscal year 2009-10 for eligible Chafee and ETV expenditures, but the federal grant amounts available were only $11.3 million. The miscoding of $621,043 represents an error rate of about 2.1%. The Department will reemphasize with the CBC lead agencies the importance of properly recording these program expenditures. In addition, when the final invoice is submitted by each CBC lead agency to the Department at the end of the state fiscal year, a final review will be completed of payments made to young adults to ensure compliance of age limitations as required by the Chafee grant. Any coding errors found will require corrections and a submission of an updated final invoice.

Policy and guidance will be provided to the CBC lead agencies of the requirement that all applications and backup documentation for young adults approved for any Independent Living Transition Services Program service type shall be scanned into FSFN and stored in the File Cabinet linked to the specific young adult. Scanning of each service type's application, along with backup documentation will enable the Department to ensure payments coded in the financial system are properly coded.

Finding No. 5: ETV Program, RTI Award, and SIL Program Spending Caps

Recommendation No. 5: We recommend that the Department perform monitoring to ensure Department payments to young adults do not exceed the annual ETV Program spending limit. Additionally, to ensure compliance with Department rules, we recommend that the Department establish procedures to monitor the RTI and SIL spending caps on a monthly basis.

Department Response: The Department concurs. Monitoring of direct payments made to young adults with the ETV funds is essential. The Department will continue to review ETV payments to young adults beginning in the fourth quarter of the fiscal year and provide notification to CBC lead agencies of any overages per young adult. When the final invoice is submitted by each CBC lead agency at the end of the state fiscal year, a final review will be completed of payments made to young adults to ensure compliance of the annual capped amount coded to ETV funds. Any overages found will require corrections, as well as submission of an updated final invoice.

The Department recently added the Subsidized Independent Living (SIL) maximum monthly payment amount to its contract monitoring tool. Therefore, as the Contract Oversight Unit monitors CBC lead agency contracts for Independent Living Transition Services, this is now available as part of the review.

A monthly process will be put in place to review SIL and RTI payments to ensure maximum monthly amounts are not exceeded. Should these monthly payment amounts exceed the maximum, notification will be sent to CBC lead agencies for correction. As mentioned above, when the final invoice is submitted by each CBC lead agency to the Department at the end of

EXHIBIT C
MANAGEMENT'S RESPONSE (CONTINUED)

RESPONSE TO OFFICE OF AUDITOR GENERAL
PRELIMINARY AND TENTATIVE AUDIT FINDINGS ON
OPERATIONAL AUDIT OF
FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
INDEPENDENT LIVING TRANSITION SERVICES PROGRAM

the state fiscal, a final review will be completed of payments made to youth and young adults to ensure compliance with the maximum monthly amounts coded to SIL and RTI. Any overages found will require corrections, as well as a submission of an updated final invoice.

Finding No. 6: SIL Case Management

Recommendation No. 6: We recommend that the Department disseminate guidance and provide training to CBCs regarding the performance and documentation of SIL Program tasks.

Department Response: The Department concurs. Administrative rule 65C-28.009, Out-of-Home Care, Adolescent Services, provides the requirements for Subsidized Independent Living (SIL). The Department will develop guidance that provides detailed explanations for all required documentation for youth seeking to participate in SIL.

Currently, the Department facilitates monthly conference calls and periodic trainings for Independent Living and case management field staff. Trainings and technical support for providing SIL services to eligible youth will be conducted through these venues.

Finding No. 7: Adolescent Case Management Tasks

Recommendation No. 7: We recommend that the Department take steps to ensure that required staffing, assessments, and case plans are properly and timely conducted and documented.

Department Response: The Department concurs. Staffings, assessments, and case plans for youth in out-of-home care should be properly and timely conducted and documented.

Administrative rule 65C-28.009, Out-of-Home Care, Adolescent Services, lists required staffing, assessments, case plans, and services to be provided for children in out-of- home care within time frames. FSFN provides the capacity to scan and store digital documents related to active casework. Recently, the Department directed that all CBC Lead Agencies must convene meetings with each case management organization to ensure they fully understand case ownership responsibility as the integrator of all services and supports identified for each child.

Finding No. 8: Florida Safe Families Network

Recommendation No. 8: We recommend that the Department consider requiring the CBCs to fully utilize FSFN's functionality related to the ILTS Program.

Department Response: The Department concurs. Florida Safe Families Network (FSFN) is the State of Florida's Statewide Automated Child Welfare Information System (SACWIS), and

EXHIBIT C
MANAGEMENT'S RESPONSE (CONTINUED)

RESPONSE TO OFFICE OF AUDITOR GENERAL
PRELIMINARY AND TENTATIVE AUDIT FINDINGS ON
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FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES
INDEPENDENT LIVING TRANSITION SERVICES PROGRAM

all child welfare services provided by the state are required to be documented in this system including services provided by the Independent Living Transition Services Program.

A directive was issued that all CBC lead agencies are to fully utilize the financial module within FSFN as the official record for payments made to and/or on behalf of clients, by July 1, 2011. In addition, the Department has provided guidance to the CBC lead agencies of the FSFN modules that are required to be completed for the federally mandated National Youth in Transition Database (NYTD) transmission of data from FSFN to the Administration for Children and Families semi-annually.

The Department has also provided policy and guidance to the CBC lead agencies for utilizing the scanning feature of FSFN, as well as the types of documents to be scanned; this included documentation required for youth and young adults receiving independent living services.

The Department will continue to provide trainings and technical assistance focused on completing these modules through webinars, desk references, monthly conference calls, and quarterly meetings for the Independent Living and Case Management staff.

Finding No. 9: ILTS Program Monitoring

Recommendation No. 9: We recommend that, in addition to the corrective action plan utilized during COU monitoring, the Department consider utilizing the Progressive Intervention and Program Improvement process to address continued CBC noncompliance in ILTS Program areas.

Department Response: The Department concurs. Once all efforts are exhausted to ensure compliance of independent living services as provided by §409.1451, Florida Statutes, Chapter 65C-31, F.A.C., and Administrative Rule 65C-28.009, F.A.C. by CBC lead agencies, the Department will utilize the Progressive Intervention and Program Improvement Process for the Independent Living Transition Services Program.

The Progressive Intervention and Program Improvement Process for any child welfare services' deficiencies provided by the CBC lead agency is already included, as a document incorporated by reference in each CBC contract. "The Department may begin this process at anytime in the event the provider is significantly below target on any performance measure, there are serious fiscal concerns, or if Quality Management review findings identify other serious systemic concerns, as determined by the District/Regional Administrator."

Rick Scott, Governor
David Wilkins, Secretary

Department of Children and Families
Independent Living Transition Services

Secretary David E. Wilkins
Senate Committee on Children, Families and Elder Affairs
January 15, 2013

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

Brief History and Background

Federal Law

- The Chafee Foster Care Independence Act (1999)

State Law

- Road to Independence Act (2002)

Privatization of Service Delivery

- Child Welfare System Institutionalized in CBCs (1998)

Categories of Independent Living Services

Preindependent Living Services

- Life skills training, educational field trips, and conferences

Life Skills Services

- Banking and budgeting skills, educational support, employment training, etc.

Subsidized Living Services

- Allows youth to live independently of daily care and adult supervision

Categories of Independent Living Services cont.

Aftercare Support Services

- Services for young adults to continue developing the skills necessary for independent living (tutoring, counseling, life skills training, etc.)

Transitional Support Services

- Short-term services including financial, housing, counseling, employment, education, etc.

Road-to-Independence (RTI) Program

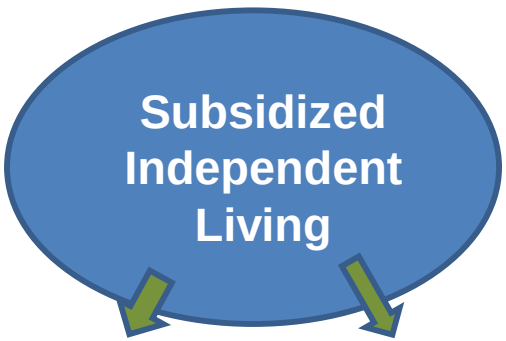
- Financial assistance to help former foster care youth receive education and vocational training to achieve independence

Allocated Funds and Expenditures

Total Independent Living Funding					
State Fiscal Year	From IL Budget	From Other CBC State Funds	Total	Funding	
				Federal	State
2009-10	$30,170,469	$21,709,631	**$51,880,100**	$9,042,586	$42,837,514
2010-11	$29,451,721	$22,828,866	**$52,280,587**	$8,161,242	$44,119,345
2011-12	$29,476,721	$19,562,437	**$49,039,158**	$8,181,242	$40,857,916

Distribution of Expenditures

# Clients Served	Total Expenditures
5212	$13,066,982



# Clients Served	Total Expenditures
76	$276,761

# Clients Served	Total Expenditures
561	$628,794

# Clients Served	Total Expenditures
1527	$5,208,321

# Clients Served	Total Expenditures
3418	$29,858,300

Today's Young Adults

Of the 2,956 young adults reported in FSFN:

- 1,103 young adults reflect some college, college degree, post-graduate work or post-graduate degree
- 217 reflect Vocational/Technical education status
- 1,615 are pursuing a high school diploma or GED
- 15 have a None or Unknown or Non-graded special education listed in their record
- 6 have no educational record

Survey Results

Survey Results for Youth 13-17

- 41% reported having an Individualized Education Plan (IEP)
- 76% reported their grades were reviewed by group care or foster parents
- 86% reported receiving medical or dental care

Survey Results for Young Adults 18-22

- 57% of young adults reported they have finished a High School or GED Program
- 7% of the young adults reported completing post-secondary education
- 19% reported having employment
- 4% reported full time employment

Challenges

- Participants not required to report results so outcomes are unknown
- Participants and advocates view program as an entitlement
- Expectations for success are marginalized
- Students feel overwhelmed

Recommendations

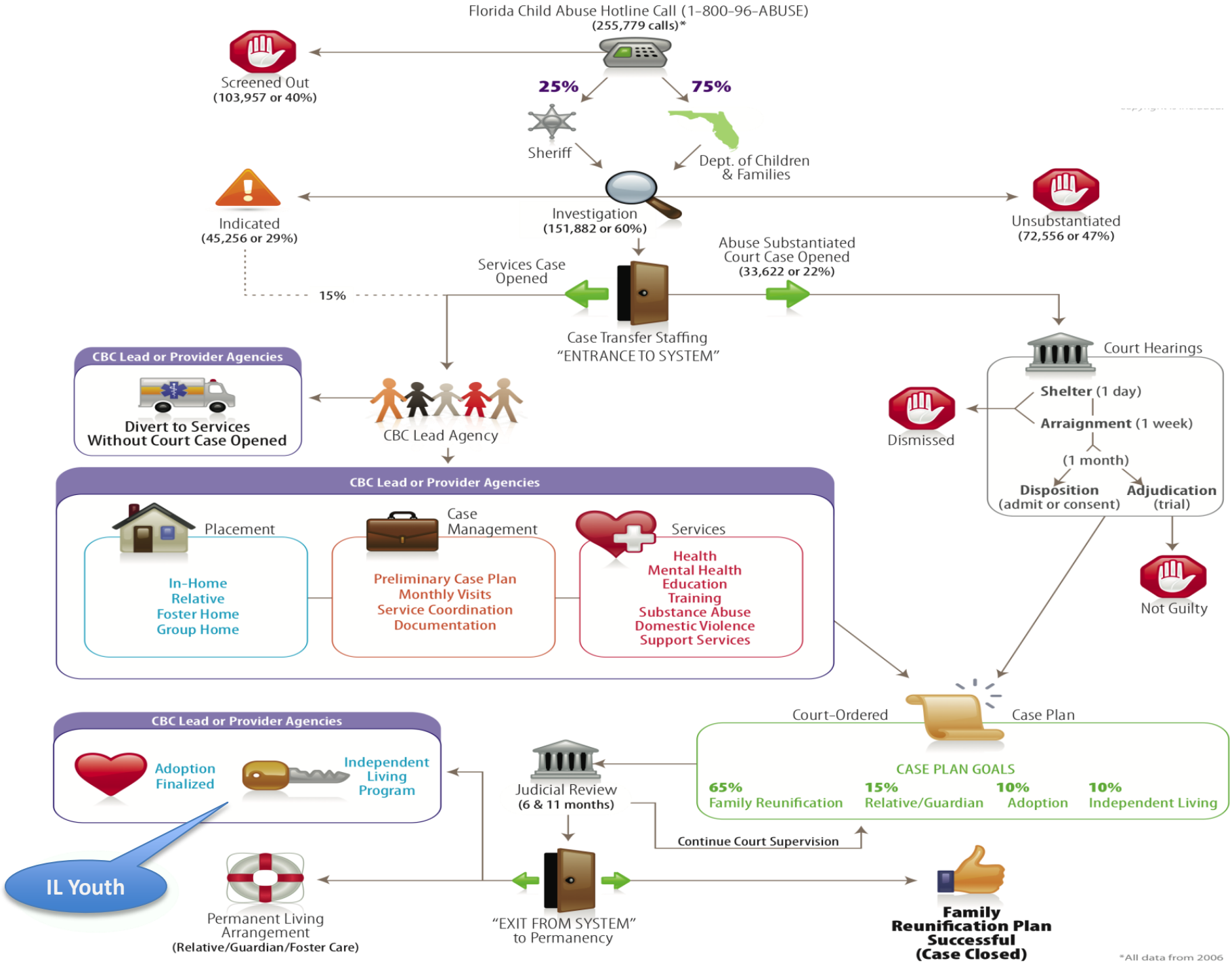
- Separate RTI from Transitional Support Services based on eligibility
  - Create criteria for eligibility and sustainability into RTI Program
  - Young adults with no RTI goal receive transitional support
- Create mechanisms to measure performance and consequences of nonperformance
- Provide exit opportunity for young adults
- Establishes mentors and additional post-secondary support services
- Avoid cost escalation

Florida's Independent Living Program
Current Practice & Future Challenges

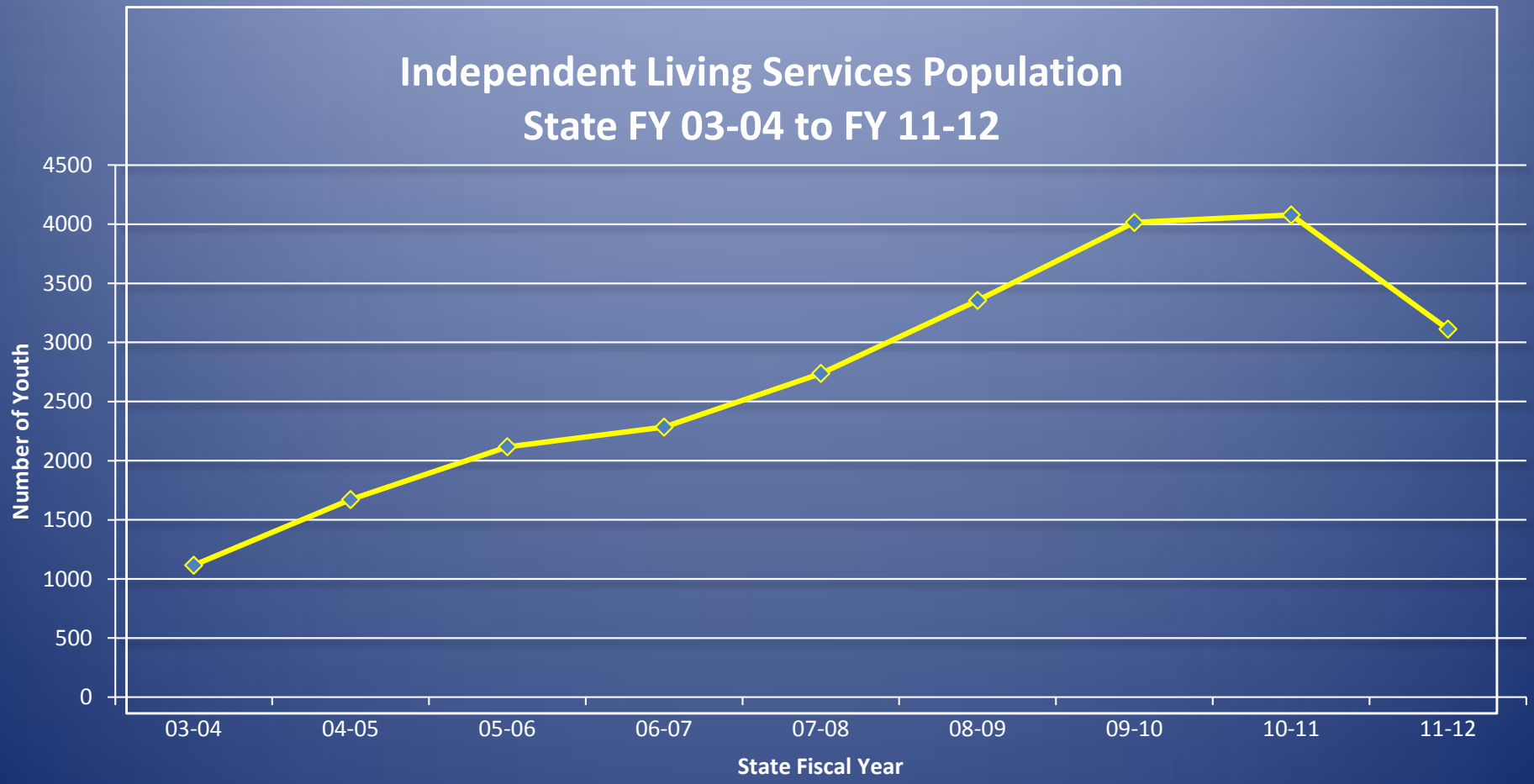
Deborah Mortham, Interim President & CEO, Florida Coalition for Children
Teri Saunders, CEO, Heartland for Children
Taj Banks, Age 18, Intervention Services, Village Resident

The Florida Senate Committee on Children, Families, & Elder Affairs
January 15, 2013

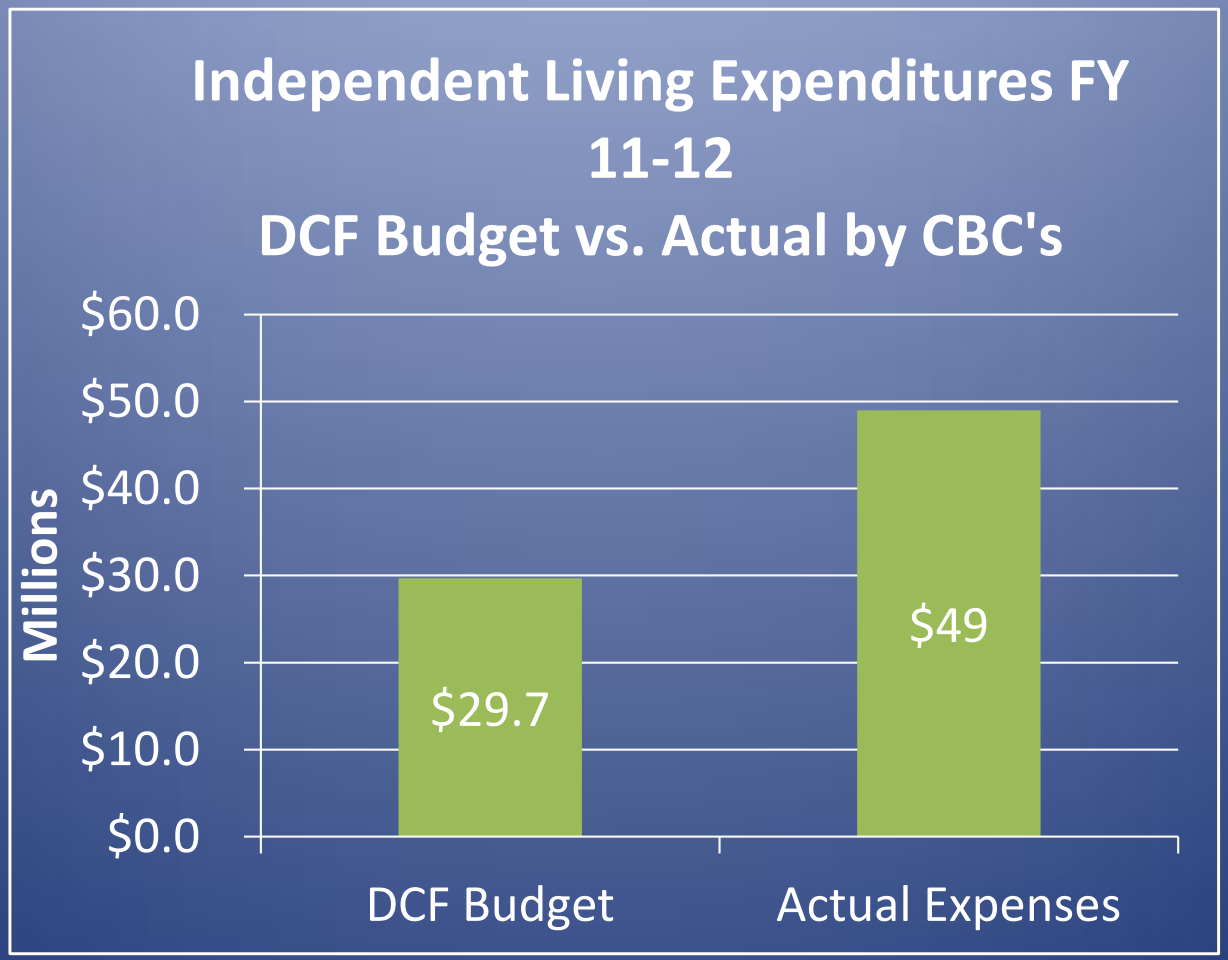
Florida's Community-Based Care Child Welfare System



The Number of Youth Receiving Independent Living Services has Risen Dramatically with the Implementation of Community-Based Care



Current DCF Budget for IL Services Does Not Reflect True Need CBC's Are Making Up the Difference Through Efficiencies in Core Services to Other Populations



The Problem With One-Size Fits All is . . .

One-Size Doesn't Fit All

- Communities Vary
- Resources Vary
- Opportunities Vary
- Youth Vary

Therefore in Community-Based Care: Solutions Vary

Here are a Few Innovative Examples of Communities Solving their IL Puzzle in Unique Ways

• **Intervention Services Inc. - Seminole County**

The Village provides dorm-style housing for former foster youth, ages 18 to 23. The Village opened in 2004 to provide affordable housing with additional support of educational advocacy, employment training and life skills instruction.

• **Brevard Family Partnership - Brevard County**

Independent Living Skills Boot Camp gives training to youth who are turning 18. Topics include: financial literacy, job seeking, interview skills, decision making, and housing matters.

• **Heartland for Children - Polk, Hardee, & Highlands Counties**

Academic Turnaround Project An initiative where Life Coaches, and Foster Parents become more visible, and involved in the educational process.

• **Family Support Services of North Florida Duval & Nassau Counties**

Splash an award winning innovative life skills program that was created in order to teach teens in foster care how to prepare for life as an adult while becoming certified SCUBA divers. The program focuses on Trust, Self Esteem, Self Efficacy, Employment, and Education.

- **The Sarasota YMCA - Sarasota County**

Kalish House Resource Center A community-based and youth-inspired teen center. Combining education, training and fun, the resource center is a place for our youth and young adults aged 13 through 23 to obtain life skills and education.

- **Hibiscus Children's Center - St. Lucie County**

Career Pathways Program provides weekly seminars on IL skills, work/internship placements, volunteer activities, and college tours across the state.

- **ChildNet - Palm Beach County**

Best Foot Forward provides tutoring, educational advocacy in order to help youth prepare for post secondary learning. These advocates ensure the appropriate classes are taken, and the completion of applications for schools, scholarships, etc.

- **ChildNet – Broward County**

The FLITE (Ft. Lauderdale Independence Training and Education) Center is a one stop resource center for current and former foster youth. Now in its fourth year, out posted staff from several community organizations and agencies in the community can offer life skill training classes in the following areas: budgeting, credit counseling, meal planning and preparation, healthy relationships, parenting skills as well as other needed skill development workshops. Additional supports offered include assistance with linkage to services available to obtain a high school diploma or GED, assistance in identifying college, post-secondary education options, and employment assistance.

Some Suggestions for IL Program Improvements That Really Will Make a Difference For Youth

1. **Focus on Permanency Until Age 16**

2. **Implement Common Sense Accountability for RTI Funds**
   - allow direct payments for essential expenses, e.g. rent, utilities
   - monthly review of educational records to insure eligibility

3. **Revise Current Needs Assessment in Admin. Code**

4. **Insure Additional Program Requirements Come with Additional Resources**

Questions?

The Florida Coalition for Children:
The Voice of Florida's
Community-Based Care Child Welfare System

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic Independent Living

Name Marcus Jacques

Job Title FYS member

Address _____
Street

_____
City *State* *Zip*

Bill Number N/A
(if applicable)

Amendment Barcode _____
(if applicable)

Phone 954.857.9597

E-mail palmbeach@floridayouthshine.org

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Youth SHINE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic Independent Living

Name Georgina Rodriguez

Job Title FYS legislative chair

Address _____
Street

_____
City *State* *Zip*

Bill Number _____
(if applicable)

Amendment Barcode _____
(if applicable)

Phone 813.850.4739

E-mail Rodriguezg1991@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Representing _____

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic Independent Living

Name Ryan Hampton

Job Title FYS member

Address _____
Street

_____
City *State* *Zip*

Bill Number N/A *(if applicable)*

Amendment Barcode _____ *(if applicable)*

Phone 954.857.9597

E-mail palmbeach@floridayouthshine.org

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Youth SHINE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic Independent Living

Name Andrea Cowart

Job Title Membership chair

Address _____
Street

_____
City *State* *Zip*

Bill Number N/A *(if applicable)*

Amendment Barcode _____ *(if applicable)*

Phone 727.492.4597

E-mail membership@floridayouthshine.org

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Youth SHINE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic Independent Living

Bill Number N/A *(if applicable)*

Name Danielle McMahan

Amendment Barcode *(if applicable)*

Job Title FYS member

Address *Street*

Phone 813·898·7270

City *State* *Zip*

E-mail dmcmahan10@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Youth SHINE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/13
Meeting Date

Topic Independent Living

Bill Number N/A *(if applicable)*

Name Otto Phillips

Amendment Barcode *(if applicable)*

Job Title FYS member

Address *Street*

Phone 561·713·3920

City *State* *Zip*

E-mail ophillips33@aim.com

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Youth SHINE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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S-001 (10/20/11)

didn't speak

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-15-13
Meeting Date

Topic Independent Living — Bill Number NIA (*if applicable*)

Name Christina Spudeas — Amendment Barcode _____ (*if applicable*)

Job Title Ex. Dir.

Address 1801 N. Univ. Drive, Ste. 3B — Phone 954-326-8923
Street

Coral Springs, FL. 33071 — E-mail Christina.Spudeas@FloridasChildrenFirst.org
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida's Children First / Florida Youth SHINE

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

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

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S-001 (10/20/11)

didn't speak

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/15/2013
Meeting Date

Topic Independent living Program — Bill Number _____ (*if applicable*)

Name BRIAN PITTS — Amendment Barcode _____ (*if applicable*)

Job Title TRUSTEE

Address 1119 NEWTON AVNUE SOUTH — Phone 727-897-9291
Street

SAINT PETERSBURG FLORIDA 33705 — E-mail JUSTICE2JESUS@YAHOO.COM
City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information

Representing JUSTICE-2-JESUS

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

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

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S-001 (10/20/11)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on Finance and Tax
Banking and Insurance
Children, Families, and Elder Affairs
Ethics and Elections
Rules
Transportation

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR MIGUEL DIAZ de la PORTILLA
40th District

January 15, 2013

The Honorable Eleanor Sobel
Chair
Senate Committee on Children, Families and Elder Affairs

Dear Chair Sobel:

I respectfully request that I be excused from the Committee meeting today due to a personal situation that requires my attention.

I regret that I did not know before the start time of 2:00 p.m. that I would be unable to attend.

Thank you for your consideration.

Sincerely,

Miguel Diaz de la Portilla
State Senator, District 40

Cc: Ms. Lynn Wells, Committee Administrative Assistant

REPLY TO:
❒ 2100 Coral Way, Suite 505, Miami, Florida 33145 (305) 643-7200
❒ 312 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5040

Senate's Website: *www.flsenate.gov*

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

Room: LL 37 **Case:** **Type:**
Caption: Senate Children, Families, and Elder Affairs Committee **Judge:**

Started: 1/15/2013 2:02:03 PM
Ends: 1/15/2013 5:01:02 PM Length: 02:59:00

2:02:24 PM Pledge of Allegiance
2:02:46 PM Chair Sobel's opening remarks
2:02:52 PM Roll call
2:03:16 PM Chair Sobel's continued remarks
2:04:02 PM Introduction of new committee staff - Karen Peterson
2:04:15 PM Chair Sobel's comments regarding Assisted Living Facilities and the Independent Living Program for Foster Children
2:05:56 PM (Tab 1) Claude Hendon, Staff Director, Assisted Living Facilities -- Interim Project 2012-128 by Health Regulation and 2012 Proposed Legislation
2:07:50 PM Chair Sobel's continued remarks
2:07:55 PM Senator Hays' remarks and question
2:08:24 PM Claude Hendon, Staff Director, response
2:08:52 PM Chair Sobel's comments
2:09:05 PM Senator Hays' continued remarks
2:09:57 PM Chair Sobel's continued remarks
2:11:15 PM Senator Detert remarks
2:12:04 PM Jim Crochet, State Long-Term Care Ombudsman, remarks
2:21:51 PM Chair Sobel's question
2:22:21 PM Jim Crochet, State Long-Term Care Ombudsman, response
2:23:55 PM Chair Sobel's follow-up question
2:24:00 PM Jim Crochet, State Long-Term Care Ombudsman, response
2:24:11 PM Chair Sobel's continued remarks and question
2:25:51 PM Jim Crochet, State Long-Term Care Ombudsman, response
2:27:54 PM Chair Sobel's question
2:28:03 PM Jim Crochet, State Long-Term Care Ombudsman, response
2:29:03 PM Chair Sobel's question
2:29:08 PM Jim Crochet, State Long-Term Care Ombudsman, response
2:29:27 PM Senator Hays' remarks and question
2:30:24 PM Jim Crochet, State Long-Term Care Ombudsman, response
2:33:32 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, remarks
2:37:06 PM Chair Sobel's question
2:37:13 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
2:37:25 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, continued remarks
2:48:33 PM Chair Sobel's question
2:48:46 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
2:49:08 PM Chair Sobel's question
2:49:17 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
2:49:32 PM Chair Sobel's question
2:49:46 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
2:50:05 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, continued remarks
2:56:26 PM Senator Hays' remarks and question
2:57:59 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
2:59:16 PM Chair Sobel's remarks and question
3:00:06 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
3:00:32 PM Susan Rice-Anderson, Department of Elder Affairs, remarks
3:09:40 PM Chair Sobel's remarks and question
3:09:50 PM Susan Rice-Anderson, Department of Elder Affairs, response
3:10:04 PM Chair Sobel's remarks
3:10:14 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, remarks
3:15:44 PM Chair Sobel's question
3:15:57 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, response
3:16:19 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, continued remarks

3:19:27 PM Senator Hays' question
3:20:07 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, response
3:20:44 PM Claude Hendon, Staff Director, response to Senator Hays' question
3:21:11 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, continued response
3:21:25 PM Senator Hays' question
3:22:39 PM Chair Sobel's question
3:23:06 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, response
3:23:45 PM Chair Sobel's remarks and question
3:24:12 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, response
3:24:45 PM Chair Sobel's remarks
3:24:54 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, continued remarks
3:34:10 PM Senator Altman's question
3:34:29 PM Chair Sobel's comments
3:34:35 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, response
3:34:56 PM Chair Sobel's continued remarks
3:35:32 PM Senator Altman remarks and question
3:36:09 PM Larry Polivka, Chair, Florida Assisted Living Facility Workgroup, response
3:37:46 PM Public Testimony, Assisted Living Facilities
4:00:18 PM Chair Sobel's question
4:00:40 PM Pat Lange, Executive Director, Florida Assisted Living Association, response
4:02:53 PM Public Testimony continued, Assisted Living Facilties
4:03:43 PM Senator Hays' question
4:04:55 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:07:01 PM Senator Hays' follow-up question
4:07:24 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:07:33 PM Senator Hays' question
4:08:30 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:09:20 PM Senator Hays' remarks
4:09:26 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:10:54 PM Senator Hays' remarks and question
4:11:22 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:12:24 PM Chair Sobel's question
4:12:42 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:13:28 PM Chair Sobel's question
4:13:30 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:13:35 PM Chair Sobel's question
4:13:43 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:14:02 PM Senator Hays' question
4:14:19 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:15:21 PM Chair Sobel's remarks
4:15:39 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:16:09 PM Senator Dean's question
4:16:31 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:16:34 PM Senator Dean's follow-up question
4:16:42 PM Molly McKinstry, Deputy Secretary, Agency for Health Care Administration, response
4:17:00 PM Chair Sobel's closing remarks (Assisted Living Facilities - Tab 1)
4:17:23 PM (Tab 2) Review of the Independent Living Program for Foster Children
4:17:33 PM Senator Detert's remarks
4:20:29 PM Chair Sobel's remarks
4:20:36 PM Trudy Petkovich, President, Florida State Foster/Adoptive Parent Association, remarks
4:32:40 PM Chair Sobel's remarks
4:32:49 PM Senator Detert's comments
4:34:14 PM David Wilkins, Secretary, Department of Children and Families, remarks
4:43:34 PM Senator Detert's remarks and question
4:44:11 PM David Wilkins, Secretary, Department of Children and Families, response
4:44:42 PM Senator Detert's remarks
4:46:56 PM David Wilkins, Secretary, Department of Children and Families, response
4:47:25 PM Senator Hays' question
4:47:34 PM David Wilkins, Secretary, Department of Children and Families, response
4:47:46 PM Senator Hays' remarks
4:49:16 PM Public Testimony, Review of the Independent Living Program for Foster Children (Florida Youth Shine)
5:00:57 PM Meeting Adjourned