The Florida Senate

Interim Report 2010-118 *October 2009*

Committee on Health Regulation

ASSISTED LIVING FACILITY LICENSURE REVIEW

Issue Description

There are 2808 assisted living facilities (ALFs) licensed by the Agency for Health Care Administration (AHCA) in this state.[1] In addition to a standard license, an ALF may have specialty licenses that authorize an ALF to provide limited nursing services, limited mental health services, and extended congregate care services. The current licensure structure has been in place for several years and may not reflect advances in noninstitutional caregiving that might allow residents to age in place for a longer period of time. Senate professional staff reviewed the ALF licensure structure in Florida with input from stakeholders and reviewed ALF licensure in other states to determine whether modifications to Florida's licensing structure might be appropriate at this time.

The ALF industry has voiced concern that the repeal during the 2009 legislative session[2] of a requirement for a medical review team to assess whether a resident is appropriately residing in an ALF created uncertainty regarding the determination of a resident's placement in an ALF. Senate professional staff also reviewed the implications of this repeal.

Background

General Description

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.[3, 4] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[5] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks. An ALF may be operated for profit or not-for-profit. ALFs range from small houses resembling private homes to larger developments with hundreds of residential beds.[6]

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[1] Source: The AHCA in an email to committee professional staff dated September 21, 2009.
[2] Section 64, ch. 2009-223, Laws of Florida (L.O.F.), (CS/CS/CS/SB 1986).
[3] s. 429.02(5), Florida Statutes (F.S.).
[4] An ALF does not include an adult family-care home or a nontransient 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, lives in the home. An adult family-care 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 nontransient 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.
[5] s. 429.02(16), F.S.
[6] Approximately 51 percent of the licensed ALFs have a bed capacity of 6 and under, representing approximately 10.5 percent of the 79,994 total ALF beds. Approximately 32 percent of the licensed ALFs have a bed capacity greater than 16, representing approximately 83 percent of the total beds. Source: The AHCA in an email to committee professional staff dated September 21, 2009.

General Regulatory Provisions

The Adult Congregate Living Facilities (ACLF) Act was enacted in 1975,[7] in ch. 400, F.S., relating to nursing homes and related health care facilities. Over the years the ACLF Act was amended numerous times, including authorizing additional services, beyond personal services, to be provided through specialty licenses. In 1987, the Legislature authorized an ACLF to provide limited nursing services (LNS) if the facility's ACLF license included that designation.[8] In 1989, the Legislature authorized an ACLF to provide limited mental health services (LMH) if the facility's ACLF license included that designation.[9] In 1991, the Legislature authorized an ACLF, pursuant to designation on the license, to provide extended congregate care services (ECC).[10] In 1995, ACLFs were renamed assisted living facilities.[11] In 2006, the regulation of ALFs was transferred from ch. 400, F.S., to part I of ch. 429, F.S., and named the Assisted Living Facilities Act (The Act).[12]

Assisted living facilities are currently licensed by the AHCA pursuant to part I of ch. 429, F.S., relating to assisted care communities and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. ALFs are also subject to regulation under Rule Chapter 58A-5, Florida Administrative Code (F.A.C.). These rules are 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).[13] An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Rule 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.[14]

Rules adopted to regulate ALFs are required to make distinct standards for facilities based upon the size of the facility; the types of care provided; the physical and mental capabilities and needs of the residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Separate and distinct standards for facilities with 16 or fewer beds are required, except for uniform fire-safety standards.[15]

Residency and Admission Criteria

All residents of an ALF must undergo a health assessment that is completed within 60 days prior to the individual's admission or within 30 days after the date of admission. This examination addresses the physical and mental status of the resident, whether supervision or assistance with the activities of daily living is required, any nursing or therapy services required, any special diet required, a list of current medications prescribed and whether assistance with administration is required, whether the individual has signs or symptoms of communicable disease which is likely to be transmitted to other residents or staff, and the examining physician's, physician assistant's, or nurse practitioner's opinion as to whether the individual's needs can be met in an ALF.[16]

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.[17]

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[7] Ch. 75-233, L.O.F.
[8] Ch. 87-371, L.O.F.
[9] Ch. 89-294, L.O.F., provided for an optional license; substantial revisions to the limited mental health license were made in ch. 95-418, L.O.F., and ch. 97-82, L.O.F.
[10] Ch. 91-263, L.O.F.
[11] Ch. 95-210 and ch. 95-418, L.O.F.
[12] Ch. 2006-197, L.O.F.
[13] s. 429.41(1), F.S.
[14] See Rule ch. 64E-12, ch. 64E-11, and 64E-16, F.A.C.
[15] s. 429.41(2), F.S.
[16] s. 429.26, F.S., and Rule 58A-5.0181, F.A.C. A resident who is placed on a temporary emergency basis by the DCF is exempt from the health assessment required for up to 30 days.
[17] s. 429.255, F.S., s. 429.26, F.S., and Rule 58A-5.030, F.A.C.

An ALF must execute a contract with each resident, or resident's representative. The contract must contain, among other things, express provisions regarding the services and accommodations to be provided by the facility.[18] Section 429.28, F.S., sets forth a Resident Bill of Rights for persons in ALFs.

A resident who requires 24-hour nursing supervision[19] may not reside in an ALF, unless the resident is enrolled as a hospice patient. 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.

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] This provision requires, among other things, at least 45-days notice. The notice requirement may be disregarded if the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care for medical reasons or the resident engages in a pattern of conduct that is harmful or offensive to other residents.

Licenses and Care Standards

Standard License

Each ALF must have a standard license. One or more specialty licenses are also required if the ALF provides any of the services authorized under a specific specialty license. As of September 2009, there were 475 ALFs licensed with a standard license only, for a total of 32,356 beds.[21]

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:

- 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 with the self-administration of medication. Persons under contract to the ALF, employees, or volunteers, who are licensed under the nurse practice act[22] and uncompensated family members or friends may:[23]

- 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

[18] s. 429.24, F.S. See also s. 651.055, F.S., relating to continuing care contracts.
[19] 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.
[20] s. 429.28, F.S.
[21] Source: The AHCA in an email to committee professional staff dated September 23, 2009.
[22] Part I of ch. 464, F.S.
[23] s. 429.255, F.S.

- 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. A resident may independently arrange, contract, and pay for additional services provided by a third party of the resident's choice.

Each ALF must have 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. If an administrator is responsible for multiple facilities, then a separate manager must be appointed for each facility. Staff may be direct employees or contracted. For a facility with a licensed capacity of 17 or more residents, the facility must develop a written job description for each staff position.[24]

An ALF must comply with the minimum staffing levels, which are based on the number of residents in the facility. In facilities with 17 or more residents, at least one staff member must be awake at all times. Notwithstanding these minimum staffing requirements, an ALF must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled services needs, resident contracts, and resident care standards. Additional staffing may be required when a facility fails to meet the fire-safety standards.[25] ALFs with the LNS and the ECC specialty licenses must also comply with the minimum staffing levels associated with those license designations.

An ALF which advertises that it provides special care for persons with Alzheimer's disease or other related disorders must have an awake staff member on duty at all times. Alternatively, if the ALF has fewer than 17 residents, the ALF may have mechanisms in place to monitor and ensure the safety of the facility's residents.[26] A specialty license is not required for a facility that provides special care for persons with Alzheimer's disease or other related disorders. Employees of these facilities must have varying levels of initial and continuing education depending upon the degree of interaction with residents with Alzheimer's disease or other related disorders.[27]

Generally, the costs of room, board, and services provided by an ALF are paid for by the resident with private funds or insurance. However, some residents qualify for financial assistance through public programs.[28]

The AHCA, county health departments, and the local authority having jurisdiction over fire safety or the State Fire Marshall are responsible for inspections for compliance with the laws and rules related to ALFs. The AHCA generally inspects ALFs with a standard license every two years.

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[24] Rule 58A-5.019, F.A.C.

[25] Ibid.

[26] s. 429.178, F.S.

[27] Rule 58A-5.0191(9), F.A.C.

[28] The Medicaid Long-term Care Community Diversion Waiver Program provides a variety of long-term care services and Medicaid-covered medical services in lieu of nursing home placement. Managed care organizations and other qualified providers receive a capitated payment to provide, manage, and coordinate a qualified enrollee's full continuum of care, including care through ALFs. The Medicaid Assisted Living for the Frail Elderly Waiver (ALE) Program pays for the additional support and services that a qualifying resident needs in an ALF with an ECC license or LNS license. It does not pay for room and board. The Medicaid Assistive Care Services (ACS) Program pays a supplement to an ACS-enrolled ALF that is in addition to the resident's payment from personal or other funds for room and board. An ALF with a standard license may qualify as an ACS-enrolled ALF. Optional State Supplementation (OSS) is a cash assistance program to help eligible persons pay for costs in certain facilities, such as an ALF. These funds may be used for housing costs in the ALF. A person receiving the OSS may also receive additional assistance through the ACS and the ALE. The Housing Choice Voucher Program (Section 8) is a federal Housing and Urban Development program to provide rental assistance for low-income persons and cannot be used to pay for meals or services in an ALF. It is possible to combine Section 8 vouchers with the OSS, the ACS, and the ALE.

Limited Nursing Services Specialty License

An LNS 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. As of September 2009, there were 966 ALFs licensed with an LNS specialty license.[29]

The nursing services authorized to be provided with this license are limited to acts specified in administrative rules,[30] 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.

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.[31]

Limited Mental Health Specialty License

An ALF that serves three or more mental health residents must obtain an LMH specialty license.[32] As of September 2009, there were 1057 ALFs licensed with a limited mental health specialty license.[33] Approximately 608 of the facilities with an LMH specialty license also have an LNS or ECC specialty license.[34]

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).[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;

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[29] Ibid, 1. The AHCA does not track the number of LNS beds.

[30] 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.

[31] s. 429.07(3)(c), F.S.

[32] s. 429.075, F.S.

[33] Ibid, 1.

[34] Source: The AHCA in an email to committee professional staff dated September 29, 2009.

[35] s. 429.02(15), F.S.

[36] S. 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, F.A.C.

- The clinical mental health services to be provided by the mental health care provider to help meet the resident's needs;
- 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;
- 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. The administrator, manager, and staff in direct contact with mental health residents in an LMH licensed facility must complete LMH training provided or approved by the DCF.[38]

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[39] to persons who otherwise would be disqualified from continued residence in an ALF.[40] As of September 2009, there were 307 ALFs licensed with an ECC specialty license and a total of 16,962 ECC-designated beds.[41]

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 appropriate for admission to the ECC facility. Facilities licensed to provide ECC services may adopt their own criteria and requirements for admission and continued residency in addition to the minimum criteria specified in law.

The ECC designation may apply to all or part of an ALF facility. Policies and procedures established for the ECC program must promote resident independence, dignity, choice, and decision-making. The ECC facility must provide a homelike physical environment which promotes resident privacy and independence.

An ECC program may provide additional services, such as:

- 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;
- 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.

[38] Rule 58A-5.0191(8), F.A.C.

[39] 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), F.A.C.

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

[41] Source: The AHCA in an email to committee professional staff dated September 21, 2009.

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 for the individual and must maintain a written progress report on each resident who receives ECC services.

The service plan sets forth how the facility will meet the resident's needs. It is to be developed and agreed upon by the resident or resident's representative and the facility's designee. It identifies the unique physical and psychosocial needs, abilities, and personal preferences of the ECC resident. The plan must describe what services will be provided, who will provide the services, when the services will be rendered, and the purposes and benefits of the services.[42] The service plan is to take into account the concepts of shared responsibility[43] and managed risk.[44] Accordingly, the service plan reflects the responsibility and right of the resident to consider options and assume risks when making choices pertaining to his or her service needs and preferences.

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. 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.[45]

Persons under contract to the ECC, employees, or volunteers, who are licensed under the nurse practice act,[46] including certified nursing assistants, may perform all duties within the scope of their license or certification, as approved by the facility administrator.[47] 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.[48]

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.

Findings and/or Conclusions

Long-term Care Delivery Models

The ALFs are an important part of the continuum of long-term care in this state. The Legislature has recognized that the ALFs should be operated and regulated as residential environments with supportive services and not as medical or nursing facilities. Regulations governing these facilities are to be sufficiently flexible to allow facilities

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[42] s. 429.02(21), F.S.
[43] Shared responsibility is defined in s. 429.02(22), F.S., to mean: exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney in fact, and the facility to develop a service plan which best meets the resident's needs and seeks to improve the resident's quality of life.
[44] Managed risk is defined in s. 429.02(14), F.S., to mean: the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly.
[45] Rule 58A-5.030, F.A.C.
[46] Part I of ch. 464, F.S.
[47] s. 429.255(2), F.S.
[48] Rule 58A-5.030(8)(c), F.A.C.

to adopt policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences. One of the purposes of the Act is to ensure that all agencies of the state cooperate in the protection of ALF residents and to ensure that needed economic, social, mental health, health, and leisure services are made available to ALF residents.[49]

Regulation of the ALFs throughout the country is diverse. Although states continue to develop standards to accommodate residents with high health care needs, many states limit services that might be provided in an ALF to assistance with or supervision of the activities of daily living. States vary as to whether non-licensed persons may assist with the self-administration of medication.[50] Florida has one of the more progressive models for ALF licensure with the ECC license that enables residents to age in place and the recognition of the special needs that mental health residents have.

Some states authorize 24-hour skilled nursing care or other skilled nursing services in an ALF for a limited period.[51] The ALFs are subject to less prescriptive regulation than nursing homes, which are licensed to provide 24-hour skilled nursing care. It is not apparent that authorizing ALFs in Florida to provide 24-hour skilled nursing care for limited periods of time comports with expressed Legislative intent to distinguish between care provided in nursing homes and ALFs.

Several states require separate licensure for facilities that provide services to persons with Alzheimer's disease or other related disorders. As discussed in this report, additional requirements are imposed on an ALF to protect and care for these residents and establishing a specialty license is not consistent with recommendations in this report related to licensure simplification.

Unlicensed Housing with Services

A model has emerged in a growing number of states to separate housing from the services to residents. In this model, the building may not be licensed but is subject only to local building codes, fire codes and the like. The building may or may not be registered. Registration generally entails a lower level of oversight than licensure. The person providing the housing arranges with licensed service agencies to provide services to residents.

The AARP Public Policy Institute published a study of four states' experiences with this model in 2007.[52] The study concluded that potential benefits include: increased access to assisted living services for people with low incomes living in subsidized apartments, a wider range of housing options, and the potential for people to live in an assisted living environment when they need a high level of services.

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[49] s. 429.01(2), F.S.

[50] Assisted Living State Regulatory Review 2009, prepared by Karl Polzer, Senior Policy Director, National Center for Assisted Living (dated March 2009), found at: < http://www.ncal.org/about/2009_reg_review.pdf> (Last visited on September 30, 2009).

[51] For example, Alaska allows for 24-hour skilled nursing care for up to 45 consecutive days; Arkansas allows a licensed home health agency to provide 24-hour nursing services in an ALF for a period of 60 days with one 30-day extension; Delaware allows a person to reside in an ALF who requires skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or reasonable potential of, an acute episode, if a registered nurse provides the appropriate care; Kansas authorizes skilled nursing services in an ALF if they are limited, intermittent, or routine in scope; Montana authorizes skilled nursing care or other skilled services related to temporary, short-term acute illnesses not to exceed 30 consecutive days for one episode or more than a total of 120 days in one year and a higher category of licensure to provide these skilled services beyond these timeframes; New York authorizes certain ALFs to retain a resident who needs 24-hours skilled nursing or medical care if the resident hires appropriately licensed personnel to provide the services, the physician and home health care services agency document that the resident can be safely cared for in the ALF, and the ALF provider agrees to retain the resident and coordinate the care for all providers; and Tennessee authorizes nasopharyngeal or tracheotomy aspiration; nasogastric feedings; gastrostomy feedings; or intravenous feedings on an intermittent basis for 21 days, with up to two additional 21-day extensions, except the limited time frame does not apply if the resident is able to self-care for such conditions.

[52] Assisted Living in Unlicensed Housing: The Regulatory Experience of Four States by Bernadette Wright, Ph.D., for The AARP Public Policy Institute found at: <http://www.aarp.org/research/ppi/ltc/assist-liv/articles/inb138_housing.html> (Last visited on September 30, 2009).

The challenges identified in the study included: ensuring that consumers are well informed of their rights, 'discharge' criteria, and where to get concerns addressed; protecting residents' rights since residents may be limited to landlord-tenant remedies; ensuring quality of care, particularly regarding assessments, service terminations, and evictions; and providing adequate oversight and enforcement while maintaining the home environment that consumers prefer.

Florida's long term care opportunities in home-style settings available through home and community based services, adult family-care homes, and ALFs afford a wide range of alternatives to consumers. Florida's opportunities also provide a higher level of oversight to protect persons as they become less able to care for themselves and help ensure that residents receive needed services. The unlicensed housing model does not appear to be an option that the state should pursue at this time.

Licensure Simplification

The current licensing structure, with four types of licenses, inhibits the ability of ALFs to efficiently adapt to changing resident needs. This may result in inadequate care for a resident, services provided to a resident that are outside the authorized regulatory scheme, or discharge of a resident who wishes to remain in his or her ALF-residence. Under the current licensure scheme, a separate or specialty license is not required for an ALF that advertises that it provides special care for persons with Alzheimer's disease or other related disorders. Nonetheless, the law requires compliance with specific provisions that have been determined appropriate for residents in a standard-licensed ALF with Alzheimer's disease or other related disorders. Logically, this same approach could apply to the LNS and LMH specialty licenses.

LNS

Associations representing the ALFs and the AHCA have communicated that separate licensure is not necessary for appropriately licensed nurses to perform the nursing services currently authorized with the LNS specialty license, if the provisions affecting quality-of-care remain in place. The standard license and the LNS license have identical admission and retention criteria, except an ALF with a standard license may not admit or retain a resident with a stage 2 pressure sore. A resident with a stage 2 pressure sore requires nursing services that are only authorized to be provided in a facility with the LNS or ECC license.

Authorizing nursing services that are currently authorized under the LNS specialty license to be provided under the standard license would not require mandatory nursing services in an ALF. This is consistent with current discretionary authority in ALFs to determine which services to provide and would be the case even if the ALF employed nurses who are licensed and capable of performing the nursing services. An ALF would be required to identify in its policies and procedures and the resident contract any nursing services that the facility intends to provide to its residents and the conditions under which it would provide the nursing services.

Collapsing the authority to provide LNS into the standard license provides greater flexibility to an ALF that has nurses on staff capable of providing some or all of the nursing services. It enables a resident to remain in the particular ALF for a longer period of time or avoid temporary relocation to another setting licensed to provide these services. It also streamlines the AHCA's and facility's administrative burdens with respect to additional licensure.

The AHCA has expressed concern that elimination of the LNS specialty license will affect fee revenue. The biennial fee for an LNS license is $296 per license with an additional fee of $10 per resident based on the total licensed resident capacity of the facility.[53] Ostensibly this fee covers the additional inspections currently required of facilities with an LNS license. To address this concern, the law could require an additional inspection fee of $296 plus $10 per licensed capacity to maintain the AHCA's funding for ongoing inspections if an ALF indicates in its initial or renewal application for a standard license that it intends to provide LNS services.

As a practical matter, the DOEA may need to modify the Medicaid Assisted Living for the Frail Elderly Waiver (ALE) since currently it is only available to an ALF with an LNS or ECC specialty license.

[53] s. 429.07(4)(c), F.S., as adjusted per s. 408.805(2), F.S.

LMH

The specialty license might not be a necessary licensing tool to enable an ALF to provide services to mental health residents. The admission and retention criteria for a standard-licensed ALF and the LMH licensee are identical.

The Agency has identified a gap in the existing licensing structure. An LMH license is only required if the ALF serves three or more mental health residents. A standard-licensed ALF may have one or two residents who meet the definition of a mental health resident. Because the ALF is not required to have the LMH specialty license it is not required to: have staff trained in mental health issues, ensure that the resident has a community living support plan and assist the resident in carrying out the activities in it, and ensure that a cooperative agreement exists for handling emergency procedures for the resident.

Additionally, the Agency has noted that since the definition of a mental health resident is tied to OSS and SSDI or SSI disability, there might be other residents in ALFs who have a diagnosis of a severe and persistent mental illness and have the case manager support system through the DCF, but who do not meet the definition of a mental health resident. There are no reporting mechanisms in place to accurately identify the extent of this group or where they are housed.

Given the unique needs of the population of persons with a diagnosis of a severe and persistent mental illness and the historical evolution of the LMH specialty license,[54] it may not be appropriate to eliminate the LMH specialty license or strengthen regulation at this time without an updated detailed study of the population and residential care needs of persons with a diagnosis of a severe and persistent mental illness. The recommendation concerning gathering data on ALF resident attributes and characteristics could play a significant role in providing meaningful data to facilitate such a study.

Unlimited Nursing Services

The industry recommended that nurses employed by an ALF, with any type of license, be able to perform any nursing activity, as approved by the facility administrator, considering the level of supervision in the ALF setting. This authority is comparable to the authority granted to an ECC license.

The industry voiced concerns regarding the importance of balancing the ALF social model of care with limited medical needs. They encourage the regulatory scheme to allow residents to age in place, tempered with the impact on other residents as one resident's medical needs increase. Authorizing unlimited nursing services would effectively obviate the need for the ECC license and potentially degrade the social model of residence that ALFs were established to provide. When one balances the interests in the social model for ALFs, and the limited regulatory oversight in ALFs, restricting this broad nursing authority to the ECC licensed setting better accomplishes this objective.

Although nursing services that may be provided under the LNS license are set forth in rule, none of the stakeholders identified additional nursing services that should be authorized. Senate professional staff received comments concerning authorizing unlicensed staff to perform some of the nursing services currently authorized under the LNS license. These recommendations involve exceptions to the scope of practice for nursing under ch. 464, F.S., which are beyond the scope of this project review, and Senate professional staff does not recommend potentially weakening health care provided in ALFs in this manner.

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[54] For additional information refer to the Review of Assisted Living Facilities Serving Residents with Severe Mental Illnesses, Report Number 96-57, dated February 19, 1997, and the Follow-Up Report on Assisted Living Facilities Serving Residents with Severe Mental Illnesses, Report No. 98-27, dated December 1998, by the Office of Program Policy Analysis and Government Accountability (OPPAGA) found at: <http://www.oppaga.state.fl.us/ReportsYearCatList.aspx> (Last visited on September 30, 2009) and Behavioral Health Services Integration: Assisted Living Facility Study by Sharon Anderson, M.S., and Lawrence Schonfeld, Ph.D., Louis de la Parte Florida Mental Health Institute at the University of South Florida, found at: <http://www.fmhi.usf.edu/institute/pubs/pdf/dean/Assisted%20Living%20Facility%20Study.pdf> (Last visited on September 30, 2009).

Inspections and Resident Attributes

There is no mechanism for identifying resident population and characteristics in ALFs. This lack of information hinders long-range planning for state decision makers and creates inefficiencies in the AHCA licensure surveys and activities of the long-term care ombudsmen.

The AHCA is authorized to use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in facilities that have a good record of past performance.[55] The AHCA has not implemented this abbreviated licensure process due to quality-of-care concerns. Primarily, the AHCA is concerned that the inspection process is currently the only mechanism for identifying the mental and physical attributes of the residents and the ability of the ALF to provide the services needed by those residents.

The LNS license and the ECC license require additional monitoring inspections, even if the facility does not have residents who require or are receiving the additional LNS or ECC services. The AHCA has explained that frequently this results in unnecessary additional site visits that could be avoided if the AHCA had information concerning the resident population before conducting the inspection. Having easily accessible information about resident population and services provided in the ALF is especially important if the recommendation regarding licensure simplification is enacted to eliminate the LNS specialty license.

Repeal of Medical Review Team

The statutory requirement for a medical review team to assess a recently completed physical examination of a resident who appears to need care beyond that which the facility is licensed to provide was repealed in the 2009 legislative session.[56] Under this requirement the AHCA could require the resident to be physically examined by an appropriately licensed practitioner when the AHCA questioned the appropriateness of a resident's placement. Generally the resident was responsible for the cost of the examination.[57]

Representatives from the ALF industry were concerned, among other reasons, that this repeal diminished the authority of an administrator to determine the appropriateness of continued residency and that a surveyor who might not be medically trained would be left with total discretion to determine the appropriateness of placement. The specific statutory authority empowering the administrator to determine the appropriateness of continued residency remains unchanged in s. 429.26, F.S.

According to the AHCA, the medical review team was not a resource that the AHCA used when it determined a resident needed care beyond that which the facility is licensed to provide. Instead, the AHCA cites the facility for a licensure deficiency. A resident placement deficiency is treated similar to any other licensure deficiency, therefore, rights under the Administrative Procedures Act are available. The administrator on behalf of the ALF or the resident is not precluded from obtaining an updated physical examination to present to the AHCA for resolution of the cited licensure deficiency. If an AHCA surveyor believes that a resident's placement in the ALF requires immediate attention, the surveyor will contact the Central Abuse Hotline.[58]

Also, the AHCA has indicated that s. 429.26(8), F.S., authorizes any facility administrator; personnel of the AHCA, the DOEA, or the DCF; or long-term care ombudsman council member who believes a resident needs to be evaluated to notify the resident's case manager, who must take appropriate action. The findings must be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities with respect to determining the appropriateness of continued residency in that ALF. The repeal of s. 429.26(9), F.S., (2008) does not alter the status quo for handling concerns regarding the appropriateness of continued residency, or adversely affect an ALF, resident, or the AHCA. No further action appears necessary at this time.

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[55] s. 429.41(5), F.S.
[56] Ibid, 2.
[57] S. 429.18(2), F.S., provides for funding for inspection-related physical and mental health examinations requested by the Agency of certain low-income residents.
[58] See ch. 415, F.S., related to Adult Protective Services.

Options and/or Recommendations

Senate professional staff recommends the Legislature:

- Repeal the LNS specialty license and authorize a standard-licensed ALF to provide the nursing services currently authorized under the LNS license. An ALF that chooses to provide some or all of the nursing services authorized by rule should be required to comply with all statutory and regulatory provisions that are in place for the LNS license. This will allow an ALF to provide a broader range of services while enabling a resident to remain in his or her residential setting when his or her condition requires limited nursing services;
- Require an additional inspection fee of $296 plus $10 per licensed capacity for initial and renewal applications for an ALF standard license of a facility indicates that it intends to provide LNS services. Also authorize the inspection fee to be adjusted by not more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase. This will maintain the AHCA's funding for ongoing inspections;
- Require ALFs to periodically report electronically to the AHCA information, as determined by rule, related to resident population, characteristics, and attributes. This will provide the AHCA with information concerning the resident population in each facility to facilitate, streamline, and coordinate surveys for compliance with applicable standards and centrally locate meaningful data for long-range planning and assessing residential needs;
- Authorize the AHCA to determine the number of additional inspections required for an ALF that provides LNS based on the type of nursing services provided and the number of residents who received LNS as reported by the ALF. This will enable the AHCA to target scarce resources to higher-risk nursing activities that are taking place in the ALFs; and
- Repeal the requirement for the AHCA to inspect all ECC licenses quarterly. The AHCA should be required to inspect quarterly only those ECC licensed ALFs that are providing ECC services as reported by the ALF. This will enable the Agency to target scarce resources to facilities that are actually providing ECC services.