The Deregulation of Assisted Living in Florida

Introduction

Assisted living is one of the least regulated industries among the continuum of long-term care. It's largely regulated by state agencies with no uniform standards. In Florida, legislation has been introduced under Senate Bill 402 to further deregulate assisted living. If passed, this bill has the potential to remove important resident rights and protections. It also stands in stark contrast to recommendations made in 2011 by the Agency for Health Care Administration's Assisted Living Workgroup in conjunction with family members, residents living in Assisted Living Facilities (ALFs), ALF administrators, and advocates. Some of these recommendations were implemented in 2015, however, many remain unaddressed while other proposed changes stand in stark contrast to the workgroup's recommendations. Furthermore, earlier this year, the regulatory power over assisted living was consolidated. The Florida Department of Elder Affairs (DOEA) was responsible for regulating assisted living operations (DOEA Rule Chapter 58A-5) and core trainer requirements (DOEA Rule Chapter 58T-1) including physical plant requirements, admission and retention criteria, medication management, staffing, training, and care standards. The Agency for Health Care Administration (AHCA) was--and remains--responsible for ALF licensing, regulatory compliance, penalties for non-compliance, and resident rights (Florida Statute 429). In July of 2019, Senate Bill 184 transferred assisted living operations regulatory authority from DOEA to AHCA representing a shift from an agency that has historically been responsible to provide community based services and to "…promote the well-being, safety, and independence of Florida's seniors…" to an agency that's Florida's primary health policy and planning entity--also responsible for administering the state's Medicaid Managed Care program including the Medicaid Long-term Care Waiver. This change, combined with the most recent proposal—Senate Bill 402—represents a significant deregulation of assisted living in Florida. The following summarizes Senate Bill 184 and the proposed changes under Senate Bill 402 and relates them to the recommendations made by the AHCA Assisted Living Workgroup.

Senate Bill 184

Changes: Transferred assisted living operations regulatory authority from DOEA to AHCA.

Issue: DOEA has greater incentive to encourage access to home and community based options like assisted living and to ensure quality.

Taskforce recommendation: "Limit the role of AHCA to regulatory oversight – consultation needed by the industry and its members can be obtained from organizations of their choice and at

their own expense. AHCA should promulgate rules establishing quality standards in collaboration with DOEA and DCF, and survey licensed facilities for full compliance with those laws and rules."

Senate Bill 402

Proposed changes under: 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.

-Redefines "adverse event" to include only events associated with the facility's intervention and adds in the "injury results in…"

-(3) Changes requirement that licensed facilities shall provide within 1 business day a preliminary report to the agency on all adverse incidents to shall initiate an investigation within 24 hours after the event. The report isn't due to the agency until 15 days after the incident whereas previously it was due within 1 business day.

-(4) and (5) are struck out. Facilities are no longer required to report monthly to the agency their liability claims (e.g., settled lawsuits).

Issues: Narrows the definition of what constitutes an adverse event and adds in the requirement that an injury must have occurred. Lengthens the timeframe for adverse incident reporting to the agency. For comparison, nursing homes are required by federal regulation to report incidents within 2 hours of their occurrence. AHCA will no longer have information about liability claims made against an ALF due to injury or a violation of resident rights.

Taskforce recommendations: "Require all ALF staff to collect and identify client information that would indicate a change of condition and notify the resident's case manager to enable early intervention and prevent escalation of symptoms that might result in a transfer, discharge, Baker Act, police involvement, injury to staff or resident, or other adverse event. Electronic collection and sharing of this information will improve timely response."

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

"Provide AHCA the necessary resources to apply the statutory and regulatory measures necessary to protect vulnerable persons. These include political support by the Legislature through substantive laws and financially through appropriations to hire sufficient numbers and quality of staff in its field offices to provide the intensity and frequency of surveys and complaint investigations necessary to protect the public."

"Prohibit any binding arbitration agreement language in resident contracts. These contract clauses limit a resident's right to access due process whenever care disputes arise."

Proposed changes under: 429.28 Resident bill of rights

-(3) (a) Strikes out "The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance with facility standards and compliance with residents' rights."

Issue: How will compliance and uniformity with residents' rights be determined?

Taskforce recommendation: "Ensure an anonymous method of regularly seeking input from ALF residents about the nature of the care received in a facility without relying only on complaint investigations or on-site surveys. CARF provides such a mechanism, as does the LTCOC."

Proposed changes under: 429.41 Rules establishing standards

-(1) Strikes out "ensure" and replaces it with "promote" a safe and sanitary environment.

-(1) (a) Strikes out "plumbing, heating, cooling, lighting, ventilation, living space." Strikes out "ensure" and replaces it with "promote" and adds housing conditions "relating to hazards" and strikes out "comfort" of residents.

-(1) (d) Strikes out "All sanitary conditions within the facility and its surrounding which will ensure the health and comfort of residents…."

-(k) Specifically names geriatric chairs or Posey restraints as prohibited physical restraints but allows other types of physical restraints, "…used in accordance with agency rules when ordered by the resident's physician and consented to by the resident…"

-(5) Strikes out "with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules" from "The agency shall develop the key quality-of-care standards…"

Issues: Replacing "promote" with "ensure" lightens the responsibility on the part of the facility to provide basic sanitation and safety. Removes requirements related to basic, modern comforts such as plumbing, air conditioning, and adequate ventilation. Physical restraints are often employed for people living with dementia and is not ethical when other options are available. In addition, the rule contains no time limit on physical or chemical restraint usage. Removes the role of the LTC Ombudsman from the development of key quality of care standards.

Taskforce recommendation: Issues relating to basic comforts, sanitation, and restraints were not addressed in the workgroup's recommendations. For comparison, however, federal nursing home regulation states with regard to sanitation and physical comforts that, "The facility must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public." With regard to federal nursing home regulation concerning physical and chemical restraints--residents have the right to be "… free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms."

With regard to the role of the LTC Ombudsman, the taskforce recommended, "Focus Ombudsman oversight on resident advocacy. Focus on communication with each resident of each ALF monitored to elicit information on ways the facility can improve as well as ways in which the facility may excel. Train members on the requirements of and be alert to regulatory requirements of ALFs so they can recognize obvious deficiencies and make complaints to regulators. Address allegations of excessive enthusiasm of Ombudsman and assure focus is on residents and not license regulation."

Conclusion

Regulation outlines requirements for a minimum standard of care, resident rights, and enforcement. Senate Bill 402 is part of a larger trend of deregulation in LTC. This year, federal legislation was passed that significantly weakened nursing home regulation and residents' rights. With Florida's 700 nursing homes with over 83,000 beds, and its 3,000 ALFs with 92,000 beds both sets of regulation will significantly impact thousands of Floridians. Assisted living is an attractive alternative to skilled nursing and ALFs are increasingly admitting individuals who have higher care needs. The number of ALFs with dementia special care units is also on the rise. These trends are occurring during a time of deregulation and the potential for harm or violation of resident rights is great. At a minimum, the AHCA 's Assisted Living Workgroup recommendations should be revisited—along with considering a rule that would reduce the number of individuals that are allowed per ALF bedroom down to 1—in order to strengthen ALF regulation and ideally, increase the role of the state's Long-Term Care Ombudsman in protecting and enforcing residents' rights.

Lori Gonzalez, Ph.D.

Claude Pepper Center, FSU

November, 2019