A Comparison of ALF Regulatory Systems

The Florida Assisted Living Workgroup

In 2011, the governor of Florida directed the Agency for Health Care Administration (AHCA) to examine assisted living facilities across the state. In response, the Assisted Living Workgroup (AL Workgroup) was created with the objective to "make recommendations to the Governor and Legislature that will improve the monitoring of safety in assisted living facilities to help ensure the well-being of residents" (2011: 1). The AL Workgroup made their recommendations based on three meetings held across the state, public testimony, and presentations from more than seventy-five people from various backgrounds – residents, family members, AL administrators and owners, provider associations, advocates and state agency representatives. The discussions focused on regulation, consumer information and choice, and long-term care services and access.

There were two phases to the workgroup. Phase I included recommendations that they felt could be addressed immediately, and Phase II allowed an additional 6-12 months of evaluation and dialogue prior to being considered as formal recommendations. The recommendations received approval by a majority of the members. Based on the AL Workshop deliberations, the following recommendations were made with the intention to strengthen oversight and reassure the public that ALFs are safe places for their residents[1]:

Phase I Recommendations

- Provide better integration of information on existing consumer resources

[1] This is just a brief summary of the recommendations, for detailed descriptions of the recommendations please refer to the original report.

- Raise the standards to become an ALF administrator and expand the CORE training curriculum for other staff:
    - Take core training and pass the competency examination, and
    - Be at least 21 years of age, and
    - Have an associate degree or higher from an 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
    - Have 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
    - Have 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
    - Have at least two years experience working in a health care related field having direct contact with one or more of the client groups, or
    - Have a valid nursing home administrator's license, or
    - Have 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.
- Improve the initial and ongoing continuing education/training for all staff, especially for Limited Mental Health (LMH) facilities
- Increase survey/inspections and reporting, focusing on ALFs with poor track records
- Initially create rigorous ALF license requirements to prevent unprepared individuals or facilities from providing care

- Provide a systematic appeal process for residents who want to contest eviction
- Assist people with their choices in order for them to make the best decision for their situation
- Create a permanent policy review and oversight council with members representing all stakeholder groups
- Require all facilities with at least one resident receiving mental health care to be licensed as a LMH facility

Overall, these recommendations address the following topics: consumer information, administrator qualifications, training/staffing, surveys and inspections, licensure, resident discharge, information and reporting, enforcement, mental health, multiple regulators, and home and community based care.

Phase II Recommendations

- Develop an electronic guide to ALFs, including a rating system and an ALF watch list
- Increase administrator requirements:
    - Create a workgroup of providers and stakeholders to evaluate the current educational requirements and curriculum for certification as an administrator of an ALF, education and training requirements for staff, continuing education requirements, and training and education requirements for administrators and staff of specialty licensed ALFs.
    - Require administrators to have a year or two mentorship under an Alf administrator with no Class I or Class II violations.
    - Increase administrator requirements for an ECC facility. Allow a registered nurse license to satisfy the requirement.

    - Create ALF administrator licensure with a Department of Health board to track and monitor discipline and core training. No exceptions for small facilities.
    - If there are increased requirements for ALF administrators, consider accepting licensure as a nursing home administrator or a registered nurse to satisfy requirements.
    - Prohibit facility administrators from owning or serving as administrator of any facility if an action to revoke or deny a license is upheld at a facility where they were previously employed.
- Revise regulations to include specific persons served in an ALF, such as individuals with serious mental illness
- Hold hospitals accountable for discharge planning that matches the individual's needs using a pre-admission screening process
- Enact legislation that provides ALF residents a formal appeal process for disputed discharge
- Increase amount and quality of activities, and allow for proper staffing ratios in order to promote resident participation
- Create online reporting for cost effective methods of collecting, reporting, and analyzing client information
- Revocation or denial of renewal license for certain violations, such as resident death due to neglect on the part of the facility
- Require more education and experience for LMH facility administrators and staff
- Improve coordination between various federal, state and local agencies with any role in LTC facilities oversight

- Ensure an anonymous method of regularly seeking input from ALF residents about care received
- Reevaluate the ALF fee structure as it relates to paying the cost of regulation and require licensure fees for certain types of beds
- Eliminate waiting lists for waiver programs and have open enrollment for MCD waiver providers

The topics revisited from Phase I with more detailed recommendations include: consumer information, administrator qualifications, licensure, resident discharge, information and reporting, mental health, multiple regulators, and home and community based care. The additional topics in Phase II of the AL workshop include the following: resident admission, resident safety and rights, funding, and resident advocacy.

> To summarize, the AL workgroup suggest:
>
> Regulations governing ALFs must be flexible enough to allow facilities to adopt policies that enable residents to age in place while accommodating their needs and preferences. When residents age in place, care becomes more complex. The challenge is balancing the provision of appropriate care without compromising the concept of a social or residential model (13).

As the growth of ALFs continue, we must continue to work together to reduce regulation in areas that are overly burdensome, while implementing safeguards and regulations that protect the ALF residents.

ALF Regulations in Other States: Wisconsin, Oregon, & Washington

This section provides a detailed description of three states that have become leaders for improving quality care in their ALFs. Many of the recommendations discussed in the Florida Assisted Living Workgroup are currently included in the ALF regulations for these states[2].

Wisconsin

Wisconsin's innovative regulatory approaches have received national recognition for improved overall quality in assisted living. Wisconsin has four strong assisted living provider associations supporting their members to improve the care and services they provide to the residents/tenants in their communities. Their ombudsman program is a national leader with committed resources to the advocacy of residents in assisted living communities.

There are three types of regulated residential assisted living providers: community-based residential facilities (CBRF), adult family homes (AFH), and residential care apartment complexes (RCAC) (NCAL 2013). CBRFs provide care, treatment, and other services to five or more unrelated adults who need supportive or protective services or supervision, and do not require care above intermediate nursing care or more than three hours of nursing care per week unless there is a waiver approved by the department. AFHs provide care to three or four adults not related to the licensee, who need no more than seven hours per week of nursing care. RCACs consist of five or more independent apartments, each of which has an individual, lockable entrance and exit; a kitchen; individual bathroom, sleeping, and living areas; and provide residents up to 28 hours per week of personal, supportive, and nursing services.

[2] The following information comes from the NCAL Assisted Living State Regulatory Review 2013.

Administration Education/Training

The administrator of a CBRF shall be at least 21 years of age and have any one of the following qualifications:

(1) An associate degree or higher from an accredited college in a health care related field;

(2) 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;

(3) A bachelor's degree in a field other than in health care from an accredited college and have successfully completed a department-approved assisted living administrator's training course;

(4) At least two years experience working in a health care related field having direct contact with one or more of the client groups and have successfully completed a department-approved assisted living administrator's training course; or

(5) A valid nursing home administrator's license issued by the department of regulation and licensing.

An AFH licensee must be at least 21 years of age with a clean criminal background check. They must ensure that the home and its operation comply with all applicable rules, regulations, and statutes, and is responsible for ensuring that staffing meets the needs of all residents.

Service managers of an RCAC simply must be capable of managing a multidisciplinary staff.

Staff Education/Training

CBRF employees must attend orientation training before they can care for residents. Their initial training includes: medication management, standard precautions, fire safety, first

aid, resident rights, the client group, and challenging behaviors. Additional training consists of: needs assessment of prospective residents, development of service plans, provision of personal care, and in dietary needs – menu planning, food preparation, and sanitation. Administrators and staff receive 15 hours annually of relevant continuing education.

RCAC staff must have documented knowledge of techniques for assisting with activities of daily living. They are also required to have training in fire safety, first aid, standard precautions, and resident rights. There are no continuing education requirements.

AFH service providers must be at least 18 years old and exercise the ability to successfully provide care for three or four unrelated adult residents. Staff are required to complete 15 hours of training related to the health, safety, and welfare of residents, resident rights, and treatment appropriate to residents including fire safety and first aid. They must have a clean criminal background check. The licensee and service providers must complete eight hours of continuing education annually related to the health, safety, welfare, rights, and treatment of residents.

Resident Admission and Discharge

CBRFs must ensure that the residents are compatible and meet the license classification of the facility. Prior to admission, each person is assessed to identify needs and abilities. Individuals who are confined to bed, destructive to property or self, or have physical, mental, psychiatric, or social needs that are not compatible with the CBRF may not be admitted. Persons requiring more than three hours of nursing care per week or restraints may be admitted with a waiver if it is beneficial for the resident. Residents may not be involuntarily discharged without 30 days' notice and have appeal rights.

Residents may not be admitted to a RCAC who have a court determination of incompetence and are subject to guardianship. A comprehensive assessment is performed with the active participation of the prospective resident prior to admission. The facility may discharge residents for the following reasons: their needs cannot be met at the facility; the time required to provide services exceeds 28 hours per week; their condition requires a nurse 24 hours per day; their behavior poses an immediate threat to the health or safety of self or others; they refuse to cooperate in a physical examination; fees have not been paid; or they refuse to enter into a negotiated risk agreement.

New residents of AFHs must have a health screening within 90 days prior to admission or within seven days after admission. The facility is required to have a service agreement with each resident. A facility may terminate a resident's placement upon 30-day notice. The 30-day notification is not required for an emergency termination necessary to prevent harm to the resident or other household members.

Funding

There is a Community Option Program (COP) that provides funds and waivers available to CBRFs depending on eligibility and waiting lists. They also receive funding from a public program called Family Care.

Certification is required for a RCAC to receive Medicaid waiver reimbursement. COP and COP waiver funds may be available depending on eligibility and waiting lists. The Family Care program also provides public funding.

Similar to CBRFs and RCACs, AFHs can receive COP and COP waiver funds depending on eligibility and waiting lists, and funds from the Family Care program.

Disclosure[3]

CBRFs require a program statement that discloses the services provided, employee availability, the availability of a licensed nurse, rates, and discharge criteria. RCACs require a services agreement that discloses the services provided, fees, and their policy and procedures. AFHs require a program statement that discloses the type of facility, clients served, services provided, rates, and discharge criteria.

Staffing Levels

At least one qualified resident care staff person is required to be in the CBRF facility when one or more residents are present. Staff must also be awake at night in facilities with one or more residents requiring continuous care.

In a RCAC, the staffing must be adequate to provide all services identified in the residents' service agreements, and a designated service manager must be available on short notice.

The licensee or service provider in an AFH must have a sufficient number of staff to meet the needs of the residents. Additionally, the licensee or service provider must be present and awake at all times if any resident is in need of continuous care.

Dementia Care

If a CBRF facility serves persons with dementia, staff must receive training within 90 days of employment. Training includes: residents' physical, social, and mental health needs; specific medications or treatments; program services; meeting the needs of persons with a dual diagnosis; and maintaining or increasing social participation, self direction, self care, and vocational abilities.

[3] The remaining recommendations were mentioned in the "Regulation and the Ideal Model of AL" section of the ALF paper, but not the Florida Assisted Living Workgroup.

There are no requirements for RCAC or AFH facilities.

Physical Plant Design

The minimum number of beds in a CBRF is five. Minimum sleeping room size is 60 to 100 square feet depending on the license classification. Bedrooms shall accommodate no more than two residents. There must be at least one toilet, sink, and tub or shower for 10 residents.

All resident units in a RCAC must be independent with lockable entrances/exits and provide a minimum of 250 square feet of interior floor space, excluding closets. Multiple occupancy of an independent apartment is limited to a spouse or a roommate of the residents choosing. Each apartment must have a bathroom that has floor-to-ceiling walls, a door, a toilet, a sink, and a bathtub or shower.

An AFH must be located so that residents can easily get to community activities and support services. There must be at least 60 square feet per person in a shared bedroom and 80 square feet in a single occupancy room (for a person in a wheelchair, the bedroom space is 100 square feet). A maximum of two residents is allowed per room. There must be at least one bathroom with at least one sink, toilet, shower, or tub for every eight household members and towel racks. The door of each bathroom shall have a lock that can be opened from outside in an emergency. Toilet and bathing facilities used by a resident not able to walk must have enough space to provide a turning radius for a wheelchair. Grab bars must be provided for toilet and shower.

Nurse Delegation and Medication Management

Medication in a CBRF is given by a licensed nurse or pharmacist unless medications are packaged by unit dose. All direct-care staff and administrative personnel must complete an eight-hour approved medication administration and management course.

Medication administration and management at a RCAC must be performed by a nurse or as a delegated task to unlicensed staff, under the supervision of a nurse or pharmacist.

In an AHF, all prescriptions must be ordered by a physician. The order must specify who by name or position is permitted to administer the medication and under what circumstances the medication is to be administered.

Oregon

In 2012, Oregon implemented several changes to the rules for their assisted living facilities. The purpose of these changes was to create standards that promote the availability of a wide range of individualized services for elderly and persons with disabilities in a homelike environment. The standards were designed to improve the dignity, independence, individuality and decision making ability of the residents and to maximize their abilities to function at the highest level possible.

An assisted living facility is defined as a building consisting of fully self-contained, individual living units where six or more seniors and adult persons with disabilities may reside in homelike surroundings. The facility offers and coordinates a range of supportive services available on a 24-hour basis to meet the activities of daily living (ADL), health, and social needs of the residents.

Administration Education/Training

The administrator is required to be at least 21 years of age, and:

(1) A high school diploma or equivalent; and

(2) Two years of professional or management experience in a health or social service related field or program; or

(3) A combination of experience and education; or

(4) An accredited bachelor's degree in a health or social service related field.

(5) A state-approved training course of at least 40 hours; or

(6) A state-approved administrator training program that includes both a classroom training of less than 40 hours and a state-approved 40-hour internship with an administrator.

Administrators must also complete 20 hours of continuing education annually.

Staff Education/Training

Employees must attend orientation training before they can care for residents. Their initial training includes: residents' rights; abuse and reporting; infection control; and fire safety and emergency procedures. If staff members' duties include preparing food, they must have a food handler's certificate.

Knowledge and performance must be demonstrated in all areas within the first 30 days of hire, including: the role of service plans in providing individualized resident care; providing assistance with ADLs; changes associated with normal aging; identification of changes in the resident's physical, emotional, and mental functioning, and documentation on the changes; conditions that require assessment, treatment, observation, and reporting; understanding resident actions and behavior as a form of communication; understanding and providing support for a person with dementia or related condition; general food safety, serving, and sanitation; perform safe medication and treatment administration unsupervised; and must be trained in the use of the abdominal thrust and first aid.

Staff must have 12 hours of continuing education for in-service training annually.

Resident Admission and Discharge

There is a standardized assessment form used by state caseworkers to determine Medicaid eligibility and service level payment. Providers do not have a designated assessment

form, but they must address certain health factors and nursing needs. A thirty-day notification for discharge must be provided except when there are urgent medical and psychiatric needs. The following are specific reasons that could lead to discharge: resident's needs exceed the level of services the facility provides; resident engages in behaviors that repeatedly interfere with the safety of others; the facility is unable to accomplish resident evacuation in accordance with fire and safety regulations; the resident engages in illegal drug use or commits a criminal act; or there is non-payment of charges.

Funding

A Medicaid home and community-based services waiver covers services to nursing home level residents in ALFs. It is a tiered system of reimbursement based on the services provided.

Disclosure

A state-designated uniform disclosure statement must be provided to potential residents. The information required in the disclosure statement includes: terms of occupancy; payment provisions; the method for assessing the residents' service needs and cost for services; policy for changes to the rate structure; a description of the scope of services available and the service planning process; resident rights; the facility system for packaging medications; criteria for move-outs or intra-facility move; notification that the Department of Human Services has the authority to examine residents' records; and staff planning.

A separate disclosure statement must be provided to potential residents and family of the Memory Care Community. This information includes: the philosophy of care; admission, discharge, and transfer criteria; the type of training for the direct care staff; and staffing ratios for each shift.

Staffing Levels

The facility must have qualified staff sufficient in number to meet the 24-hour needs of each resident. Based on resident acuity and facility structural design, there must be adequate caregivers present at all times to meet the fire safety evacuation standards. The licensee is responsible for assuring that staffing level is adequate for the evaluated care, service needs, and any changes in physical and mental needs of the residents.

Dementia Care

A Memory Care Community is defined as a special care unit in a designated separate area for individuals with Alzheimer's disease or other dementia that is locked, segregated, or secured to prevent or limit access by a resident outside the designated area. For an administrator of a Memory Care Community, 10 of the 20 hours of required annual continuing education must be related to the care of individuals with dementia. All staff must be trained in required topics addressing the needs of people with dementia prior to providing care and services to residents, and within 30 days of hire. They also must receive four hours of dementia-specific in-service training annually.

Physical Plant Design

Newly constructed private resident units must be a minimum of 220 square feet and preexisting facilities being remodeled must be a minimum of 160 square feet (not including bathroom). Resident units may only be shared by couples or individuals who choose to live together. Private bathrooms are required.

Nurse Delegation and Medication Management

Medication may be administered by specially trained, unlicensed personnel over the age of 18. A registered pharmacist or registered nurse must review all medications every 90 days and recommendations must be documented and followed up on.

Washington

Assisted living communities are required by law to meet quality measures that set healthcare standards in Washington above assisted living care in other parts of the country. In 2012, the state legislature changed the licensure term from "boarding home" to "assisted living facility" and the regulations were updated. An ALF provides housing, basic services, and assumes general responsibility for the safety and well-being of the residents. It may also provide domiciliary care for seven or more residents.

Administration Education/Training

The administrator must be at least 21 years of age, and have the education, training, and experience outlined in chapter 388-112 WAC. Administrators must complete 12 hours of continuing education each year by their birthday.

Staff Education/Training

Staff must complete an orientation and safety program before having routine interaction with residents. They must also complete a basic training class and demonstrate competency in the core knowledge and skills needed in order to provide personal care services effectively and safely. Most workers must complete 75 hours of training within 120 days of hire and become certified home care aides within 150 days of hire. They must have direct supervision when providing hands-on personal care until competency in the basic training has been demonstrated. Certified or registered nursing assistants who accept delegated nursing tasks must complete nurse

delegation training. The nurse will continue to meet with the nursing assistant once a week for the first four weeks of delegation. Staff must complete 12 hours of continuing education each year by their birthday.

Resident Admission and Discharge

A preadmission assessment must be conducted before each prospective resident moves in to the ALF. The resident may be admitted and retained as long as the following criteria are met: the ALF can serve the individual with appropriate available staff; the individual does not require the frequent presence and evaluation of a registered nurse; and the resident is ambulatory.

Funding

A Medicaid home and community-based services waiver covers assisted living services in ALFs that contract with DSHS/ADSA to serve Medicaid clients. Medicaid payments to ALFs are based on the assessed needs of the residents. ALFs may contract with DSHS/ADSA to provide specialized dementia care.

Disclosure

ALFs have a standardized form to disclose to the potential resident of the scope of care and services they offer. The information required in the disclosure statement includes: activities; food and diets; services related to coordinating health care services; laundry; housekeeping; level of assistance with ADLs, intermittent nursing services; assistance with medication; services for residents with dementia, mental illness, and developmental disabilities; transportation; ancillary services; limitation on end-of-life care; payments; bed hold policy; Medicaid payments; fire protection features; and security services.

Staffing Levels

The ALF must have a qualified administrator who is responsible for the overall 24-hour operation of the facility. The ALF must have adequate trained staff to: provide the services and care needed for each resident; maintain a hazard free area; and implement fire/disaster plans. Staff must have a federal and state background check.

Dementia Care

If an ALF serves residents with dementia, the facility must provide specialized training with specific learning outcomes to staff who work with those residents.

Physical Plant Design

Resident rooms must be a minimum of 80 square feet for a single occupancy room and shared resident units must be a minimum of 70 square feet per resident. ALFs receiving Medicaid funding under an assisted living contract with the state must provide a private room, a minimum of 220 square feet, with a kitchen area and private bathroom. For ALFs licensed after 1989, a maximum of two residents is allowed per unit. Under an assisted living services contract with DSHS/ADSA, only one resident per room is allowed unless the resident requests to share the room with another person, such as a spouse. One toilet and one sink are required for every eight residents and one bath/shower is required for every 12 residents. A private bathroom is required for all residents served under a contract with DSHS/ADSA.

Nurse Delegation and Medication Management

Medication assistance may be provided by staff other than licensed nurses without nursing supervision. The ALF has the option to provide medication administration services directly through licensed nurses or through formal nurse delegation. Residents or family members are allowed to administer medications, and those who are assessed as capable have the

right to store their own medications. Residents have the right to refuse medications. Nurses may fill medication organizers for residents under certain conditions.