APPENDIX "B"

Multiple Regulators

A. AHCA as Lead & Evaluating Responsibilities

1. 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. (Phase II, Pg. 7, Recommendation #1)

2. Improve coordination between the various federal, state and local agencies with any role in long-term care facilities oversight; especially ALFs. This includes the Agency for Health Care Administration; the Long Term Care Ombudsman Program; local fire authorities; local health departments; the Department of Children and Families', Adult Protective Services and Substance Abuse and Mental Health Programs; the Department of Elder Affairs Area Agencies on Aging; local law enforcement; and the Attorney General's Office. (Phase II, Pg. 7, Recommendation #2)

3. Agency responsibilities and lines of communication, coordination, and cooperation between agencies with oversight/regulatory responsibility for ALFs be clearly defined and formalized in written inter-agency agreements. (Phase II, Pg. 7, Recommendation #3)

4. Retain multiple visitors in non-compliant facilities. (Phase II, Pg. 8, Recommendation #11)

B. System Changes & Enhancements

1. Consider a document vault to allow off-site compliance review and share information between regulatory agencies. (Phase II, Pg. 8, Recommendation #10)

2. Enhance DCF Adult Protective Services electronic case management system (Florida Safe Families' Network) to identify trends in abuse, neglect and exploitation by modifying the system to coding investigations by resident setting (facility type). Currently, all institutional reports are lumped under one category. The system could be modified to capture discrete types of facilities, which would enhance our ability to look for patterns and plot frequencies. (Phase II, Pg. 8, Recommendation #9)

C. AHCA Enforcement & the use of DCF Findings

1. 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. (Phase II, Pg. 7, Recommendation #4)

2. Allow AHCA to use DCF Adult Protective Services findings and pursue sanctions for repeated verified abuse findings in a facility. (Phase II, Pg. 8, Recommendation #5)

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3. Authorize for AHCA to deny, revoke or suspend a license if the licensee is a named perpetrator in a verify report of abuse, neglect, or exploitation, similar to APD licensure authority in s. 393.0673, F.S. (Phase II, Pg.8, Recommendation #6)

4. Authorize use of DCF Adult Protective Services finding and investigations in employment matters. 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 (under a disqualifying criminal offense). 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. Such a legislative change would require that DCF offer due process hearings for perpetrators prior to the closure of all abuse investigations with verified indicators. (Phase II, Pg. 8, Recommendation #7)

5. Modification of existing administrative rules should also be considered 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., 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. (Phase II, Pg. 8 Recommendation #8)