



**EXTENDED CONGREGATE CARE  
ADMINISTRATOR'S GUIDE**

**Fall 1999**

**Florida Department of Elder Affairs**



# INTRODUCTION

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This Guide has been designed to acquaint assisted living facility (ALF) administrators and/or ALF extended congregate care supervisors with the explicit requirements, as well as the implicit values, which are an integral part of the development and day-to-day operations of a facility licensed to provide extended congregate care (ECC) services. The Guide should serve as a supplement to the Assisted Living Facilities Administrators Guide, Fall 1999 Revision.

The concept of extended congregate care was developed to extend the continuum of care for older adults living in assisted living facilities in Florida. ECC facilities enable residents to age in place by providing a higher level of care and an expanded scope of services to a more frail population than is permitted in a standard ALF, or an ALF licensed to provide limited nursing (LNS) or limited mental health services (LMH).

The Guide will identify the values specified in the legislation establishing extended congregate care facilities, and will provide a context for understanding the intent of the statutory requirements. The Guide will also assist administrators in the practical application of ECC values. Finally, the Guide will describe the rule requirements regulating ECC facilities.

In many ways, Florida's extended congregate care initiative embodies the essence of the philosophy of assisted living. Regardless of whether a facility has an ECC license or only a standard license, the values and perspective provided here, offer an excellent model for the provision of assisted living care to persons who have chosen to make an ALF their home.

ALF administrators, as well as ECC facility administrators and supervisors, are encouraged to use this Guide as a reference for effectively implementing ECC values in the day-to-day operation of their facilities.



# CHAPTER 1

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## OVERVIEW OF EXTENDED CONGREGATE CARE

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### INTRODUCTION

The Extended Congregate Care ALF license was developed in response to a growing awareness of the desire of individuals to 'age in place.' That is, older and disabled adults typically express a preference to remain in their own homes and to retain as much dignity, autonomy and independence as possible. For residents of an ALF, who consider the ALF their home, extended congregate care addresses this consumer preference by expanding the scope of services which an ALF is able to provide to more frail residents, and by incorporating the values which are integral to the concept of aging in place in the standard of care provided to ECC/ALF residents.

This chapter will examine the role consumer values and needs play in the concept of extended congregate care. In addition, the development of state policies and programs to address those concerns will be described. Finally, the concepts and values which are the foundation of extended congregate care will be discussed.

### ROLE OF CONSUMER VALUES

In Florida, as in the rest of the United States, older and disabled adults have repeatedly expressed a desire to remain at home. This preference often keeps the elderly or those with special needs in their homes beyond the time when it is safe for them to continue to live there. This preference stems from the following concerns:

- ❖ **The desire to maintain personal autonomy.** Like all of us, the elderly and populations with special needs share a desire to retain as much independence as possible. They want to make their own choices and live a lifestyle of their own choosing. For the most part, they believe they will be able to maximize their independence

if they are able to remain in their own homes.

- ❖ **The desire to receive individualized services/care.** Most people wish to be treated as individuals and to have their unique needs and preferences recognized. When receiving needed care or services, the elderly or disabled want the care-giver(s) to be aware of, and to respect, their unique needs and choices in the provision of services. Consequently, they want needed care to be tailored as much as possible to their own personal situations.
- ❖ **The desire to avoid living in an institutional setting.** Our society has developed a negative stereotype of most institutional settings. In fact, one survey found that for the majority of older Americans, the fear of living in a nursing home was even greater than the fear of death. This negative stereotype has developed partially as a result of actual experiences with less-than-ideal institutional settings. However, part of this stereotype has also been attributed to reports of inadequate care and abuse which has occurred in some institutional settings.

## **The Institutional Environment**

The fact that most disabled and elderly individuals desire to receive needed care in their homes does not mean that institutions, such as nursing homes, are inherently bad. Most institutions exert considerable effort to provide quality care to their clients. However, they are often faced with external constraints which limit the types of services they may provide and/or the manner in which the services are provided. Examples of such constraints generally stem from regulatory requirements and long-standing industry traditions. Many institutions are also limited by mechanisms for reimbursement, or a lack of sufficient funding for the provision of services. All institutions, regardless of the type, are faced with such constraints.

The following are some of the characteristics of institutions which have developed as a result of various external constraints. These limitations tend to make institutions less homelike in their design and functioning.

- ❖ **Use of commercial and/or health care furnishings.** The rooms are usually not large enough to accommodate most furnishings. As a result, residents of institutional settings are typically not allowed to bring furniture or

belongings with them. They may only be allowed to bring smaller items such as pictures or memorabilia.

Further, the furnishings which are provided in institutional facilities are generally not homelike in nature. For example, residents are usually required to use hospital-type beds in nursing facilities. In addition, most institutions utilize furnishings which require low maintenance and are long lasting. Institutional furniture, such as chairs, often have plastic or vinyl surfaces. Flooring usually consists of linoleum, instead of more homelike carpeting.

- ❖ **The size and use of space.** The size and use of space in an institutional environment tends to make such settings seem less homelike. For example, residents typically do not have private rooms or bathrooms. They may share a room with one or more other residents, with the living areas separated only by curtains.

There is generally limited space for the storage of personal belongings, such as clothing. In addition, there is typically no *personal* living space provided for residents, aside from their sleeping areas. Common areas designed for residents may be limited and are typically not furnished or decorated in manner which promotes the privacy or comfort of residents.

- ❖ **Required adherence to special life-safety regulations governing occupancy and furnishings.** Life-safety regulatory requirements can impact the environment of institutions. For example, institutions must adhere to mandated codes regarding building construction (e.g. size of corridors, type of doors, etc.) which may detract from a homelike environment. In addition, furnishings in institutions typically are required to meet specified fire-safety codes which may limit the use of homelike fabrics.
- ❖ **Policies and procedures defining and governing day-to-day operations.** Institutional settings typically operate under stringent policies and procedures which may limit the choice, autonomy and independence of residents. Although these policies may be dictated by regulatory requirements, many also result from the desire to achieve and maintain an efficient and controlled environment.

For example, an institution may establish and adhere to scheduling procedures which dictates when food service is available to residents. There may be policy limitations on the visitation of residents' guests. Cost concerns may create policies which place restrictions on the use of resident supplies, equipment or staff, (e.g., residents may not be allowed to keep their own over-the-counter medications).

### **Autonomy in Institutional Settings**

Residents of institutional settings often have difficulty maintaining their autonomy. This typically becomes an issue when residents experience decreasing abilities to function without assistance. As residents become less able to perform tasks independently, staff members may assume that the residents also have decreased ability to make appropriate decisions about their own care and/or preferences.

Thus, staff members may ignore or override residents' choices when decisions about the residents are made. Often "professional judgment" (i.e., decisions about what is best for a resident) conflicts with the residents' own values and preferences. Concerns about providing maximum protection and security for residents as well as liability for the quality of care provided, often result in an institutions imposing these "professional" opinions even if they vary from resident choices.

Another factor which makes it difficult for residents to maintain autonomy in institutional settings is the routinization of tasks and activities. It is the adherence to routines which makes institutions efficient in the delivery of services, and therefore less costly to the resident. However, this same efficiency often acts to depersonalize the very residents it is intended to serve. Such depersonalization occurs in the following ways:

- ❖ **Maximum efficiency occurs with minimal deviation from routines.** Most institutions want to obtain a maximum level of efficiency in an effort to optimize staff productivity and maintain effective cost control. This efficiency is usually obtained through the development of and adherence to routines for frequently performed activities and tasks. However, adhering to predetermined routines typically does not allow staff members to respond to residents in an individualized manner.

- ❖ **The recognition of individual differences requires effort and creativity.** Recognizing and responding to individual differences in residents requires considerable effort and creativity on the part of individual staff members and institutions as a whole. Staff members must be willing to observe the individuality of each resident; to see each as an individual with his/her own values, interests, and preferences. They will also have to expend extra energy in asking residents about their desires or preferences, and be willing to actively listen to the residents' responses.
- ❖ **Maximizing the individuality of residents often conflicts with institutional goals of efficiency.** The recognition of and response to residents' needs and preferences may detract from the efficiency which could be achieved in a completely mechanized environment. Institutions often are not willing to sacrifice this efficiency in order to maximize the individuality of residents.

### **The Response to Consumer Preferences**

Although the institutional factors described above may apply to some ALF settings, many ALF are distinguished by their attempts to work within regulatory constraints to minimize the institutional aspects of their facilities. The ECC regulations were developed to further assist providers in this regard. These regulations have been developed to enable ALF's to respond effectively to the concerns voiced by consumers in regards to institutional policies and practices.

## **ECC DEVELOPMENT IN FLORIDA**

Extended congregate care evolved from a recognition that ALF regulations often make it difficult for older Floridians to age in place. These rules place limits on the services ALFs are allowed to provide and on the types of residents which they may accept and retain.

Standard ALF regulations can make it difficult for facilities to provide services in a manner which addresses the preferences of frail seniors who require ongoing or more intensive care. As a result, they are often required to be moved to another setting, such as a nursing home, which is capable of providing a higher level of care.

Because of a recognition of these regulatory limitations, alternatives were sought to meet the needs of frail seniors who had more intensive care needs. This led to the following actions of the former Department of Health and Rehabilitative Services (HRS):

1. Studying various models of supportive housing for seniors and/or disabled individuals.
2. Conducting an in-depth study of the housing needs of older Floridians.
3. Initiating a process to solicit input from the owners/operators of facilities for seniors and the disabled, from senior advocates, and from the consumers of senior housing.
4. Drafting statutory language which would make it possible to extend the services which were currently allowable in a standard ALF, while simultaneously embracing consumer values, (e.g., the desire to maintain autonomy and to remain in their own homes).
5. Supporting statutory changes to the ALF law.
6. Holding public hearings to solicit and incorporate consumer feedback and input into the proposed rules.
7. Negotiating with special interest groups on the proposed regulations, to facilitate agreement for rules which would be beneficial to all parties involved.
8. Revising, adopting, and publicizing the new regulations.

The result of these measures resulted in the establishment of a special license to provide extended congregate care to seniors and/or disabled persons residing in assisted living facilities.

## **STATEMENT OF ECC VALUES**

The law adopted for ECC differ from those of the standard ALF in that they include an explicit statement of values which ECC facilities are expected to promote. These values reflect commonly held beliefs and attitudes about how people should

be treated and include facilitating aging in place, and promoting independence, dignity, choice and decision-making for residents of an ALF. The regulations require the ALF to adopt policies which implement these values so that they are incorporated into a facility's ECC program. In addition, the regulations expand ALF residency criteria and services in order to permit the facility to accommodate this policy.

### **Aging in Place**

The ECC rules enhance the ability of an ALF, with an ECC license, to support the desire of residents to age in place. That is, ECC facilities are able to retain and care for residents as their care needs increase beyond what is permitted in a standard ALF.

Not only are residents able to remain in the same facility, they are also permitted to remain in the same room within the ECC facility even as they require increased levels of assistance (provided that the room is within the ECC licensed part of the facility if the entire facility is not so licensed).

ECC facilities are also able to meet the increasing care needs of residents because they are permitted to provide an expanded scope of service, including nursing care, assistance or total help with decreased levels of ADLs (activities of daily living), and increased bed care for temporary illnesses. Thus, to actively promote the philosophy of aging in place, ECC facilities should strive to retain residents whose needs fall within the expanded scope of allowed practice.

### **ECC Values**

The rules governing ECC facilities identify four specific values which are to be actively promoted in an extended congregate care program. These values provide guidance regarding the underlying principles of ECC, and define the approach which should be used in providing services to ECC residents. These values are:

- ❖ **Independence.** ECC facilities should enhance the independence of residents by identifying and supporting the abilities of residents, while compensating for their limitations. Staff members should encourage residents to do as much for themselves as possible, providing assistance only when it is needed.
- ❖ **Dignity.** In ECC, the dignity of residents should be preserved by validation of their self-worth. Residents should always be treated as individuals, and should be shown courtesy, acceptance and respect at all times.

- ❖ **Choice.** ECC facilities are required to adopt policies which provide choices to residents about what services they will receive, and how services will be provided. Residents should also be allowed to choose from a variety of social and recreational activities, including activities in the community, to choose their room and roommate, and to have the freedom to control and use their private space as they wish.
- ❖ **Decision-making.** The decision-making of ECC residents should be encouraged at all times. Residents should be allowed to participate in decisions about their own care and to make decisions about their personal habits and living space. Residents should also be encouraged to provide input into the facility policies and procedures which affect their lives.

Incorporating these values into the daily operation of an ECC licensed facility are important as they are key to the concept of aging in place. This Guide will discuss these values in detail and provide ideas on how to successfully incorporate these four values in an effective ECC program.

## CHAPTER 2

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# EMBRACING THE VALUES OF CHOICE, DIGNITY, INDEPENDENCE & DECISION MAKING

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### INTRODUCTION

The ECC rules require facilities to embrace the values of independence, dignity, choice and decision-making in all aspects of the provision of services to residents. To effectively promote these values, facilities must recognize and respect the diverse backgrounds of their residents. Staff members must be sensitive to the cultural, ethnic, and racial diversity of residents, and must respond in an effective and appropriate manner to this diversity.

This section will explore the key concepts involved in each of the specified values and the barriers to the utilization of each value. It will also provide suggestions for incorporating these principles into the day-to-day operation of an ECC facility.

### CHOICE

#### Key Concepts

ECC facilities are expected to actively promote the choices of all residents. Whenever possible, residents should be allowed to make selections based on their own preferences and individual lifestyles. The freedom to choose and to act on those choices increases the autonomy of residents and their feelings of control over their own lives. The idea of choice can be applied in ECC through the implementation of the following key concepts:

- ❖ **Create an environment in which residents can exercise greater control over their lives.** The physical environment in which residents live can significantly influence the number of choices a resident will have. For example, private accommodations enable residents to choose when they prefer to wake up or go to bed. It also allows more freedom to maintain personal space according to preferences,

(e.g., cluttered or tidy). The more control residents have in their personal environment, the more control they will feel over their lives.

- ❖ **Structure services to maximize resident opportunities to act on preferences.** The services available to residents should be flexible enough to allow the incorporation of resident preferences. For example, residents might be given a choice between whether they prefer to shower in the morning or at night; whether they want to get up in time for breakfast or to sleep in and skip breakfast; and which of a variety of planned social/recreational activities they wish to participate in.
- ❖ **Support resident expressions of autonomy.** The autonomy of residents should be actively promoted in ECC facilities. That is, the preferences of residents should be incorporated, whenever possible, into decisions which directly affect their lives. For example, active resident involvement in the development, implementation, and revision of service plans is required. This facilitates the provision of services according to the priorities and preferences of residents, and increases their feelings of control.

### **Barriers to Utilization**

Several factors can limit how effectively the concept of choice is incorporated into an extended congregate care program. These limiting factors include the following:

- ❖ **Institutional behavior and resource limitations.** Residents' choices may be restricted if the facility primarily focuses on streamlining the provision of services in order to maximize efficiency and reduce cost. The incorporation of resident preferences into policies and procedures can detract from the facility's resources. Facilities may therefore be tempted to limit resident choices to maximize the use of such resources, (e.g., time, money, and staff).
- ❖ **Perceptions about the competency of impaired individuals.** Resident choice may also be stifled by staff members who make generalized judgments about the competency of residents. Staff members may erroneously assume that frail residents are not capable of making rational choices, and thus may not provide these residents with opportunities to express

their preferences. The capabilities of residents must be evaluated on an individual basis, with the choices they are allowed to make based on their actual, not assumed, capabilities. All residents are capable of making some choices, regardless of the level of their impairment. Even though a confused resident might not be capable of choosing the activities in which he/she would like to participate, he/she may be able to state a simple preference such as between wearing a blue or red shirt.

- ❖ **Professional bias/familial directives.** Professional judgements and family opinions or requests may also serve as barriers to resident choice. For example, a resident's physician may order a special diet for the resident which constrains the choices the resident is able to make in regards to what he/she prefers to eat. If a resident is very clear that he/she does not wish to follow specific orders from his/her physician(s), the facility should recognize and respect that preference. Staff should work with the resident and the resident's health care provider(s) in identifying and managing any consequences which might occur as a result of the preference. [Refer to section on *managed risk* in chapter 4.]

Families can limit resident choices when their directives are followed over resident preferences. For instance, a resident's family may insist that staff involve the resident in organized social activities. However, the resident may prefer to engage in more solitary activities, such as reading or watching television. In such situations, residents' choices should be honored to the maximum extent possible.

### **Incorporating Choices into Day-to-Day Operations**

To incorporate choices into the day-to-day operations of an ECC facility, staff members must follow guidelines designed to promote resident choice. These guidelines should address the following:

- 1. Articulate service choices in discreet, incremental steps.** All services should be provided in a manner appropriate to the level of each resident's functioning. Thus, services should be broken down into incremental steps which may then be matched to

the level of assistance needed by residents. For example, the provision or arrangement of transportation could be segmented into the following steps: providing residents with information about available transportation services; calling to schedule or arrange transportation; providing residents with rides; and arranging for and providing escort services if needed. If a resident requires or requests assistance with transportation, the services they receive should be tailored to their levels of functioning and their individual preferences.

- 2. Assess the ability and willingness of residents to make choices.** Staff members must actively assess the capability and desire of residents to receive and evaluate information about their options, to make choices based on those options, and to execute the decisions they have made. Staff members must be aware that both the ability and willingness of residents to make choices may vary from time to time and from task to task. Thus, staff members should encourage residents to make choices in accordance with their level of functioning and desire to choose at that particular time. Staff members must be careful not to make blanket assessments about residents' abilities and/or desires to choose.
- 3. Be willing to accept choices which may differ from decisions others would make for residents.** Residents may make choices which others (e.g., family, staff, or professionals) do not believe are in the best interest of the resident. However, residents should be allowed to act on their preferences if the choices they make do not place the resident or others at risk of imminent harm. Resident choices should be fully supported whenever possible.
- 4. Be willing to waive operating policies to accommodate resident needs and preferences.** Policies and procedures should serve as guidelines for the provision of resident services. However, if a particular facility policy limits the choice of a resident, the resident's preference is a high priority for that resident, and the choice will not adversely affect the resident or other residents, then the facility policy should be waived in order to accommodate that resident's choice.

- 5. Offer only choices which can be honored.** Staff members should never offer residents options which cannot be honored. This includes generalized, blanket statements about the provision of services, (" . . . sure, we always . . . etc.") If a resident is offered a choice, staff members must be careful to follow-up with the resident's decision regarding that choice. Importantly, choices should never be used to bribe or pacify residents.

### **Tips for Offering Choices**

The following are several practical suggestions which may be helpful in actively promoting resident choice:

- ❖ **Always ask residents what they prefer, even if you think you know what their needs and/or choices are.** Don't assume that residents' preferences will remain the same as they have been in the past. Respect is conveyed to residents when they are specifically asked about their preferences and needs.
- ❖ **Always provide residents with specific and personalized information.** Avoid speaking to residents in vague generalities. Instead, personalize your conversation to the resident and the resident's individual situation.
- ❖ **Tailor information about choices to the abilities of residents.** To effectively promote resident choice, a resident's ability to process information and make appropriate choices must be assessed. This will enable conversations with residents to be tailored to their individual levels of functioning. Some residents may have the ability to make choices from the full range of information. However, other residents may be able to process only a reduced range of information in making choices, (i.e., "Would you rather have this one or that one?").
- ❖ **Identify techniques most useful in assisting individual residents in acting upon their choices.** Techniques which can be used to help residents execute their choices include general reminders to residents about their decisions; specific prompting or cuing; encouraging or motivating the residents;

directing or focusing the activity of the residents; or actually assisting the residents in executing their decisions. Different residents will respond to different techniques depending upon their level of ability and willingness to execute the choices they have made.

- ❖ **Realize that you may not be able to meet all resident preferences.** Some residents will have preferences which are not objectively necessary. Those choices need to be recognized and discussed with the resident. However, staff members must realize that some resident preferences may be of a lower priority than are their objectively assessed needs.

## **DIGNITY**

### **Key Concepts**

Respecting the dignity of residents is crucial to the underlying philosophy of extended congregate care. All services and support should be provided in a manner which validates the self-worth of residents and respects their privacy.

Residents should always be affirmed for who they are as individuals, regardless of their levels of functioning or the specifics of their situation. This may involve acknowledging the skills or knowledge which a resident exhibits, affirming specific personality traits, or asking for assistance from the resident in the performance of tasks.

Residents should always be treated with courtesy, acceptance and respect, and should be expected to treat others in a similar manner. If behavior is demonstrated which is not courteous or does not show respect, the behavior should be acknowledged and discussed with the offending person.

Manipulation should never be used to gain compliance from residents. Coercion or deceit are not acceptable methods to influence the behavior of residents. Staff should always treat residents in an honest manner.

Staff members should recognize and respond to all residents on an individual basis. Respect and dignity is portrayed to the resident when the individuality of each resident is recognized. This means acknowledgment of and response to the unique needs, capabilities and characteristics of each resident.

### **Barriers to Utilization**

There are several factors which can inhibit the successful enhancement of dignity in an ECC facility. The most common barriers to the utilization of dignity are as follows:

- ❖ **Confusing empathy and sympathy.** Staff members may have difficulty distinguishing between empathy and sympathy. Empathy is the ability to feel what another individual is experiencing. Sympathy involves feeling pity for another person. Empathizing with residents conveys respect and understanding, while expressing sympathy typically conveys an attitude of condescension and/or superiority.
- ❖ **Embarrassment over or dislike of certain disabilities or personal characteristics.** Staff members may have difficulty treating residents with dignity if they are uncomfortable with the residents' disabilities or personality styles. Staff members may also be uncomfortable in assisting residents with certain personal care tasks, such as bathing or toileting. This lack of comfort and/or the embarrassment may result in the depersonalization of resident services, or in demeaning remarks or behavior toward residents.
- ❖ **Institutional behavior/resource limitations.** The enhancement of dignity may be constrained by a tendency toward institutional-like behavior. Maximizing the efficiency of staff members can result in a mechanization or depersonalization of tasks in which residents are no longer recognized and treated as individuals. The dignity of residents will also be reduced if staff members refer to them in institutional terms (i.e., "Room 101").

### **Incorporating Dignity into Day-to-Day Operations**

To successfully incorporate dignity into the day-to-day operations of an ECC facility, the following guidelines should be followed.

**1. Mutual acceptance, courtesy and respect toward both staff and residents should be fostered.**

Clear expectations must be established as to what behavior will be accepted or condoned. Abusive behavior should not be accepted or tolerated at any time. Neither residents or staff members should be allowed to engage in demanding, critical, humiliating, or threatening behavior. Such behavior should be taken seriously and addressed in an appropriate manner at the time in which it occurs.

**2. The individuality of residents should be acknowledged and their self-expression supported in tangible ways.**

The cultural, racial and ethnic diversity of all residents should be respected, and policies which constrain variation in personal lifestyles should be limited. Staff should not be unduly influenced in their perceptions and attitudes toward residents by societal or facility norms. For example, residents should have the freedom to dress in a manner of their own choosing and to maintain habits which may vary from the norm (e.g., a night owl's sleep cycle). Residents should also be encouraged to maintain their personal space as they please.

**3. Variable competencies should be recognized and actively promoted.**

Staff members should be capable of evaluating the varying abilities that residents exhibit. They should focus primarily on these capabilities, and downplay or compensate for a resident's disability. Staff members should be careful not to create additional dependencies by doing more for residents than they require, (e.g., selecting clothes for a resident instead of assisting the resident in choosing the clothing).

**4. Information should be presented to residents in a frank, constructive and adult manner.**

Residents should always be addressed with respect and dignity. When issues or concerns must be discussed with residents, they should be presented in a positive manner. Such discussions should always reflect the fact that residents are adults, regardless of any disabilities they may have.

## **Tips for Engendering Dignity**

To successfully embrace dignity in extended congregate care, staff members should first make every effort to learn about each resident's:

- ❖ Need for privacy
- ❖ Level of modesty
- ❖ Sources of pride and pain
- ❖ Means of communicating
- ❖ Sense of ability

This will facilitate the ability of staff members to treat all residents as individuals and with the respect which they deserve.

Staff members should also avoid saying phrases to or about residents that demean them or negate their abilities. Such phrases include:

- ❖ "You can't do that. I'll do it for you . . ."
- ❖ "He/she can't do that. I have to . . ."
- ❖ "Let me . . ."
- ❖ "He/she isn't able to . . ."

Staff members should always discuss residents as if they were present. If there is any doubt over whether a comment is appropriate, staff members should be "stranger polite." In other words, they should not only be discreet in what they say, but with their nonverbal language as well. In addition, staff members should also be as careful in what they write as what they say.

## **INDEPENDENCE**

### **Key Concepts**

Independence is another important value in the philosophy of extended congregate care. A setting which successfully promotes independence supports residents in expressing their preferences, and provides an environment in which residents are free to act on their choices. The capabilities of residents should be recognized, supported and built upon. This will enable residents to make and exercise decision-making to the full extent of their abilities. Furthermore, in an environment which facilitates independence, residents are given full responsibility for the outcomes of their decisions.

## **Barriers to Utilization**

Several barriers may inhibit the independence of residents in ECC facilities. These barriers include the following:

- ❖ **Resident, staff, professionals, and family attitudes.** The attitudes of individuals involved in the care of residents may adversely impact the level of independence that the residents are able to enjoy. For example, staff members, families, or professionals may be concerned about residents who fall frequently. They may attempt to limit the residents' mobility because of fear of risk to the residents. Residents too, may exhibit behavior or attitudes which limits their own independence. Fear of falling may cause a resident to remain seated for long periods.
- ❖ **Inadequate information or inability to segment tasks associated with care needs.** To successfully support the independence of residents, residents must be allowed to do as much as they are capable of. Each individual task must be broken down into incremental steps so that a determination can be made as to what residents may perform without assistance vs. what they require help with. For instance, a stroke victim may not need complete assistance with dressing; he/she may only require help in fastening his/her clothing.
- ❖ **Institutional behavior/resource limitations.** Maximizing the independence of residents often utilizes, at least initially, more resources than does the promotion of dependency. It is usually more time consuming for staff to allow a resident to perform a task without assistance than to perform the task for the resident. For example, it takes less time for a "slow walker" to be placed in a wheelchair and taken to the dining room than for a staff member to escort the resident, allowing him/her to walk at his/her own pace. Thus, staff members must make concerted efforts to embrace and encourage the independence of residents.

## **Incorporating Independence into Day-to-Day Operations**

In maximizing the independence of residents, staff members should follow the guidelines outlined below:

- 1. Identify the abilities of residents and develop service plans around those abilities.** Staff should first identify and acknowledge the capabilities of

residents in all areas of functioning. Service plans can then be developed which build on the identified competencies and strive to compensate for any noted limitations. These plans should be as specific as possible in order to successfully maximize the independence of residents.

- 2. Be pro-active in motivating residents to utilize their abilities.** Staff members should use every opportunity to encourage residents to utilize their identified competencies. Residents should be supported in their efforts and should be given positive feedback for tasks performed which maintain or increase their independence.
- 3. Be supportive of partial success in task completion.** Residents should be given positive feedback and support for the successful completion of any portion of a task, regardless of whether the entire task was completed. This will encourage residents to perform the tasks again, and will increase their self-esteem and confidence. Each incremental step taken in performing a task or in participating in activities should be seen as potential accomplishments.
- 4. Use creativity in devising supportive strategies.** Staff members should actively brainstorm for ideas which may increase the independence of residents. Strategies to maximize independence may involve a manipulation of the physical environment or may entail the use of methods to increase the desire of residents to become more independent. The key is to be as creative as possible in developing possible strategies.

### **Tips for Supporting Independence**

The following are practical suggestions which may be utilized by ECC staff members in supporting and increasing the independence of residents:

- ❖ **Assume competency unless the resident demonstrates otherwise.** Staff members should always assume that residents have full capabilities until the residents demonstrate otherwise. This assumption will enable staff to better assist residents to maximize their independence. The abilities of residents can then be monitored or assessed to verify or disprove this assumption. This process can be facilitated by the use of standardized assessment

procedures which measure the level of functioning exhibited by residents in various areas.

- ❖ **Break tasks down into discreet parts and offer assistance with those task parts which match individual impairments.** Each activity should be broken down into incremental steps and a determination made as to which steps residents are able to perform independently. Assistance should be provided only for those task parts which residents are unable to perform independently.
- ❖ **Begin with less assistance, but be prepared to adjust the level of assistance upward as needed or wanted.** Residents should initially be given the least amount of assistance needed (based on an assessments of their functioning) to encourage them to do as much for themselves as possible. Staff members should then observe residents as they perform tasks, and make any necessary adjustments in the amount of assistance required by and provided to residents.
- ❖ **Plan for independence.** Staff members can help in maximizing the independence of residents by actively developing strategies designed around each resident's individual needs. Such plans should be pro-active in nature. That is, they should be developed *before* the resident's level of independence has decreased. For example, when residents first experience difficulty in fastening their clothing, staff should provide assistance in obtaining clothes that pull on instead of fastening, or that fasten with velcro instead of with buttons or snaps.
- ❖ **Use positive reinforcement to motivate residents to perform tasks.** Residents should be provided with positive motivation to perform tasks which will maximize their independence. Staff should first determine what will serve as a positive reinforcement for the resident. They should then utilize that reinforcement to motivate and encourage the resident.

## DECISION-MAKING

### Key Concepts

To successfully embrace the values of extended congregate care, an ECC facility must support the ability of residents to make and execute decisions. This involves recognizing and supporting the ability and willingness of residents to express feelings which reflect their preferences. Residents must also be given opportunities to express those preferences. In addition, staff members must respect the ability and willingness of residents to act on decisions and to take responsibility for the consequences for those decisions. Finally, residents must be provided with opportunities which are appropriate for the execution of their decisions.

### Barriers to Utilization

Several factors may limit the abilities of residents to make and execute decisions. These factors include:

- ❖ **Stereotypes of older and/or disabled adults.** Patronizing stereotypes of the elderly and/or disabled are prevalent in our society. If individuals involved in the care of residents, (e.g., families, staff or professionals) hold these stereotypes, the opportunities for residents to engage in decision-making may be limited. For example, a family member may speak for a resident even when the resident is present, assuming that the resident is not capable of effectively expressing himself/herself.
- ❖ **Family, professional, or staff aversion to risk and/or poor outcomes.** Individuals involved in the care of residents may try to protect residents by limiting the risks to which they are exposed. However, the reduction of possible risks also decreases the opportunities for residents to make and execute decisions. Most decisions involve some possibility of poor outcomes, (e.g., a resident wants to keep a throw rug in his/her room, even though the rug will increase the probability that he/she will trip and fall). The possible risks must be evaluated carefully so as not to unnecessarily constrain the opportunities for resident decision-making.
- ❖ **Resident abilities and expectations.** The decision-making of residents may be constrained by limited capabilities to make choices or execute decisions in an

appropriate manner. Residents may not be able to process all of the information needed to make decisions and/or may lack the ability to act on their preferences. Residents may also express an unwillingness to make decisions, and expect others to make decisions for them.

- ❖ **Institutional behavior and resource limitations.** Staff members may have a tendency to limit residents' decisions because of institutional constraints. For example, staff may feel administrative pressures to perform tasks in an efficient manner. Supporting residents in making and acting on decisions is typically more time consuming than simply making decisions for them (e.g., choosing something for the resident to wear because he/she takes too long to decide). Staff members may also automatically adhere to decisions which professionals have made about residents even when those decisions conflict with the preferences of the resident. [Refer to the section on *managed risk* in Chapter 4.]

### **Incorporating Decision- Making in Day- to-Day Operations**

Decision-making is an important factor in the successful implementation of an extended congregate care program. Engaging in the process of decision-making allows residents to exercise control over their own lives, and helps to increase their self-esteem and confidence.

Unless residents have legal guardians, they have a legal right to make their own decisions regardless of the perceived quality of those decisions. Staff members should be cautious in restricting that right, and be respectful and supportive of residents who wish to make and execute own decisions. Even if residents do have legal guardians, they still have the right and are often able to make decisions about their daily lives. For example, a guardian may determine whether care for a particular need is provided to a resident. The resident, however, may express his/her preference for a particular care provider. Similarly, a guardian might maintain control of personal funds for a resident who can decide how he/she spends the money he/she receives.

Staff must also realize that even though some residents may not have legal guardians, they may not have the capability to make fully informed decisions. These residents should be assisted with their decision-making to

the degree necessary, based on the limitations which they exhibit.

Staff members should actively encourage resident decision-making in all appropriate situations. Resident decision-making is beneficial not only to residents, but also to staff. When residents are invested in decisions, the execution of those decisions becomes much easier for the staff.

### **Tips for Respecting Decision-Making**

The following recommendations should be helpful to staff members as they encourage and support resident decision-making:

- ❖ **Offer information about the costs and benefits of decisions.** Residents must be provided with complete and accurate information about all aspects of the decision-making process, including full information about available options. Residents should also be informed of the possible benefits and consequences of each alternative. This will assist them in making and executing appropriate and advantageous decisions.
- ❖ **Assume that most decisions are not life-threatening and that coercion may result in higher risk.** The outcomes of most resident decisions will not endanger the resident or others. In fact, if staff members try to force or coerce a resident into an action which conflicts with his/her preference, the resulting outcome may actually carry more risk than would the outcome based on the resident's decision. For example, a staff member may give a resident a higher dose of anti-anxiety medication because the resident refuses to go bed at an "appropriate" time. Even though the medication makes the resident drowsy and ready to sleep, it also causes him/her to experience increased lethargy and a decreased awareness of his/her surroundings the next day.
- ❖ **Help residents practice decision-making at the level of their abilities.** Staff members should be aware of each resident's capabilities to make and execute decisions. Does the resident routinely make decisions which have high degrees of risk? Are his/her decisions consistently outside the norm, (e.g., wearing four sweaters on a 90 degree day)? Does it take the resident either an unreasonably short or long amount of time to make a decision? Is the resident able to

make decisions only if limited amounts of information are available?

Once the ability of residents to make decisions has been assessed, they should then be assisted in the decision-making process at their individual levels of functioning. For example, one resident may only need assistance in determining all of his/her options. Another resident may need his/her alternatives narrowed down to two possible choices from which he/she may then make a selection.

- ❖ **Broaden the definition of good outcomes to include meeting the priorities of residents.** Positive decision outcomes should be thought of in broad enough terms to include those results which are most important to the resident which the decision affects. For instance, a resident might prefer to have a staff member assist him/her in writing a letter instead of receiving his/her scheduled bath. Meeting the priorities and preferences of residents should be seen as a positive outcome of the decision-making process.

## **ECC REGULATORY REQUIREMENTS FOR RESIDENT CHOICES & DECISION MAKING**

ECC rules explicitly state that all ECC facilities must have written policies and procedures which provide opportunities and encouragement for the resident to make personal choices and decisions (see Rule 58A-5.030(2)(g), F.A.C.). At a minimum, ECC facilities must allow residents to make choices regarding the following:

- 1.** To participate in the process of developing, implementing, reviewing, and revising the resident's service plan.
- 2.** To remain in the same room in the facility, except that a current resident transferring into an ECC program may be required to move to the part of the facility licensed for extended congregate care, if only part of the facility is so licensed.

3. To select among social and leisure activities.
4. To participate in activities in the community. At a minimum the facility shall arrange transportation to such activities if requested by the resident.
5. To provide input with respect to the adoption and amendment of facility policies and procedures.

**Resident Choice  
& Decision-  
Making Policies**

These policies and procedures should provide numerous opportunities and encouragement for the resident to make personal choices and decisions. The ECC rules also require that if a resident needs assistance in making choices or decisions, a family member or other resident representative must be consulted.

Although ECC residents should be given the opportunity to select roommates and/or rooms when possible, ECC facilities must also have a policy for mediating conflicts among residents regarding choice of room or apartment and roommate. All written policies must be kept with the facility's records.

## CHAPTER 3

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# ENHANCING CAPACITY TO AGE-IN-PLACE

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### INTRODUCTION

A key concept in the development of extended congregate care is the ability to allow residents to 'age in place.' Aging in place is statutorily defined as "the process of providing increased or adjusted services to a person to compensate for the physical or mental decline that may occur with the aging process, in order to maximize the person's dignity and independence, and permit them to remain in a familiar, noninstitutional, residential environment for as long as possible." This concept is the basis for the provision of extended congregate care services.

This chapter will address the role of each of the following factors in promoting the concept of aging in place.

- ❖ The role of the environment.
- ❖ Admission and continued residency criteria.
- ❖ The expanded scope of services.
- ❖ Staffing.

#### **Aging in Place Policy**

ECC facilities are required to develop and implement written policies and procedures which addresses aging in place. The policy should be kept with the facility's records and be available to all potential residents.

This chapter will provide practical guidelines that will aid ECC facilities in successfully incorporating the concept of aging in place into their policies and procedures, and also into the facility's day-to-day operations.

### THE ROLE OF THE ENVIRONMENT

#### **Physical Site Requirements & Aging in Place**

ECC rules were developed to allow older adults to receive more intensive services, while remaining in a homelike environment that promotes resident privacy and independence. The area where services are delivered is

critical for promoting this type of environment. In addition to the basic physical site requirements of a standard facility, ECC rules require that each resident be provided with the following:

- 1. A private or semi-private room or apartment.**  
The maximum number of residents permitted in an designated ECC room is 2. If a resident has a roommate, it should be someone that each resident has agreed to share a room with. The door to the room or apartment shall have a lock which is operable from the inside by the resident with no key needed. The resident should be provided with a key upon request. However, if a resident's safety would be jeopardized by a locking door, the resident's service plan may allow for a non-locking door.
- 2. A bathroom which is shared by a maximum of 4 residents.** Each bathroom must consist of a toilet, sink, and bathtub or shower. A centrally located hydro-massage bathtub may substitute for the bathtub or shower in two of the bathrooms. The entry door on the bathroom shall have a lock which is operable from the inside by the resident with no key needed. As with bedrooms, if the resident's safety could be jeopardized by a locking bathroom, the service plan may allow for a non-locking bathroom.

As with standard ALFs, ECC facilities are required to provide at least 80 square feet of space in private rooms and 60 square feet per person, in semi-private rooms.

### **Creating a More Normal Environment**

ECC facilities should develop and maintain policies which facilitate a "normal" or homelike environment. These policies should include the following:

- ❖ **Encourage residents (or their families) to fully personalize their units.** When residents move into an ECC facility they should be encouraged to bring with them personal belongings and furnishings. Such items may include furniture, linens, towels, pictures, and/or knickknacks. Residents should be allowed to furnish and decorate their units in a manner of their own choosing and according to their personal styles. Any requests for modification of resident units, such as wall papering or changing color schemes, should be accommodated whenever possible (at the resident's

expense).

- ❖ **Support residents,(including impaired individuals) who wish to prepare and/or store food.** Residents should be provided with the means to prepare and/or store food in their units. If their units do not include kitchen facilities or if stove-tops have been disconnected, the facility may want to provide residents with small refrigerators, toaster ovens, microwaves, and/or tea kettles (with an automatic shut-off). Opportunities for residents to purchase grocery items should also be provided.
- ❖ **Facilitate familial involvement.** The families of residents should be encouraged to become actively involved in the ECC community. They should be allowed to assist in the provision of services to residents if they wish, and should be made to feel to feel welcome at the facility at all times. Any restrictions on visiting hours and overnight stays should be reduced or eliminated, whenever possible.
- ❖ **Maintain lifestyle patterns.** Residents should be encouraged to maintain the lifestyles which they prefer and are accustomed to. This may be facilitated through policies which permit pet ownership, smoking, the consumption of liquor, and adherence to individual sleep schedules, (e.g., night owls).
- ❖ **Enhance homelike feelings.** To effectively facilitate a homelike environment, residents must be able to exercise control over their own personal space. This includes control over who has access to their units and how their units are maintained and used. ECC facilities should encourage residents to exercise this control by making and executing decisions which reflect their preferences in this area.

### **Life Safety Requirements & the Environment**

ALF law and rule establish specific requirements for life safety and the personal space of residents. ECC facilities must adhere to all regulatory requirements for standard ALF's pertaining to life safety.

- ❖ **Fire safety requirements.** As with standard ALF's, fire regulations for ECCs are governed by § 400.441, F.S., and Rule Chapter 4A-40, F.A.C. Administrators for ECC facilities should already be familiar with and in

compliance with these regulations.

- ❖ **Emergency management.** Like standard facilities, ECC facilities must also follow guidelines established for all ALF's regarding disaster planning and emergency management.

Because ECC residents are often more frail they typically need more time to evacuate a facility than do ALF residents. Thus, the presence of ECC residents in a facility may lead to more stringent requirements than those for ALF facilities. That is, an ECC facility may have additional requirements for structural materials, means of escape and security systems, interior finish, automatic extinguishing systems, and/or construction of corridor walls.

In some circumstances, such additional requirements may be modified if other approved means to protect residents during emergencies are utilized, (e.g., increased staffing to assist residents in evacuation and/or the installation of sprinkler systems). Refer to Chapter 6 of NFPA 101, Alternative Approaches to Life Safety, for additional information on modification of the evacuation requirements.

- ❖ **Biomedical waste.** Because of increased nursing care permitted in ECC, the facility may also be subject to biomedical waste regulations established by the Department of Health (see Rule Chapter 64E-16, F.A.C.).

## **RESIDENCY CRITERIA**

### **Admission Criteria**

Because ECC facilities are designed to provide a greater level of care, ECC facilities may admit an individual with greater needs or impairments than permitted in a standard ALF. Nevertheless, a potential resident must meet the following minimum criteria to be admitted into a facility with an ECC program:

- ❖ Be at least 18 years of age.
- ❖ Be free from signs and symptoms of a communicable disease which is likely to be transmitted to other

residents or staff; however, a person who has human immunodeficiency virus (HIV) infection may be admitted to a facility, provided that he/she would otherwise be eligible for admission.

- ❖ Be able to transfer, with assistance if necessary. [The assistance of more than one person is permitted.]
- ❖ Not be a danger to self or others as determined by a licensed health care provider or mental health practitioner.
- ❖ Not be bedridden.
- ❖ Not have any stage 3 or 4 pressure ulcers.
- ❖ Not require any of the following nursing services:
  1. Oral or nasopharyngeal suctioning.
  2. Nasogastric tube feeding.
  3. Monitoring of blood gases.
  4. Intermittent positive pressure breathing therapy.
  5. Skilled rehabilitative services as described in rule 59G-4.290, F.A.C.
  6. Treatment of a surgical incision, unless the surgical incision and the condition which caused it have been stabilized and a plan of care developed.
- ❖ Not require 24-hour nursing supervision
- ❖ Have been determined appropriate for admission to the facility by the facility administrator.

### **Determining Appropriate Placement**

Like a standard ALF, The administrator of an ECC facility is responsible for determining the appropriateness of admission for a potential ECC resident. The administrator should base this decision on the admission criteria and the following:

- ❖ An assessment of the potential resident's strengths, needs, and preferences.
- ❖ The health assessment.
- ❖ A preliminary service plan.

- ❖ The facility's residency criteria, and services offered or arranged for by the facility to meet the resident's needs.
- ❖ The continued ability of the facility to meet uniform fire safety standards for an assisted living facility.

**Health Assessment**

*Prior to admission to an ECC program, all persons, including residents transferring within the same facility to that portion of the facility licensed to provide extended congregate care services, must be examined by a physician or advanced registered nurse practitioner (ARNP), and obtain a completed health assessment form (DOEA form 1823). A health assessment conducted within 60 days prior to admission to the ECC program shall meet this requirement. Once admitted, a new health assessment for ECC residents must be obtained *annually*.*

**Continued Residency Criteria & Hospice**

In keeping with the concept of aging in place, ECC facilities may retain individuals who may exceed the admission criteria. Specifically:

- ❖ A resident may be bedridden for up to 14 consecutive days.
- ❖ A terminally ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
  1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed.
  2. Continued residency is agreeable to the resident and the facility.
  3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service within the scope of their license including 24 hour nursing supervision, and total help with the activities of daily living.

4. Documentation of all of the requirements pertaining to hospice care are kept in the resident's file.

### **Facility Residency Policy**

In addition to the expanded minimum residency criteria for ECC residents established in law and rule, an ECC facility must develop its own residency policies, and establish its written admission criteria. This policy should be kept with the facility's records and provided to prospective residents upon request.

In addition to facility information made available to prospective residents by a standard ALF, facilities which also have an ECC license must provide a copy of the facility's ECC residency criteria, a description of the additional personal, supportive, and nursing services available, any additional costs, and any limitations, if any, on where ECC residents must reside.

## **EXPANDED SCOPE OF SERVICES**

The ability of ECC facilities to provide or arrange for an expanded scope of service is crucial to the concept of aging in place. Through their ability to provide additional services, ECC facilities are able to be more flexible in responding to individual service needs and cater to individuals who would otherwise not meet standard ALF residency criteria and possibly have to transfer to a nursing home.

In addition to the services provided by a standard ALF, ECC facilities may also provide:

- ❖ Nursing Services.
- ❖ Enhanced Personal Care.
- ❖ Supportive Services.

### **Providing Enhanced Scope of Services**

To effectively provide these ECC services, ECC facilities should follow the guidelines outlined below:

1. **The abilities, limitations and personality traits of residents should be incorporated into their service plans.** Staff members should identify and assess the unique capabilities, limitations and personality characteristics of all ECC residents. A

determination should be made as to how these factors will impact the resident's service needs. These factors should then be reflected in the service planning process and the provision of services.

- 2. Service levels and the method of service provision should be adjusted, as needed, to meet resident needs.** ECC facilities must be able to respond in a timely and effective manner when the care needs of residents change. For instance, if a resident who required only minimal assistance with ADLs has a stroke and returns to the facility after undergoing initial rehabilitation, his/her service level must be adjusted to appropriately respond to his/her increased needs.
- 3. Staff members must work successfully with ancillary and/or third-party providers.** ECC residents may require or desire services which the facility is unable or unwilling to provide directly. When such services are needed, the facility should work with ancillary or third-party providers to facilitate access to the services. This may entail establishing and maintaining working agreements with hospitals for emergency care, nursing facilities for skilled care, psychiatric services for mental health treatments, and in-home health providers for temporary or intermittent skilled nursing services. Procedures should also be developed to incorporate the provision of additional services into the service planning process.
- 4. Strive to maintain continued residency at all times.** ECC facilities should view continued residency as an attainable goal for all residents. Staff members should attempt, at all times, to ensure the continued residency of residents.
- 5. Recognize that increased service needs may be not be permanent.** Staff members should realize that resident needs for additional services may be temporary or transitional in nature. If a resident develops increased needs, staff should be careful not to assume that it is permanent and observe the resident carefully.

All services should be provided in the least restrictive environment, and in a manner which respects the resident's independence, privacy and dignity.

## **Nursing Services**

An ECC program may provide any nursing service so long as the resident does not exceed minimum residency criteria, and the service is consistent with the facility's residency requirements and the facility's written policies and procedures.

In addition, all nursing services must be provided in compliance with the following requirements:

- ❖ Authorized by a health care provider's order and pursuant to a plan of care.
- ❖ Medically necessary and appropriate for treatment of the resident's condition.
- ❖ In accordance with the prevailing standard of practice in the nursing community.
- ❖ A service that can be safely, effectively and efficiently provided in the facility.
- ❖ Recorded in nursing progress notes.
- ❖ In accordance with the resident's service plan.

### **Nursing Progress Notes**

*Nursing progress notes (or progress report)* are a written record of nursing services, other than medication administration or the taking of vital signs, provided to each resident who receives such services in an ECC facility. The progress notes must be completed by the nurse delivering the service and include the following:

- ❖ Date.
- ❖ Type of service.
- ❖ Scope of service.
- ❖ Duration.
- ❖ Outcome of services rendered.
- ❖ General health status of resident.
- ❖ Any noted deviations.
- ❖ Any contact with the resident's physician.

The progress notes must be signed by the nurse who performed the service and contain his/her credentialing initials. Nursing progress notes are kept as part of the resident's records.

### **Nursing Assessments**

A *nursing assessment* means a written review of information collected from observation of and interaction with a resident, the resident's record, and any other relevant source; the analysis of the information; and recommendations for modification of the resident's care, if warranted. The nursing assessment is part of the resident's record.

A nursing assessment must be conducted at least monthly (or more frequently if required by the resident's service plan). Nursing assessments must be done by a registered nurse or under the direct supervision of a registered nurse.

### **Nursing Policy**

ECC facilities are required to develop a policy outlining the nursing services the facility intends to provide, identification of staff positions to provide the nursing service and the nursing license status required, duties, general working hours, and supervision of such staff. This policy should be kept with the facility's records.

### **Expanded Personal Care**

An ECC facility is required to provide all the basic services that is required of a standard ALF, such as the provision of nutritious meals, general supervision, and assistance with ADLs.

In addition, ECC facilities are required to provide or make available the following services if required by the resident's service plan:

- ❖ Total help with bathing dressing, grooming and toileting.
- ❖ The provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output.
- ❖ Supervision of residents with dementia and cognitive impairments.

- ❖ Nursing assessments conducted more frequently than monthly.
- ❖ Measurement and recording of basic vital functions and weight.
- ❖ Assistance with self-administered medications, or the administration of medications and treatments pursuant to a health care provider's orders.
- ❖ Supervision of residents with dementia or cognitive impairments.
- ❖ Health education and counseling and the implementation of health promoting programs and preventive regimes.
- ❖ Provision or arrangement for rehabilitation services.
- ❖ Provision of escort service to health-related appointments.

ECC facilities are required to develop policies and procedures which address both the personal and supportive services the facility intends to provide, how the services will be provided, and the identification of staff positions to provide the services, including their relationship to the facility. In addition, the ECC facility is required to develop a policy for identifying potential unscheduled service needs and the mechanisms for meeting those needs, including the identification of resources to meet those needs. Such policies must be kept as of the facility's records.

### **Supportive Services**

In addition to the services provided by a standard ALF, ECC facilities may provide supportive services that will enable a resident to age in place, while promoting the resident's independence, privacy, and dignity. These services may include, but are not limited to:

- ❖ 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.
- ❖ Volunteer services

The family and friends of ECC residents should be encouraged to provide supportive services. ECC facilities are required to provide training to family and friends to enable them to provide such services in accordance to the resident's service plan. Formal volunteer programs may also be established to facilitate community support in the facility.

### **Personal & Supportive Services Policy**

As stated above, ECC facilities are required to develop policies and procedures which address the personal and supportive services the facility intends to provide, how the services will be provided, and the identification of staff positions to provide the services, including their relationship to the facility.

### **Resident Discharge**

Although an ECC program is designed to provide residents with the opportunity to age in place, some residents may deteriorate to the point where they are no longer appropriate for an ECC facility. In other cases, the resident and the facility may not be able to agree upon a service plan, or the facility may not be able to provide for the needs required by the service plan.

Discharge procedures are the same as in an ALF with a standard license. If at anytime the resident appears to need care beyond that which the facility is licensed or able to provide, the resident shall be given a written 30 days notice of relocation and be assisted in making any necessary arrangements. However, if a resident is certified by a physician to require emergency relocation to a facility providing a more skilled level of care, the resident engages in a pattern of conduct that is harmful or offensive to other residents, or there is imminent danger to the health, safety, or welfare of the resident, the 30 day notice may be waived.

## STAFFING AN ECC FACILITY

Staffing is an important factor in an ECC's ability to effectively support aging in place. Although ECC facilities typically require staff members to have higher skill levels than standard ALFs, a greater number of staff members is not necessarily needed to facilitate an enhanced capacity to age in place. In addition to possessing specific job-related skills, ECC staff members should have:

- ❖ Good observation skills, including the capability of selected staff members to assess and evaluate resident conditions.
- ❖ Good communication skills, including the ability to be an active listener and accurate provider of information.
- ❖ Good negotiation skills, including a willingness to mediate the effects of professional judgments, institutional policies and procedures, and familial directives on the ability of residents to make and act upon decisions.

These skills enhance an ECC facility's ability to recognize and respond to a resident's changing needs, and to deliver services in a manner which upholds the values of choice, dignity, independence and decision-making.

### **Implementing Appropriate Staffing Patterns**

To provide expanded scope of services in an effective and efficient manner, ECC facilities should follow staffing guidelines which facilitate the optimal use of all staff members. Although these guidelines should be helpful in an ALF, they are even more important in an extended congregate care facility because of the additional services which must be provided.

- 1. Utilize peak and variable staffing techniques to respond to variations in demand for staff time.** Staff members should be scheduled according to the demand for services. That is, during heavy service times, additional staff should be scheduled to adequately meet the demand.

- 2. Expand staffing capacity and increase flexibility by reducing task/job segmentation.** Staff members can be cross-trained to allow them to provide a variety of non-licensed services (e.g., housekeeping, laundry, personal care, activities). This will facilitate greater flexibility in the development of staff schedules. Cross-training may also reduce the number of staff members needed by increasing the tasks which each individual is able to perform.
- 3. Focus staff efforts on resident priorities.** If residents indicate that they do not want and/or need particular services, staff should determine whether repeated attempts to provide the services are warranted, and if so, whether other methods of service might be more effective. Resident preferences and priorities should always be incorporated into the service planning process.
- 4. Focus staff efforts on improving the self-care abilities of residents.** Residents should be encouraged to do as much for themselves as is possible, and should be assisted in developing or maintaining the skills needed to perform tasks independently. Staff members should accept less-than-perfect task performance from residents, and should provide residents with positive feedback for any completed task segments. Whenever possible, staff should only start or complete tasks for residents, instead of carrying out the entire task.
- 5. Encourage staff autonomy to improve the performance of job tasks.** Staff members should be involved as much as possible in assessment and service planning activities. Such involvement will provide staff members with added insight into why and how services should be provided; which in turn, should lead to an increased effectiveness in the provision of resident services.

**ECC  
Requirements  
for Staffing**

Based on the number of residents, all ALFs are required provide enough staff to meet the minimum weekly hour requirements as outlined in rule. In addition, all ALFs must ensure they provide sufficient staff to adequately meet the needs of the residents.

Although ECC facilities must meet the same minimum hourly staffing requirements as standard ALFs, many ECC facilities typically need to provide more staff as ECC residents generally have greater service needs. Therefore, the staffing requirements for an ECC facility are primarily based on not only the number of residents, but also the amount and type of service provided to those residents.

In addition to the minimum staffing requirements of a standard ALF, ECC facilities are required to meet the following staffing requirements:

- ❖ Specify a staff member to serve as the Extended Congregate Care Supervisor, if the administrator does not perform this function. If the administrator supervises more than one facility, he/she must appoint a separate ECC supervisor for each facility holding an ECC license.
- ❖ Provide by staff or by contract, the services of a nurse who shall be available to provide nursing services as needed by ECC residents, participate in the development of resident service plans, and perform monthly nursing assessments.
- ❖ Provide enough qualified staff to meet the needs of ECC residents and the amount and type of services established in each resident's service plan.
- ❖ Regardless of the number of residents, provide awake staff as necessary to meet scheduled and unscheduled resident night needs.

If a facility has been determined to require more staff due to an inability to meet the needs of the residents as outlined by their service plans or due to a lack of qualified staff, the Agency for Health Care Administration may require the facility to immediately provide additional or more qualified staff.

### **ECC Supervisor Requirements**

The ECC supervisor is responsible for the general supervision of the day-to-day management of an ECC program and ECC service planning.

The ECC supervisor must have a minimum of 2 years managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or

acute care setting or agency serving elderly or disabled persons. A baccalaureate degree may be substituted for one year of the required experience. A nursing home administrator licensed in under chapter 468, F.S., is considered qualified.

The ECC supervisor or administrator, must also successfully complete ALF Core Training and the 6 hour Extended Congregate Care Initial Training offered by the Department of Elder Affairs. Core training is a prerequisite to the ECC training. The ECC training must be completed within 3 months of beginning employment in the facility as an administrator or ECC supervisor.

Once the initial training has been completed, the administrator or ECC supervisor must obtain an additional 6 hours of continuing education training every 2 years in areas related to extended congregate care.

**ECC Nursing Requirements**

ECC facilities are required to provide by contract or as staff, the services of a licensed nurse to meet the needs of the residents. While there is no limitation on the type of nursing license required, nursing services must be provided in accordance with Florida nursing practice. This may mean that certain nursing services can only be provided by nurses holding at least an RN license.

**Direct Care Staff Requirements**

In addition to the standard ALF staff training requirements, ECC direct care staff must receive 2 hours of in-service training within 6 months of beginning employment in the facility. The training must address the extended congregate care concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This training should be conducted by the facility's ECC supervisor or administrator who has attended the 6 hour ECC training course.

## **CHAPTER 4**

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# **ASSESSMENTS, SERVICE PLANNING & THE CONCEPT OF SHARED RESPONSIBILITY & MANAGED RISK**

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### **INTRODUCTION**

Shared responsibility and managed risk are important concepts in the implementation of an ECC program. Through the effective implementation of shared responsibility and managed risk, residents are able to maintain control over their lives while minimizing any potential negative consequences.

To successfully implement these concepts into the day-to-day operations of an ECC program, providers must consistently conduct effective assessments, develop ongoing service plans, and keep accurate documentation.

This chapter will outline the steps involved in accurate and effective assessments of residents; the service planning process and requirements for service planning; and, finally, the concepts of shared responsibility and managed risk, with practical guidelines provided as to the effective implementation of these concepts.

### **ASSESSMENTS**

The assessment process is an important part of an ECC program. Resident assessments are conducted both prior to admission, and throughout the entire residency to identify resident needs. Assessments establish the baseline information about residents, which can then be used to identify and measure any changes which occur in the status of residents. In addition, the assessment process enables facilities to estimate the anticipated costs and staffing needed for the provision of the identified services. This allows facilities to be adequately prepared to meet residents' needs and preferences.

## **Initial Assessment**

Prior to admission to an ECC program, the ECC supervisor must conduct a preliminary assessment which includes a determination of a potential resident ability to meet facility's ECC residency criteria, an appraisal of the resident's unique physical and psycho social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs. This assessment becomes the basis for the preliminary service plan, and eventually lead to the development of the resident's written service plan if the resident is accepted for admission.

ECC facilities should establish specific, uniform procedures for conducting and documenting resident assessments. The following are some guidelines for establishing a standardized assessment tool:

- 1. Make a list of the types of services provided in the ECC facility.** The first step in the development of a standardized assessment tool is to list all of the services which the facility is able to provide. This list should take into account the allowable services, facility's staff, and staffing patterns.
  
- 2. For each service listed, identify the range, scope and intensity of services the facility is willing and able to provide.** With each of the services listed, a facility should specify the types of assistance which is available to residents. For example, when addressing meal service, the following expanded list could be developed:
  - ❖ Tray or room service (on demand?)
  - ❖ Scheduled meal service (table-waited?)
  - ❖ Special diets (diabetic/therapeutic?)
  - ❖ Escort service (verbal/physical?)
  - ❖ Eating assistance (verbal/physical?)
  - ❖ Food preparation (puree, cutting?)

This list should be as specific as possible, identifying the range, scope and intensity of all services which will be provided in the ECC facility.

- 3. Utilize your list of available services to develop a written assessment tool.** A written assessment tool which permits an evaluation of the services the facility provides with the needs of the resident should be developed and utilized for each potential

admission. It should focus on a resident's functional abilities and the relationship of these abilities to their service needs. In addition, this tool should facilitate consistency in all assessments conducted. By using an assessment tool, the facility will be able to determine what tasks residents are able to perform and what tasks the resident will require assistance or total help with.

## **Assessment Procedures**

Once a standardized assessment tool has been developed, staff members should be able to utilize the assessment tool in the assessment process. The following steps should be followed when assessments are performed:

- ❖ **Involve residents and their significant others in the process.** Resident involvement is crucial to an effective assessment process in order to accurately identify service needs and preferences. If residents are not competent to assist in the assessment process and/or want others to participate in the process, their significant others, (e.g. spouse, adult child, friend, etc.) should be involved in the assessment process.
- ❖ **Gather Information face-to-face.** Assessments should always be conducted in person with the resident and/or their significant others. Assessments may be conducted either at the facility or at the resident's current residence. Meeting with potential residents in person is critical in determining appropriateness of placement. In many cases, meeting a potential resident in person is the only way of obtaining an accurate perspective of the resident's condition or service needs.
- ❖ **Ask the residents and/or their representatives which services are needed or preferred.** The standardized assessment tool should be utilized in conducting the assessments, to determine what services the residents need and/or prefers. The residents and/or their representatives should be asked about each service listed on the assessment form. Detailed information should be gathered about the type and intensity of assistance needed in each service category.

A determination should also be made as to whether a service need is based on a personal preference

(he/she doesn't want to cook anymore), or is due to a functional limitation or disability, (e.g., is unable to meet his/her nutritional needs because paralysis limits his/her arm and hand use).

- ❖ **Be sensitive to resident concerns.** In conducting assessments, it is crucial that sensitivity be demonstrated to the residents. They may be embarrassed or feel uncomfortable discussing their service needs, particularly in personal care areas such as bathing or toileting. Residents must be treated with acceptance and respect throughout the entire assessment process. A sufficient amount of time should be taken in conducting assessments to allow residents to feel at ease and comfortable in sharing their needs and concerns.
- ❖ **Gather information from collateral sources.** After all appropriate information has been gathered directly from the residents and/or their representatives, additional information should be collected from third-party sources. For example, residents' physicians, social workers or discharge planners may be able to provide pertinent information about the residents, which may be helpful in identifying their service needs and preferences. If a resident is being transferred from another facility, hospital, nursing home, or within the same facility, information should be gathered from the transferring institution. In all cases, authorizations for the release of information must first be obtained from the resident. All pertinent information by third party sources should be incorporated into the assessment process.

## **SERVICE PLANS**

The process of service planning is an important element in extended congregate care. Through service planning, residents' needs and preferences are identified and documented in an effective and organized manner. Service priorities are also determined through the planning process. This helps to ensure appropriate direction for staff members to perform needed services effectively.

### **Preliminary Service Plan**

Prior to admission to the ECC program, the ECC supervisor shall develop a preliminary service plan based on the information gathered from the initial assessment of the potential ECC resident. As stated above, this includes the facility's admission criteria; the appraisal of the resident's unique physical and psycho social needs and preferences; and an evaluation of the facility's ability to meet the resident's needs.

### **Service Plan Requirements**

Once a resident is admitted to an ECC program, the ECC supervisor must coordinate the development of a written service plan within 14 days of admission.

If required by the resident, the service plan should address the following:

- ❖ Health monitoring.
- ❖ Assistance with personal care services.
- ❖ Nursing Services.
- ❖ Supervision.
- ❖ Special diets.
- ❖ Ancillary services.
- ❖ The provision of other services such as transportation and supportive services.
- ❖ The concept of "shared responsibility" and "managed risk."
- ❖ The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences

### **Developing a Service Plan**

ECC facilities should establish a standardized process and format for the development of service plans. Standardizing the process will help to ensure consistency and thoroughness in all service plans. The guidelines outlined below will be helpful in developing an effective service planning process:

- 1. Tie the service plan directly to identified needs and preferences.** A primary purpose of the service planning process is to develop specific plans which will meet the needs and preferences identified through the assessment process.
- 2. Involve residents and their significant others in the service planning process.** Facilities are required to have policies and procedures that ensures that residents or family members are actively involved

in the development and implementation of service plans. This requirement enables residents to have their needs met in a manner which they prefer.

- 3. Use specific and detailed language on all service plans.** Service plans should be concrete and specific to facilitate a personalized approach to all services provided. For example, a mildly confused resident might need reminding of meal times. Although this statement identifies the service need, the plan should specify details as to how and when the service should be performed. The plan should also include any resident preferences related to the particular service.
- 4. Create a defined set of expectations regarding the delivery of services.** Service plans should be concrete enough to ensure that residents will receive the same service, regardless of the staff member providing the assistance. All service needs identified through the assessment process should be specifically addressed on service plans. The following items should be addressed:
  - ❖ Who will perform the service.
  - ❖ What specifically will be done.
  - ❖ When, where, and how the service will be done.

For instance, if a resident needs assistance with bathing, the plan should not simply say, "assist with bathing twice a week." It should detail the specific assistance needed and/or preferred. Thus, the plan might state, "Assist with bathing every Tuesday and Friday A.M., in his/her unit; provide support in getting into and out of the shower; wash his/her back; stand-by for additional assistance if requested.

- 5. Support ECC values through the service planning process.** The dignity, choice, independence and decision-making of all residents should be promoted through the service planning process. The manner and method in which all services are provided should support and maximize each of these values. The service plan should also reflect the commitment of ECC to provide services in a home-like environment with the least amount of restrictions possible.

- 6. Establish service priorities and preferences.** Through the service planning process, the provision of services can be prioritized. This will facilitate an effective organization of the tasks and responsibilities required of staff members.
- 7. Identify expected outcomes.** The expected outcomes for each service identified on service plans should be specified. This will allow staff to determine if the services provided are effective in meeting the residents' needs. For example, the expected outcome of a resident's adherence to a low-fat diet might be to lower his/her cholesterol level. The cholesterol level could then be monitored to determine the effectiveness in achieving the expected outcome. Other examples of expected outcomes might include an increase in socialization or a decrease in episodes of incontinence.
- 8. Incorporate the service plan into the resident's record.** Service plans should be maintained in the resident's records. Current service plans should be easily accessible so staff members can use the plans as a guide in performing their required tasks and responsibilities.

### **Updating Service Plans**

As residents continue to age in place, residents may experience deterioration in physical or mental functioning that may require modification of the service plan. In other cases, a resident's preference may change. To accommodate these changes, service plans need to be reviewed and modified periodically.

Service plans must be reviewed and updated at least quarterly to reflect any changes that in the manner of the service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment.

Residents, ECC supervisors, and the ECC nurse, should initial and date the service plans to demonstrate that the plan has been reviewed and agreed upon by all parties involved.

## **SHARED RESPONSIBILITY & MANAGED RISK**

Shared responsibility and managed risk are important concepts in the successful extended congregate care program.

### **Shared Responsibility**

Shared responsibility means “exploring the options available to residents 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.”

In other words, there is a mutual agreement about the levels of responsibility both the resident and the provider have in regards to decisions made by the resident. This concept enables residents to exercise greater control over their own lives.

### **Managed Risk**

Managed risk means “the process by which the facility staff discuss the service plan and the needs of the resident with resident and, if applicable, the resident’s representative or designee, 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.

Managed risk advocates a formal process of negotiating a service which addresses residents’ decisions while decreasing the probability of poor outcomes or adverse consequences.

### **Making Shared Responsibility & Managed Risk Work**

By incorporating the concepts of shared responsibility and managed risk into the service planning process, ECC providers will find it easier to meaningfully empower residents. However, it typically takes some practice to identify and respond skillfully to situations which involve risk or conflict arising from resident’s choice or decision-making. The key to successful implementation of shared responsibility and managed risk is to:

**1. Learn to assess the degree to which choices, if executed, will result in undesirable outcomes.**

Outcomes are undesirable if they:

- ❖ **Place an unwarranted burden on the resident, other resident, and/or the provider.** Some resident decisions, if acted upon, would be unfair to either the resident or other involved parties. For example:

A resident expresses a desire to shower at night, but is told by staff that he/she can't because staff members are too busy at that time, an unwarranted burden on the resident is present. The undue burden results from the failure of staff members to try to accommodate a reasonable request. The facility must evaluate the importance of the resident's preference to him/her in light of the economic burden the implementation of the preference would place on the facility.

A resident is afraid and asks staff to stay with him/her but won't come out of his/her unit, the resident's request places an unwarranted burden on other residents. Execution of the request would unduly occupy staff time which would be unfair to other residents.

A resident wants only "white" people to take care of him/her, the resident's preference places an unreasonable - and illegal - burden on the provider, as a facility cannot arrange staffing around the request of one resident.

- ❖ **Violate societal or personal norms.** Some resident decisions, if executed, would violate societal norms, such as appropriate sexual behavior (e.g., a resident who chooses to drink and then becomes sexually suggestive with female staff members).

Other choices may violate the personal norms of either the resident or other individuals. For example, if a resident chooses to maintain poor grooming and as a result, has strong body odor, he/she may violate the norms of other residents

who may refuse to sit with him/her during meals because they are offended by his/her odor.

**2. Learn to distinguish between normal negotiation of services/intervention and the need for formal managed risk agreements.**

Managed risk agreements should be utilized when the execution of a resident decision may place the resident or others at risk for adverse consequences. The need for formal managed risk agreements can be assessed by evaluating the following factors:

- ❖ **The severity of any negative consequence for the resident, other residents and/or the provider.** To determine if a managed risk agreement is appropriate, staff members should assess the impact which any adverse consequences of a resident's choice may have on the resident and/or others. For example, if a resident who is diabetic and an alcoholic refuses to adhere to his/her prescribed diet, he/she may experience insulin shock. In this case, the severity of this consequence should warrant a managed risk agreement.
- ❖ **The immediacy of any negative consequence for the resident, other residents or the provider.** The immediacy of any adverse consequences should be considered when evaluating the need for a formal managed risk agreement. For instance, if a resident is a careless smoker who frequently drops cigarettes in his/her unit, the consequence of his/her actions could be very immediate (e.g., could start a fire in the building).
- ❖ **The impact of any negative consequence on the resident, other residents or the provider.** Resident choices which may have a severe impact on the resident and/or other individuals may warrant a formal managed risk agreement. For example, if a confused resident has a history of wandering, and is allowed to leave the facility unsupervised, the possibility exists that the resident could cross the street in traffic and be struck by a car. The impact of this consequence on the resident would obviously be quite severe.

- 3. Learn to distinguish between the roles of an "enabler" and a "preventor."** Staff must be able to differentiate between "enabling" and "preventing," and should be capable of determining the circumstances in which each of these roles is appropriate.

An "enabler" supports and/or collaborates with residents to allow them to execute their decisions. Enabling would be helpful in a situation where a confused resident is restless and wants to socialize during the middle of the night. Staff members could assist the resident in finding a means by which he/she could execute his/her preference.

On the other hand, a "preventor" denies or removes opportunities for residents to express their decisions. Such a role is necessary when the probable consequences are of an extreme and negative nature. For example, "preventing" might be appropriate if a resident wants to go into another resident's room to retaliate because he/she believes that resident has taken something from their room. Staff may prevent this behavior and redirect the resident to a more acceptable manner to confront the accused.

- 4. Learn to assess the likelihood that the resident is a fully-informed decision-maker.** Staff members should be capable of determining whether residents have complete information regarding their decisions. In making such a determination, several factors should be considered:

❖ **Situation-specific competency.** The decision-making ability of residents may vary, depending on the situation. Staff should take all influencing factors into consideration when making a determination of a resident's competency to make decisions and/or act on his/her preferences. For example, if a resident is experiencing delusions because of a urinary tract infection (UTI), he/she is probably not capable of making and executing appropriate choices at that point in time. However, after the UTI has cleared up, the resident might be highly competent in defining his/her preferences and acting on those choices.

- ❖ **Delineation of options with attendant benefits and risks.** Staff members must assess the degree to which residents are fully aware of their options and the benefits and risks associated with each alternative. This will be influenced by their levels of functioning (i.e., the ability to process information) and the quality/quantity of pertinent information which has been presented to them.
- 5. Learn to evaluate accurately the sources of concern and how to mediate them.** All issues regarding resident decisions must be assessed to determine the sources and validity of the concerns. Specifically, staff members must learn to evaluate whether a resident's choice poses a threat to:
- ❖ **The well-being of the resident, other residents, or to the professional doctrine of "best interest."** Staff members must be sensitive to issues which threaten professional judgements of what is best for residents. For example, a resident may refuse to bathe for two months and may then tell the nurse to leave him/her alone. Professional doctrine would typically assert that it is not in the resident's best interest to allow him/her to go without bathing. However, staff members must evaluate whether the resident's refusal to bathe is actually posing a threat to his/her well-being or is simply threatening what is thought to be a "professional" response to the situation.
  - ❖ **The well-being of the resident or the facility's image.** In some situations, a resident's preference may not pose an actual threat to the resident's well being. However, the decision may threaten the public's image of the facility. For example, if a resident prefers to wear four layers of clothing at one time, his/her preference will typically not cause him/her any undue harm. However, staff members may be concerned about the opinion of the facility visitors or family members might have if the resident is observed in what is usually considered inappropriate clothing.

- ❖ **The well-being of the resident or to the stereotypical, patronizing view of the elderly/disabled.** Our society holds many stereotypes of the elderly and disabled. These stereotypes, which are often of a negative and patronizing nature, may have a subtle impact on the willingness of staff to support the decisions and preferences of residents. For example, if two residents wish to become romantically involved, staff members and/or their families may view such involvement as "inappropriate" and may try to prohibit any romantic or intimate behavior from occurring.

## CHAPTER 5

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### LICENSE REQUIREMENTS

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All Extended Congregate Care facilities in the State of Florida must be licensed by the Agency for Health Care Administration (AHCA). Licenses may be issued either to new facilities or to existing facilities holding a current ALF license.

Only that portion of a facility that meets ECC physical site requirements and is staffed in accordance to ECC staffing requirements can be considered eligible for an extended congregate care license.

#### **New Facility**

A new facility may apply for an ECC license when applying for the initial standard ALF license. To be eligible for an ECC license, the facility must meet all of the standard ALF license requirements.

A provisional license issued pursuant to an initial application for license shall *not* be considered equivalent to a standard license for the purposes of the issuance of an ECC license.

#### **Existing Facility**

Existing facilities qualifying to provide extended congregate care must have maintained a standard license and not have been subject to administrative sanctions during the previous 2 years or since initial licensing, for any of the following reasons:

- ❖ A class I or II violation.
- ❖ Three or more repeat or recurring class III violations of resident care standards from which a pattern of noncompliance is found by AHCA.
- ❖ Three or more class III violations that were not corrected in accordance with the corrective action plan approved by AHCA.
- ❖ Violations of resident care standards resulting in a requirement to employ the services of a consultant

pharmacist or consultant dietitian.

- ❖ Denial, suspension, or revocation of a license for another facility in which the applicant for an ECC license has at least 25% ownership interest.
- ❖ Imposition of a moratorium on admissions or initiation of injunctive proceedings.

A provisional license issued pursuant to a change of ownership application can be considered equivalent to a standard license for the purposes of issuing an ECC license.

### **License Application**

To apply for an extended congregate care license, a facility must complete and submit an application, including the portion on extended congregate care. Applications may be obtained from:

**Agency for Health Care Administration  
Assisted Living Unit  
Division of Health Quality Assurance  
2727 Mahan Drive  
Tallahassee, FL 32308-5403  
(850) 487-2515**

Like standard licenses, ECC licenses must be renewed every two years.

### **License Fees**

In addition to the license fees for a standard ALF, the Agency for Health Care Administration will require payment of an ECC license fee per facility. All fees must be paid at the time of license renewal.

Fees for facilities already holding a standard license who are applying for an ECC license during the 2-year biennial period will be prorated in order to have the have the ECC biennial license renewal come due at the same time as the facility's standard license.

License fees for extended congregate care are adjusted annually in keeping with the average rate for inflation. The application package will provide information on the current fee. There is no per bed fee associated with the ECC license.

**Monitoring  
Visits**

ECC facilities are subject to biennial surveys as are all ALFs. In addition, a registered nurse from AHCA will visit ECC facilities at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with the rules pertaining to ECC facilities. One of these visits may be in conjunction with the regular biennial survey.