FLORIDA HEALTH CARE ASSOCIATION

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PULSE

A PUBLICATION FOR FLORIDA'S LONG TERM CARE COMMUNITY

Governor Scott signs generator legislation

On March 26, Governor Rick Scott signed HB 7099 and SB 7028, which make permanent the emergency rules requiring every nursing center and assisted living facility (ALF) in Florida to have emergency generators to keep residents safe.

Governor Scott said, "Florida is one of the first states in the nation to require emergency generators at nursing homes and ALFs, and I appreciate the work of Senate President Joe Negron, House Speaker Richard Corcoran, and all the legislators who supported this important legislation. As we near the 2018 hurricane season, families can now know the facilities responsible for caring for their loved ones will have the resources needed to be fully prepared ahead of any potential storms."

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Forward momentum

It's been a long and challenging road for the Association and our members over the past six months. From the aftermath of Hurricane Irma to the threats we faced in the Legislature and the Constitution Revision Commission (CRC), it was as if the roller coaster ride was never going to come to an end.

By John Simmons, NHA, MSW
FHCA President

And while we know there will always be challenges in this profession, it's good to have closure — or at least certainty — in the areas of generators, as well as legislation and proposed amendments that threatened to expand lawsuits against us.

By now you have likely read our 2018 Legislative Wrap Up and know the outcomes of the session. Increased Medicaid funding, generator rule ratifications and legislation that focused on resident care and improved operations were a big reason *Florida Politics* named FHCA as one of the "winners" during the 2018 session. Shortly thereafter, CRC Proposal 88 was withdrawn and Proposal 54 was amended so nursing centers were no longer in the crossfire of this governing body.

And while we can never take our hands off the wheel, it's good to move forward with positive momentum as we shift gears toward a series of professional development opportunities.

By the time you read this article, FHCA will have hosted its annual Quality Symposium, with much of its focus on solutions for our workforce needs. If you missed the event, you can rest assured that you'll have similar sessions to choose from during our signature event, FHCA's 2018 Annual Conference & Trade Show.

Set for July 15-19 at The Diplomat Beach Resort in Hollywood, this year's Annual Conference is shaping up to be another success. ACC Chair Julie Morris and her team have lined up a dynamic list of speakers with sessions designed for professionals at all stages in their long term care career. Topics run the gamut — from clinical/care practices, finance/development, legal/regulatory/survey and operations/quality improvement. We'll also host an assisted living day with four dedicated sessions, and full Conference registrants will receive a free copy of the required Medical Errors course. This, along with over 61 educational sessions and the potential to earn up to 24 contact hours, is the reason FHCA's Annual Conference & Trade Show is the leading event in the southeast. Check out all the details at www.fhcaconference.org, where you can also register and reserve your hotel room beginning in April.

And for your nurses, you'll want to make sure they attend FHCA's Nurse Leadership Program in St. Pete Beach (May 31-June 1 at the Don CeSar Hotel). This is the leading clinical care conference in our state and an excellent way for them to network with their colleagues while also learning about the new survey process, the CMS Mega Rule, elopement prevention and other regulatory topics. Nurses are our leaders on the front line, and keeping them informed of what's developing in our profession is critical to helping maintain and enhance our continuous quality improvement.

As you can tell things never slow down at FHCA. The staff operates at full speed throughout the year, whether its advocating for our issues or planning high-quality educational offerings. We're always moving forward — focused, strategic and with a momentum that ensures our success.◆

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by J. Emmett Reed, CAE
FHCA/Our Florida Promise Executive Director

From tragedy to triumph

It was one of those, "do you remember where you were when..." moments. It was an early September morning and I had just finished shaving when I noticed a text come through over my cell. I wouldn't normally take a call at that time, but just days before Hurricane Irma had pounded our state, and all of us at FHCA were on call 24-7 throughout the storm.

The text alluded to the tragedy in Hollywood Hills. My heart sank. As the day went on the news got worse; the death toll continued to climb. Like all of us I tried to understand how this could happen, a question that has yet to be answered as part of the ongoing criminal investigation into the tragedy.

The story dominated the news for weeks. The issue sadly, but predictably, became a political football.

Our profession was under assault 24/7. FHCA withstood months of intense calls from reporters looking for someone to blame.

It didn't matter that our members delivered over 68,000 residents and patients safely through the storm, nor that Hollywood Hills was not a member of our Association. To this day, I believe that had they been a member, maybe, just maybe, they would have availed themselves to the numerous training opportunities we offer. This is one case where the return on membership investment is now higher than anyone could have imagined.

Amidst the intense scrutiny of the press and rhetoric from personal injury lawyers, Governor Scott issued emergency generator rules, with a 60-day deadline that made it difficult, if not impossible, to meet.

With so much at stake to achieve compliance, FHCA took immediate action. We hosted an Emergency Preparedness Summit to bring together experts from the generator and fuel industries, local governments, legislators and regulators to discuss a realistic approach to accomplish the Governor's goal.

In the weeks following, the concern from members grew as compliance was impossible in the timeframes outlined. FHCA was thankful the administration, Agency for Health Care Administration and Department of Health provided us with numerous opportunities to communicate concerns and offer solutions that would not only ensure compliance could be achieved safely and timely, but also strengthen the procedures to keep residents safe during disasters.

It almost didn't happen that way.

Soon after the Governor issued the Emergency Rules, every association representing long term care filed legal challenges. Every association that is, except the Florida Health Care Association.

FHCA leadership instead chose to remain steady on the path to finding solutions, to maintain open communication and do what is right by our residents. We worked hard, listening to member's concerns and relaying them to all the stakeholders throughout this process. It was the right decision.

Eventually, the other associations that challenged the rule came to the table.

I would be remiss if I did not take a moment to discuss Governor Scott's performance during this entire time. As a fifth generation Floridian, I have been in this state for every hurricane since 1969; I've even ridden a few out. I have seen the work of several governors throughout those storms and am proud of how they handled themselves.

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FAMILY FORUM

"We have had such a great overall experience with St. Andrews Bay and would recommend it to anyone. From the minute I walked through the doors, I liked the presence, from the sweet daily receptionist [to the CNAs]…they represent well, wonderful caretakers. Our most favorite nurse is Ms. Bonnie, very knowledgeable and has a heart for her patients. …You have a great crew at St. Andrews Bay and I am so thankful I don't have to worry about my Mom there. Thank you for listening and being my eyes and ears when I cannot be."

— Paula H, daughter of Miriam B. to the team at St Andrews Bay Skilled Nursing and Rehabilitation Center in Panama City.

Preventing elopement in the assisted living facility

By Karen Goldsmith

Last year, Florida Health Care Association established a Risk Management/Compliance Council (Council) to study elopement and create tools that members could use for helping to prevent elopement of vulnerable residents. As part of my responsibilities to the Council, I researched the law relative to assisted living facilities (ALFs).

While we work toward finalizing the tools and developing education, I wanted to share some of what I learned in the short term.

Elopement in the ALF can be much different than in a nursing center, or it can be much the same. This depends on the makeup of the facility's residents, the building and the staff. The new regulations applicable to nursing centers require the provider to complete a facility assessment. Even though there is no similar requirement for ALFs, they can use this concept to assist in developing policies and procedures to avoid elopement and address it when it occurs.

I recommend every ALF provider look at the facility assessment provisions found in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual (available in the Survey Readiness section of FHCA's website). Take from it the elements which would pertain to your ALF. Although not required to prepare a facility assessment, doing so helps an ALF focus on the aspects of the facility that are critical to preventing elopement.

Start with the basics

58A-5.0131 (14), F.A.C. defines elopement as …"an occurrence in which a resident leaves a facility without following facility policies and procedures." First, the ALF must have policies and procedures. Because of the diverse characteristics of member facilities, these policies and procedures cover a broad spectrum.

Below are some characteristics of a facility's operation and examples to consider when writing policies and procedures for prevention:

- Location — is the facility on a busy street, is there water behind the building, such as a lake, swamp or retaining pond? Characteristics like this must be evaluated when designing policies and procedures.
- Building — is it two-stories with an elevator that opens into a busy lobby? The building structure will play a part as well.
- Do you have an alarm system?
- Facility population — are the residents young with the need for minimal supervision? Do some suffer from memory loss? Do some routinely leave the premises for socialization with friends or family?
- How do you maintain knowledge of where residents are when they are not on the premises? 58A-5.0182 requires a "general awareness of [your] resident[s] whereabouts" and recognize the resident's right "to travel independently in the community." Of course, a facility would not allow a resident with cognitive impairments to leave the building unsupervised; that is not what the requirement states. Rather, the facility should have a system for knowing where even the most independent resident has gone. The facility should have procedures in place for contacting that resident while he or she is not on site.
- An assessment of the resident for elopement is required by 58A-5.0182. With many residents, the assessment should include a thorough assessment of his/her ability to travel independently. This is an important part of the facility's process and should be included in the policies and procedures and enhanced by your practices (see below for specific case studies).
- Supervision and support should be identified as needed, and follow-through is important.
- Facilities are required to have two resident elopement drills per year. See F.S. 429.41(1)(a)3 for detail.
- Residents at risk or with a history of elopement must be identified so staff can be aware of their needs for supervision.
- Facility policy must include photo identification for those residents assessed at risk for elopement or with a history of elopement.

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Karen Goldsmith of Goldsmith & Grout, PA serves as FHCA's Regulatory Counsel. Her office is located at PO Box 875, Cape Canaveral, FL 32920. She is available to members by phone at (321) 613-2979 or e-mail at klgoldsmith@ggfllawfirm.com.

Nursing center discharge and transfer

"Dumping" or discharge

By Deborah Franklin

AARP and the Long Term Care Ombudsman have indicated to the Centers for Medicare and Medicaid Services (CMS) that there is an issue in the nation that nursing centers are "dumping" patients who complain or have a high cost of care. If your nursing center was surveyed on your discharges, which story would your documentation tell? Would it be a discharge or a "dump"?

The National Ombudsman website states: "Transfer and Discharge continues to be one of the top complaints that ombudsmen report encountering, and these cases can be complex and extremely time consuming. The threat of transfer or discharge from a nursing home can be both frightening and stressful for residents and their families. Too often, a facility may respond to resident's difficulties or increasing need for care or repeated questions or complaints from family members by transferring or discharging the resident. The Nursing Home Reform Law of 1987 protects residents from involuntary transfer and discharge." Despite these protections, discharges which violate federal regulations continue to be one of the most frequent complaints made to State Long Term Care Ombudsman Programs. CMS has begun an initiative to examine and mitigate facility-initiated discharges that violate federal regulations.

The facility requirements under 483.15 is that each resident is permitted to remain in the facility and not be transferred or discharged unless: it is necessary for the resident's welfare and the resident's needs can't be met in the facility; the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; the safety of others is endangered; the health of individuals in the facility would be endangered; the resident has failed, after reasonable and appropriate notice, to pay for or to have paid under Medicaid or Medicare, a stay at the facility or the facility ceases to operate.

The regulation at 42 CFR 483.15 requires that before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must also send a copy of the notice to Ombudsman. Each facility should contact their local Ombudsman office to determine if they want each form or a list monthly. When the facility transfers or discharges a resident, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation must include the basis for the transfer. If it is because their needs cannot be met, the facility must document how they attempted to meet their needs and the need must be able to be met at the receiving facility.

Facility-initiated transfer or discharge means a transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

Resident-initiated transfer or discharge means the resident, or the resident representative, has provided verbal or written notice of intent to leave the facility. This does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.

Transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected. Transfer and discharge includes movement of a resident to a bed outside of the certified facility, whether that bed is in the same facility or not. Transfer and discharge does not refer to movement of a resident within the same certified facility.

When the surveyor is investigating a discharge or transfer, they must ensure the facility has fully evaluated the resident and does not base the discharge on the resident's status at the time of transfer to the acute care facility. The resident must be re-evaluated if his or her condition improves to return to the nursing center.

"The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless…." means that once admitted, for most residents other than short-term rehab

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Deborah Franklin is FHCA Senior Director of Quality Affairs. She can be reached at dfranklin@fhca.org.

Constitution Revision Commission update

By Bob Asztalos

Every 20 years, a Constitution Revision Commission (CRC) is appointed to review Florida's Constitution, hold public hearings across the state and recommend for voter consideration proposed changes to the Constitution. Florida is the only state with such a mechanism. Two proposals were offered by CRC members which impacted Florida's long term care profession.

Proposal 88 enumerated a specific set of rights for residents of nursing centers and assisted living facilities in the Constitution. If passed and approved by the voters, this proposal would have created a new section in the Constitution to establish a "bill of rights" with expanded litigation for residents of nursing centers and assisted living facilities in Florida.

FHCA members, including administrators, frontline caregivers and residents, turned out across Florida to speak during the CRC public hearings

A second proposed amendment, Proposal 54, eliminated Certificate of Need (CON) for all health care institutions in Florida, including hospitals, nursing centers, hospices and intermediate care facilities for individuals with developmental disabilities.

Throughout the process, the CRC afforded FHCA numerous opportunities - through committee meetings and public hearings - to discuss our concerns about the devastating impact these proposals would have on Florida nursing centers and assisted living facilities. FHCA members played an important role in sharing their stories with the CRC about the high-quality care and comfort they provide to residents every day. Their commitment to that exceptional care did not go unnoticed.

After passing its initial committee and facing opposition from long term care providers across the state, the sponsor of Proposal 88 withdrew it from consideration during the Commission's floor debate.

During its floor debate, the sponsor of Proposal 54 offered a major revision in which the provision would only apply to counties where a hospital's infection rates fall below the average. Thus, the language to eliminate CON no longer applied to nursing centers, hospices and intermediate care facilities for people with developmental disabilities. At press time, Proposal 54 was officially withdrawn, officially ending FHCA's work with the Constitution Revision Commission.

Both of these issues have been addressed in previous Legislatures, and we believe that is the proper place for these types of discussions. We appreciate our members for extending their advocacy beyond our legislative priorities to the Constitution Revision Commission (CRC). As it stands now, our work with the CRC is complete. With the legislative session and CRC activity behind us, we can continue our focus on working with lawmakers, regulators and other stakeholders on policies that prioritize resident care.◆

Bob Asztalos is FHCA's Chief Lobbyist. He can be reached at basztalos@fhca.org.

LONG TERM CARE

Business News

By Lorne Simmons, Moore Stephens Lovelace

Tax reform and the generator rule

As of the penning of this article, the new "Generator Rule" (The Rule) for skilled nursing facilities (SNFs) has been ratified by the Legislature and signed by the Governor, requiring compliance from all skilled nursing facility providers by June 1 of this year. We've heard from several providers asking about the impact of Public Law 115-97 (the Tax Reform) and depreciation guidelines for asset investments. Certainly, one way to recoup the investment in tangible property faster is by taking advantage of the benefits of the tax depreciation. In general, tax depreciation results in additional deductions against a taxpayer's taxable income, which results in less income tax to be paid at the end of the day.

The amount of the tax depreciation depends on several factors, such as the property's acquisition value, useful life and recovery period, the allowable depreciation method and other deductions which allow for an accelerated write-off of the cost of investment, such as the Bonus Depreciation and Section 179 deductions. Some major acquisitions, such as power generators, have allowable recovery periods of 15 years or more. The application of the Bonus Depreciation and Section 179 deduction allows for higher deduction in the acquisition year and therefore recoups faster the cost of the investment. The benefits are even greater when we consider the time value of money.

With the enactment of Tax Reform, the Bonus Depreciation is yet more attractive as it allows for 100% write-off (previously 50%) of the cost of qualified property placed in service after September 27, 2017. Generally speaking, property qualifying for Bonus Depreciation includes tangible property with useful life of 20 years or less and certain qualified improvement property, whereas property qualifying for a Section 179 deduction includes personal property and certain qualified real property placed in service after December 31, 2017.

For instance, generators installed and attached to a structure are considered real property with a useful life of more than 20 years except power generators with a rated total capacity of more than 500 kilowatts which are usually considered personal property with a recovery period of less than 20 years, hence the latter qualifying for bonus depreciation. Generators not meeting the description above have other alternatives ranging from classification of some or all of the cost of the generator as personal property on the basis that it directly or indirectly supports other personal property, hence qualifying for bonus depreciation.

On the other hand, any portion of a generator which is classified as real property will not qualify for Section 179 deduction since it is not considered qualified property as it is typically installed outside the building structure and the facility is a residential property.

If you placed in service or plan to acquire a power generator, we suggest consulting your tax advisor to confirm the proper classification and determine if it qualifies for Bonus Depreciation.

PPS treatment under New FRV

Recovery of the cost of compliance with The Rule will be more challenging for not-for-profit entities or others that do not qualify or cannot take advantage of the above Tax Reform rules. Under the new Medicaid Prospective Payment System (PPS) effective October 1 of this year, the new Fair Rental Value (FRV) rate component will be calculated based on standardized parameters to determine the economic age and rental value of a facility's assets, not the actual cost of the assets themselves. New renovations or additions, such as generators and other large projects, will be included as part of the weighted economic age of a facility. The economic age of the facility will determine the amount of depreciation that is removed from the calculated rental value of the facility. Renovation and improvement projects costing more than $500 per bed will lower the economic age of a facility and therefore reduce the amount of depreciation applied to the rental value.

Fortunately, the new FRV rate method will in most instances accelerate the recoupment of the investment compared to the current FRV method depending on the size, occupancy and Medicaid utilization. It is important to note that your facility age upon PPS implementation will be based on information you have provided to AHCA by April 30 via the FRV portal on their website. If you have recently purchased additional equipment or upgraded your facility, it is extremely important that you report those assets in the portal by April 30 to get credit for those additional outlays on your initial PPS rate. Even if you have no additional information to report, now is the time for all providers to visit the FRV portal and review all previous submissions for accuracy and completeness. Otherwise, you will have to wait until your next cost report is submitted and AHCA rebases the FRV based on new assets reported on the cost report the following year. For a better understanding of how the cost of compliance with The Rule will impact your individual rate, contact your friendly reimbursement guru to assess your situation.◆

Lorne Simmons and Sandy Swindling are with Moore Stephens Lovelace, P.A., FHCA's CPA Consultant. Learn more about MSL at www.mslcpa.com.

PPS update

By Tom Parker

Effective October 1, 2018, Medicaid nursing center rates are changing to a new Medicaid prospective payment system (PPS). The 2018 Legislature recently passed a budget that included one year in new funding for nursing center rates in a variety of ways, all of which take effect October 1 when the PPS is implemented. The budget includes $102 million in funding for increasing the direct care price level from 100% to 105% of the median, increasing the quality funds from 6% to 8.5% of non-property related costs, and funds to offset increased capital projects cost through the FRVS calculation (this could include, for example, the purchase of a generator). There is an additional $25 million that will increase the overall rates through the budget neutral adjustment. The budget also includes a separate $9.8 million in transition funding to support providers as they prepare the transition to the PPS.

As providers plan for the transition to the new payment system, we wanted to provide a refresher on the key characteristics that make up the PPS. The three major rate components of direct care, indirect care and operating still exist; however, under the PPS, providers will now be paid a percentage of the median cost for other providers in their peer grouping rather than receiving their actual cost. In addition, the direct and indirect components will have a rate "floor" which will ensure funding is used to enhance quality through required spending in those categories. Providers who spend less than the floor will have their reimbursement rates reduced accordingly:

- Direct Care: 105% of the cost median with a floor of 95%
- Indirect Care: 92% of the cost median with a floor of 92.5%
- Operating: 86% of the cost median with no floor

While the major rate components remain the same, there was some change to which costs make up the components. Costs that have the greatest impact on resident quality of life are included in the Direct Care component; costs with a strong impact are included in the Indirect Care component; and costs with less of an impact on resident quality of life are mapped to the Operating component. Most of the current cost mapping already meets these goals; however, changes include moving: a) all therapy and dietary costs to Direct Care; b) complex medical equipment, medical supplies and other allowable ancillary cost centers to Indirect Care, and c) medical records to the Operating component.

The property component is now reimbursed through a system that strongly incentivizes renovations and replacements for aging assets and adequately funds such improvements. The new system takes into account the size of the facility and the adjusted age based on improvements to determine a property rate. It is important providers make sure they have submitted the appropriate data to the Agency for Health Care Administration (AHCA) to capture these projects. Providers can go to the AHCA Fair Rental Value portal at http://ahca.myflorida.com/medicaid/Finance/finance/nh_rates/frvs.shtml to submit information. Submissions must be made by April 31, 2018, to be reflected in this initial rate setting cycle.

The PPS includes a supplemental payment for ventilator dependent patients of $200 per day. This payment is an addition to the per diem that providers already receive. This is the first time Florida has paid providers for delivering care to residents who are ventilator dependent. The issue has long been voiced as something that should be reimbursed at a higher level.

The move to PPS is historical for Florida Medicaid, as it will be the first time nursing centers are financially rewarded for providing high quality of care. The PPS includes a quality incentive payment to providers who score points on a quality matrix. Measures include direct care and activities and social work staffing, overall 5-star rating, nationally and state recognized awards or accreditations, and several Centers for Medicare and Medicaid Services (CMS) long-stay Quality Measures. A total of 8.5% of funds are set aside for the quality incentive which will create large financial rewards for providers scoring well, and strong incentives for others to improve.

Lastly, because of wide variances in reimbursement changes for centers moving from the current, cost-based system to a PPS, the PPS plan includes a five-year transition period with new funding to cover losses of those centers facing reimbursement reductions. Funds will be directed as special payments over a three-year period for holding harmless those centers experiencing rate reductions under the new system.

At the end of three years, all centers' reimbursements rates would be rebased using updated cost reports. In years four and five, centers still projected to lose funding under the new plan would see those losses capped at 5% less than their cost-based rates resulting from rebasing.

More information on all things PPS can be found on the FHCA web page under the Reimbursement section. Any members who wish to ask questions or provide comments are encouraged to contact me at *tparker@fhca.org.*◆

Tom Parker is FHCA's Director of Reimbursement. He can be reached at tparker@fhca.org.

Starting an Antibiotic Stewardship Program in a nursing center

By Robin Bleir

Antibiotics now give us the ability to treat common types of infections that were once lethal; however, they can be detrimental when used inappropriately. According to the Centers for Disease Control and Prevention (CDC), 70% of nursing center residents receive one or more courses of systemic antibiotics per year and 40%-75% of antibiotics prescribed may be unnecessary or inappropriate. Some of the risks associated with inappropriate use of antibiotics include increased morbidity and mortality, increased risk of hospitalization, increased risk of C. difficile infection, and increased treatment costs. Overuse can also lead to antibiotic resistant organisms, for which there are limited treatment options.

In response, the CDC began urging health care facilities to implement an antibiotic stewardship program (ASP) with the goal of optimizing the treatment of infections while reducing the adverse events associated with antibiotic use. Both the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission (TJC) have also recognized the importance of antibiotic stewardship and now require implementation of an ASP in accordance with the CDC core elements of antibiotic stewardship as of November 2017 for CMS and January 2018 for TJC. There are seven core elements of an ASP according to the CDC publication, The Core Elements of Antibiotic Stewardship for Nursing Homes:

- Facility leadership commitment to safe and appropriate antibiotic use;
- Appropriate facility staff accountable for promoting and overseeing antibiotic stewardship;
- Accessing pharmacists and others with experience or training in antibiotic stewardship;
- Implementing policies or practices to improve antibiotic use;
- Tracking measures of antibiotic use in the facility (i.e., one process and one outcome measure);
- Regular reporting on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff; and
- Educating staff and residents about antibiotic stewardship.

To assist nursing centers with starting an ASP in accordance with the CDC core elements, the Agency for Healthcare Research and Quality (AHRQ) has developed a detailed toolkit, Start an Antimicrobial Stewardship Program, which emphasizes four steps to implementing an ASP.

Identify champions and gather a team

Establish a multidisciplinary team consisting of staff with varying responsibilities such as charge nurses, the director or assistant director of nursing, the medical director, the infection preventionist, and an information technology staff member (if an electronic medical record is used). The team may also include consulting pharmacists, prescribing clinicians, and/or resident or family representatives. Two champions should be appointed to ensure program leadership through times of staff turnover, to promote the importance of the program, and to be accountable for outcomes. Champions should be responsible for developing agendas and policies, and leading trainings. Other team members can be assigned responsibilities such as assisting with developing training, the implementation of new tools, abstracting data for monitoring, and reporting data.

Conduct a readiness assessment

The purpose of the readiness assessment is to determine what resources the program will need and how ready the organization is to take on new interventions. It takes into account each nursing center's unique characteristics and can help to determine which stewardship goals are reasonable. The assessment also helps to select and prioritize specific interventions. A step-wise implementation is encouraged in which only one or two interventions are rolled out at a time.

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Robin A. Bleier is the President of RB Health Partners, Inc., a clinical risk Medicare and operations consultancy firm that consults with FHCA on quality affairs. Robin can be reached at (727) 786-3032 or robin@rbhealthpartners.com.

LTC LEGAL ISSUES & TRENDS, cont. from 5

Preventing elopement in the assisted living facility

- Residents should carry identification. See 58A-5.0182(1) and (8) for more details on these requirements.

These are just some of the factors to consider when drafting policies and procedures. The Council is working on several tools to assist facilities in responding to an elopement when it occurs, determining its root cause and implementing preventive measures for the future. FHCA will make those tools available once our group has completed its activity.

The need for assessment - case studies

Most of the regulatory cases argued in the Division of Administrative Hearings relate to the failure of facilities to conduct meaningful drills. There are two cases which provide good discussion of when an elopement is a violation of the regulation and when it is not.

Case no. 16-7558/17-2087 involves a resident who routinely left the facility to go to various local places to drink alcohol. The facility policy and procedure required him to sign out, which he often did not. On more than one occasion, he could not find his way back and knocked on neighbors' doors who gave him directions or escorted him back. On the occasion for which the facility was cited, he left at 11:00 a.m. (per one witness) or later in the afternoon (as per another). On this occasion, he knocked on a neighbor's door, who called the police. Officers returned him to the facility and found no supervision there. At the hearing, the administrator argued that it was this resident's routine to leave without signing out and to seek help when he couldn't find his way back. The resident having a dangerous routine did not negate the facility's requirements to follow its policies and procedures; thus, the resulting deficiency.

In contrast, in case 15-4847, the facility required that when residents were leaving they notify staff as to where they were going. The resident in question routinely left for a few days at a time to visit friends and family. He always returned when he said he would. He had two assessments to determine whether he was safe to leave the facility; both were positive. He left the facility and told staff he was going to visit family for a week, which was documented in his record. A day after he left, the resident was hit by a car and died in the hospital. The facility was unaware of this until, after almost a week, his mother came to the facility to tell them about the accident. The administrative hearing officer found that the facility had assessed this resident for safety; the resident followed facility procedure in saying where he was going and when he would be back; and the facility played no role in the accident. Therefore, the administrative hearing officer found the deficiency was not supported by the evidence.◆

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Starting an Antibiotic Stewardship Program in a nursing center

Plan for intervention

Based on the readiness assessment, the team can develop a plan including a timeline, responsibilities and a schedule for team meetings. When planning the timeline for the project, consider time for training staff, developing policies, and informing all parties involved with the process. Developing new policies and procedures that support the selected interventions will help hardwire and sustain the ASP. Meetings leading up to implementation should include a review of the purpose of the program, discussion of the tools that will be implemented, how the workflow will be adjusted to incorporate new tools, and a projected budget. Also discuss what materials need to be developed to support implementation as well as methods to communicate information about the intervention to staff, prescribing clinicians, and other facilities as necessary.

Introduce new policies and procedures to staff

New policies and procedures should answer the questions of who, what, when, where, why, and how. Prior to implementation, policies and procedures should be shared with staff via clear and easy-to-understand methods. A statement of the organization's commitment to quality of care as well as the purpose, scope and goals of the program should be expressed in the policy. Additionally, details regarding when the program will start and who will be involved should be included. Procedures should include the goals of specific interventions, what tools will be used to support the intervention, how the intervention will be implemented, and the staff responsible for the intervention. Depending on the scope of the new procedures, staff training may also be necessary.

As with any successful QAPI project, there should be a plan for monitoring and sustainment, which will also be addressed by the ASP team. The team should discuss what to monitor, who will collect the necessary data, how often the data will be collected, and the data source. Both process measures and outcome measures should be collected to adequately demonstrate progress of the ASP. To ensure that the ASP will be sustained, ongoing evaluation and reassessment based on feedback from staff as well as process and outcome measures is vital. By using quality improvement tools such as the plan-do-study-act (PDSA) model, continue to adapt and modify the program as necessary. Most importantly, celebrate successes as they occur to keep staff engaged.◆

CDC. The Core Elements of Antibiotic Stewardship for Nursing Homes. Atlanta, GA: US Department of Health and Human Services, CDC; 2015. Available at: http://www.cdc.gov/longtermcare/index.html.

Implement, Monitor, and Sustain an Antimicrobial Stewardship Program. Content last reviewed October 2016. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/nhguide/toolkits/implement-monitor-sustain-program/index.html.

Highlights of EEOC Performance & Accountability Report for FY 2017

By Mike Miller

Miller Tack & Madson, FHCA Labor Relations Consultant

The Equal Employment Opportunity Commission (EEOC) issued its Performance and Accountability Report for Fiscal Year 2017, which saw the lowest number of workplace discrimination charges, i.e., 84,254 charges filed with the agency since FY 2007. Retaliation comprised the majority (48.8%) of charges followed by race, disability and sex discrimination. The least amount of charges were based on genetic information, which comprised only .2% of the total charges filed. Reasonable cause determinations (i.e., determinations that reasonable cause exists to believe that a violation of law occurred) were made in only 2,909 cases comprising less than 3% of the total charges filed with the agency. In Florida, 6,858 workplace discrimination charges were filed comprising 8.1% of the total charges filed nationwide. Of the Florida charges filed, retaliation comprised the largest percentage (50.8%).

The EEOC filed 201 lawsuits in FY 2017 and secured $484 million for victims of discrimination through mediation, conciliation, settlements and litigation. The majority of lawsuits filed by the EEOC were filed under Title VII of the Civil Rights Act, followed by the Americans with Disabilities Act. The EEOC secured $42.4 million for alleged victims of discrimination through its litigation efforts.

The EEOC's substantive priorities for FYs 2017-2012 are: (1) eliminating barriers in recruitment and hiring; (2) protecting vulnerable workers, including immigrant and migrant workers, and underserved communities from discrimination; (3) addressing selected emerging and developing issues; (4) ensuring equal pay protections for all workers; (5) preserving access to the legal system; and (6) preventing systemic harassment. Under the emerging and developing issues priority, the EEOC will continue its focus on, among other things, "issues related to complex employment relationships and structures in the 21st century workplace, focusing specifically on temporary workers, staffing agencies, independent contractor relationships, and the on-demand economy" as well as "backlash discrimination" against those who are, or are perceived to be, of Muslim, Sikh, Arab, Middle Eastern or South Asian descent.

Victory for transgender funeral director

Recently, the U.S. Sixth Circuit Court of Appeals concluded that a funeral home violated Title VII of the Civil Rights Act, which prohibits, among other things, discrimination based on sex, by firing an employee after she announced that she would begin transitioning from a male to female. The funeral home is owned by a Christian man who testified that he holds a sincere belief that allowing one of the funeral home's employees to deny their sex while acting as a representative of the company would violate "G-d's commands." A mission is included in the funeral home's website, which identifies its "highest priority" as "honor[ing] G_d in all that we do as a company and as individuals." According to the discharged employee, the reason given by management for terminating her employment was that the public would not accept her transition.

Concluding that the EEOC could not sue for discrimination based solely on the employee's transgender and/or transitioning status, the lower court nonetheless found that the EEOC stated a claim for discrimination in violation of Title VII based on the employee's failure to conform to the funeral home's sex based preferences, expectations or stereotypes. The Sixth Court overturned the lower court's decision in part, and expressly held that discrimination on the basis of transgender and transitioning status alone violates Title VII. Additionally, the Sixth Circuit overturned the lower court's holding that the Religious Freedom Restoration Act (RFRA) precluded the EEOC's suit against the funeral home. Under the RFRA, the government is prohibited from "substantially burden[ing] a person's exercise of religion even if the burden results from a rule of general applicability," unless the government "demonstrates that application of the burden to the person: (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." In rejecting the funeral home's RFRA defense, the Sixth Circuit concluded as a matter of law that a religious claimant cannot rely on the presumed biases of customers to establish a substantial burden under the RFRA and that tolerating an employee's understanding of her sex and gender identity is not tantamount to supporting it.

The Sixth Circuit case is instructive based on its express holding that discrimination based on an individual's transgender and/or transitioning status is prohibited under Title VII in addition to sexual stereotyping based on an individual's gender identity. Gender identity claims under Title VII are actionable in the Eleventh Circuit, which covers Florida.◆

Mike Miller is with Miller Tack & Madson, FHCA's Labor Relations Consultant. Learn more about MTM at www.peolawyers.net.

FHCA establishes Life Safety Advisory Panel

By Deborah Franklin

Caring for residents is the top priority for our member centers, and improving quality in every aspect of a center's operation is integral to success. Caring for residents extends beyond resident care practices to include the center's life safety practices, too. Life safety is a large part of a nursing center's operations, and it is regulated by a complex set of Life Safety Codes and rules, both at the national, state and local levels. Recognizing the need to have experts available to assist on life safety topics, FHCA President John Simmons appointed a Life Safety Advisory Panel to serve as expert advisors to the Association and its members.

Comprised of corporate and regional life safety experts from member companies, the FHCA Life Safety Advisory Panel will advise the Association on both current life safety issues as well as bring to the table issues from the field that need to be addressed in a broader forum. This level of intentional collaboration on life safety issues is a new approach and will help the Association both identify emergency life safety trends, but also best practices from across the state and nation. The Panel will be a key contributor in the development of educational topics and "just in time" webinars to address the needs of physical plant directors of member centers. FHCA strives to keep members informed of the latest developments in fire and life safety for the best protection of our residents. To learn more about this Panel, contact Deborah Franklin at *dfranklin@fhca.org*.

Deborah Franklin is FHCA's Senior Director of Quality Affairs. She can be reached at dfranklin@fhca.org.

DIRECTOR'S DESK, cont. from 4

From tragedy to triumph

Nobody, however, came close to displaying the resilience of Governor Scott during Hurricane Irma. He was everywhere, all the time. He was in constant communication with our sector, and every other sector in the state of Florida. Excellent falls far short of describing the type of leadership that the Governor displayed throughout this process. From after the storm on through the legislative session, the Governor was the epitome of leadership.

Last month, Governor Scott invited FHCA to participate in the bill signing for the nursing center and ALF generator rules at Calusa Harbour, an FHCA member. It was a ceremonial event and the culmination of months of hard work. As I watched the Governor sign each bill, I could not help but think about the long road we traveled to get to this point. It was a proud moment for FHCA, and certainly one of our finest.

None of it would have been possible without the support and leadership of our members. Thank you for your trust, your encouragement and your support all along the way. Because of you, the frail and elderly of our great state will have an even greater sense of assurance that their care and comfort is the highest priority.◆

New Medicare beneficiary cards start in April

By Kim Broom

Beginning in April, the Centers for Medicare & Medicaid Services (CMS) will be mailing all Medicare beneficiaries new Medicare cards that remove their social security numbers. The change is intended to prevent fraud and identity theft.

CMS will be mailing the new cards in waves between April and June 2018. The new cards will have the members' new Medicare Beneficiary Identifier (MBI) which is effective immediately unless the patient is new to Medicare, in which case refer to the "coverage starts" date on the card. Providers are encouraged to start using the MBI as soon as your patients get their new cards (individuals new to Medicare will only have a Medicare card with an MBI).

Providers can obtain a patient's new MBI directly from their patient's new card. A patient's new MBI can also be obtained from the Medicare Administrative Contractor (MAC) portal for your area beginning in June 2018, when a look-up tool will be available on the MACs portal. Beginning in October 2018, the Medicare Remittance Advice (RA) will include both the MBI and HICN. This will continue through December 2019.

CMS has created an informational page for providers explaining what they need to do to get ready. Visit https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html to learn more.

New goals help assisted living providers advance in quality

During the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) Quality Symposium, AHCA/NCAL announced the new three-year Quality Initiative Goals for skilled nursing centers and assisted living facilities. The three-year goals for assisted living communities will work in tandem and include 1) reduce turnover among direct care staff to a rate of 50 percent or less; 2) at least 90 percent of customers (residents and/or families) are satisfied with their experience; 3) safely reduce hospital readmissions within 30 days of hospital discharges to a rate of 20 percent or less; and safely reduce the off-label use of antipsychotics to a rate of 15 percent or less.

FHCA's Quality Affairs department will be working with ALF members by offering resources and tools, as well as educational programs, to help providers achieve these goals over the next three years. In the meantime, learn more about the assisted living goals at qualityinitiative.ncal.org◆

Kim Broom is FHCA's Director of Clinical & Regulatory Services. She can be reached at kbroom@fhca.org.

Nursing center discharge and transfer

residents, the facility becomes the residents' home. Surveyors must determine whether a transfer or discharge is resident or facility-initiated. The medical record should contain documentation or evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge care plan and documented discussions with the resident or the representative concerning the discharge plan. In addition, the comprehensive care plan should contain the resident's goals for admission and desired outcomes, which should align with the discharge if it is resident-initiated.

If the nursing facility transfers a resident to the hospital and then does not re-admit the resident because they can't meet his or her needs, the facility would need to issue both transfer and discharge paperwork, as the resident was transferred and then discharged.

The nursing center may develop their own form for the transfer and discharge or they may use the one on the Agency for Health Care Administration's website.

CMS issued S & C 18-08 NH in late December which states, "As part of the effort to fully address facility-initiated discharges that violate federal regulations, CMS will review deficiencies precipitated by facility-initiated discharges. Unless directed otherwise by the CMS Regional Office (CMS RO), State survey agencies must transfer any case involving facility initiated discharge violations to the CMS RO for review where there is placement in a questionable or unsafe setting, where residents remain hospitalized, where there is a facility pattern, or other circumstances that the RO may identify of cases they would like transferred. This does not change any other enforcement policies that identify cases that must be transferred to the RO. Following review, the ROs may take enforcement action if they deem it is proper."

Nursing centers should ensure documentation is in place to tell the story that the resident is discharged and not "dumped." When transferring an individual to the hospital, centers must issue a transfer notice, and if the resident does not return, a discharge notice. Make sure you are sending your list or copies of your notice to Ombudsman.◆

Governor Scott signs generator legislation

The bill signing ceremony took place at Calusa Harbour, an FHCA member continuing care community in Ft. Myers. Executive Director Bill Brewster hosted the Governor and other key dignitaries, including Agency for Health Care Administration Secretary Justin Senior and Deputy Secretary Molly McKinstry. Florida Health Care Association (FHCA) Executive Director Emmett Reed also took part in the event, recognizing the team at Calusa Harbour as well as member centers across the state for their role during Hurricane Irma to keep residents safe.

"Emergency preparedness in our state's long term care centers is a continuous process, and for all of us, the goal is always to put the safety and comfort of our residents first," said Emmett Reed, FHCA Executive Director. "Governor Scott has shown tremendous leadership in ensuring that our state's seniors are a priority. This legislation is another important step to strengthen our centers' emergency procedures so they remain resident-focused."

The nursing home rule (59A-4.1265) requires facilities to have alternative power sources, such as generators, that can keep temperatures at 81 degrees for at least 96 hours. Areas cooled must be the equivalent of 30 square feet per resident. Also, nursing centers must keep 72 hours of fuel on site.

Assisted living facilities have similar requirements (Rule 58A-5.036); however, for planning purposes, no less than 20 net square feet per resident must be provided. For ALFs, the 72-hour onsite fuel requirement is mandated for facilities with 17 beds or more.

Nursing centers and ALFs must comply by June 1, the start of the 2018 hurricane season. To learn more about the nursing center and ALF rules, visit the Emergency Preparedness session of FHCA's website at www.fhca.org.◆

good news

florida health care association around the state

Groundbreakings

New State Veterans' Nursing Home Begins Construction

Gov. Rick Scott and Senate President Joe Negron joined civic, community and veteran leaders in the Port St. Lucie community of Tradition on March 20 for a groundbreaking ceremony for the new 120-bed Ardie R. Copas State Veterans' Nursing Home. Florida's newest state veterans' nursing home is named in honor of a Medal of Honor recipient from the Vietnam War — Fort Pierce and St. Lucie County native Sergeant Ardie R. Copas, who was killed in Cambodia in May 1970. Members of the Copas family participated in the groundbreaking, honoring their loved one.

Gulf Coast Health Care Expands to Lake City

In February, Gulf Coast Health Care broke ground on The Rehabilitation Center of Lake City, a 113-bed facility offering skilled nursing, post-acute care and short-term rehab. The 83,000 square foot center will also offer expanded dining options, active Life-Enrichment programs, salon services, outdoor courtyards, private dining for family celebrations and more. When asked about the new center, Gulf Coast Health Care President and CEO Jamey Richardson said, "A complex clinical approach with its vast array of rehabilitative services and amenities is a testament to our commitment as well as our pursuit of innovation to meet future health care needs."

UPCOMING EVENTS

Some meetings noted herein may also carry CE credits. Additional information and registration can be found at www.fhca.org.

CONTINUING EDUCATION/TRAINING

MAY

May 30 - June 1, 2018

***Pre-sessions May 29**

FHCA Nurse Leadership Program

Don CeSar Hotel

St. Pete Beach, FL

JULY

July 15-19, 2018

FHCA 2018 Annual Conference & Trade Show

The Diplomat Beach Resort

Hollywood, FL

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WELCOME NEW MEMBERS

NURSING HOMES

Bridgewater Park Health & Rehabilitation Center, *Ocala*

Florida Hospital North Pinellas, *Tarpon Springs*

ASSISTED LIVING FACILITIES

Bay Pointe Terrace, *Hollywood*

Bellatage Assisted Living, *Winter Haven*

Brookdale Bayshore, *Tampa*

Canterfield of Ocala

Finnish-American Village, *Lake Worth*

The Forum at Deer Creek, *Deerfield Beach*

ASSOCIATE MEMBERS

Antibiotic Adjuvant, Inc., *Gainesville*

BSI Supplies, Inc., *Gastonia, NC*

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Coastal Staffing Solutions, *Orlando*

Duke Energy Florida, *St. Petersburg*

Family Elder Law, *Lake Wales*

Genesight Assurex Health, *Mason, OH*

Integrated Health Systems, *Overland Park, KS*

IV Access, Inc., *Delray Beach*

LindaShell.com, *Lakeville, MN*

North Carolina Clean Energy Technology Center, *Raleigh, NC*

Reno Davis & Associates, Inc., *Sarasota*

Senior Care Eligibility Consulting, *Ellentown*

Senior Safety Technologies, *Tampa*

Sniff 'n' Stop, Inc., *Sanford*

SOAR Life Products, *Greenville, WI*

Teleco, South Florida, *Deerfield Beach*

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EDGE INFORMATION MANAGEMENT INC.

Since becoming an approved service corporation company for FHCA in 1993, Edge has helped over 250 FHCA members meet their background screening requirements and kept them informed of pertinent legislative issues. Edge offers a variety of background checks including: drug screening, fingerprints, criminal, sexual offender, license verifications and references. Contact Laura Aguiar at (800) 725-3343 ext. 60 or by email at info@edgeinformation.com, or visit www.edgeinformation.com for more information.

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SENIOR CRIMESTOPPERS

The Senior Crimestoppers program is a proven, effective, proactive crime prevention system that combines proven components to help provide safe, crime-free facilities for residents, staff, visitors and vendors. Personal lock boxes for use by residents and/or family members, an around-the-clock, completely anonymous "tip line" call center, cash rewards of up to $1,000 posted on any and all incidents that occur and educational materials for residents, families, management and staff members are a few of the components that make up the program. More details can be found at www.seniorcrimestoppers.org or contact Kay Joest at (800) 529-9096 for more details.

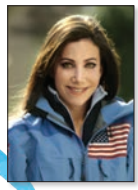
2018 Annual Conference & Trade Show

Navigating the Seas of Change

Incredible Keynote Speakers

Steve Taubman has dedicated his life to showing people how to thrive through their challenges through his mission to understand the nature of happiness and the remedy for emotional turmoil. He will share his understanding of happiness and its impact on success.

Adam Goodman is The Victory Group's principal creative and communications strategist, producing award-winning work for candidate, corporate and advocacy campaigns. Goodman provides regular commentary for FOX News, CNN, and MSNBC. He will guide you through communicating in the current and crazy world.



Alison Levine served as team captain of the first American Women's Everest Expedition, climbed the Seven Summits and skied to the North and South Poles. Hear from this history-making adventurer who understands what it takes to lead teams through challenging situations.

2018 Annual Conference Highlights

- **61 Continuing Education Sessions**, with the potential for 24 contact hours
- **275+ Booth Trade Show** featuring products and services, the AMSC Wine Toss and Scratch-Off Ticket, FHC PAC Silent Auction, raffle prizes and more
- **Networking and Social Gatherings**, including the Opening Social, Quality Award Ceremony & Celebration, Fun Night, Annual Golf Tournament and Cardio Networking
- **Bonus Education**, including the Preceptor Refresher Course and CNA Train-the-Trainer Course
- **Free Medical Errors: Prevention and Analysis 2-Hour, Self-Study Course** for Administrators and Nurses to all Conference full registrants

Don't forget 2018 is a renewal year for licensed administrators, make sure to get all the CE hours needed before the deadline.

To register, reserve your hotel room or learn more about FHCA's 2018 Annual Conference & Trade Show, visit www.fhcaconference.org.

July 15-19, 2018

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