Accreditation Report

Quality Improvement Plan
& Benchmarking Data

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Quality Improvement Plan & Benchmarking Data

Prepared for
Armed Forces Retirement Home - Gulfport

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Accreditation Decision

Five-Year Term of Accreditation
Expiration: October 31, 2021

Five-Year Accreditation

Organization

Armed Forces Retirement Home - Gulfport
1800 Beach Drive
Gulfport, MS 39507-1508

Organizational Leadership

Jeffrey Eads, Administrator
Vicki Marrs, Chief Financial Officer
Cynthia A. Lee, RN, M.S.N., Performance Improvement Integrator

Survey Dates

August 29-31, 2016

Survey Team

Kathleen E. Bowman-Estrada, Administrative Surveyor
Patsy H. Long, B.S., ADM, RN, Program Surveyor
Peggy Valdivia, Virtual Finance Surveyor

Programs/Services Surveyed

Continuing Care Retirement Community

Previous Survey

October 24-26, 2011
Five-Year Term of Accreditation

Survey Summary

Areas of Strength

Armed Forces Retirement Home - Gulfport (AFRH-G) has strengths in many areas.

- The staff at AFRH-G is approachable and attentive to the residents. There is a strong working relationship across departments and across management/staff lines of responsibility.
- The interdisciplinary team demonstrates a comprehensive understanding of the needs of the persons served and clearly articulated the individuals' needs and preferences. The organization demonstrated excellent and effective communication within and among the various departments. This communication is in the form of a weekly Needs Assessment Team (NAT) meeting as well as one-to-one reporting. Through this communication process, departmental and organizational leadership and staff seemed to consistently adapt a collaborative approach to meeting the residents' needs. Management and staff form a passionate and committed team that continually demonstrated its philosophy of person-centered care.
- Throughout the physical facility, the organization maintains a homelike environment that is warm and inviting. The attention to detail provides a welcoming and comfortable environment. These touches, which are evidenced throughout AFRH-G, include fireplaces, small sitting areas, secure patios, and large windows that are open to the beautiful landscaping and take advantage of natural light and the expansive ocean views. The walls have been decorated with paintings by resident artists and are attractive, meaningful, and intriguing. The contract maintenance team takes pride in maintaining the beautiful interiors and exteriors.
- A strong commitment to the residents is evidenced by the fact that a significant number of staff members, both management and direct care staff, have been part of the organization for many years. The staff members are open and welcoming and obviously well loved by the residents and their families. Their dedication and commitment to what they do is clearly evident in their interaction with residents, family members, and colleagues. One staff member noted she is proud to tell her family and friends she works at AFRH-G and that it is a "five-star" community.
- The safety and security staff demonstrate exceptional customer service practices while ensuring that a comprehensive safety and security plan is executed daily.
- The resident services team ensures a clean, attractive community for the residents. Many residents complimented the staff that provides housekeeping and custodial services, noting staff is courteous and comprehensive in carrying out its duties.
- The recreation team offers many off-site adventures for residents in the Gulf states region as well as in the local area and on site. Staff is friendly and approachable and incorporates a dynamic and robust team of volunteers. The transportation team does an exceptional job in supporting the recreation staff's efforts as well as taking care of the residents' medical appointment and shopping needs.
- The administrative team offers a strong backbone of administration, oversight, and business functions for the staff that supports the community as well as for the residents.

- Dining service staff members were responsive to the residents' changing needs and requests. The kitchen and back hall area were neat and clean. The staff maintained nutritional requirements while adding elements of hospitality to the lunch meal. The dining service team utilizes a foodborne illness monitoring system, which enables it to quickly define the origin of a food-related outbreak of illness within the community.
- The nurse educator has a detailed and well-organized training program. Her annual skills assessment fair provides staff members with comprehensive competency training and testing and helps to ensure a well-prepared workforce. She is commended for her detailed and preventive approach in ensuring that each member of the contract agency workforce is provided a required two-day comprehensive orientation prior to being granted clearance to work on campus.
- The on-site Wellness Center provides a variety of convenient medical services for the residents, including primary, dental, eye, and pharmacy care as well as in-home visits for those in need of such. Several residents commented on the convenience of this service and especially on the welcoming nature of the staff.
- Family members reported that the culture of AFRH-G has embraced the basic principles of person-centered care. Family members are complimentary about the strong bonds formed between staff and residents and staff and families. The use of the Dignity Blanket and the honor guard is a wonderful example of celebrating life changes and treating residents with dignity and respect.
- The community has a robust resident council that has representation from each tower floor of the community. Resident council members expressed that they feel leadership is receptive to their concerns and willing to work through the tough issues until a resolution is found. Noting that contract personnel were not included in the quarterly award program for general schedule staff members, the resident council developed its own quarterly awards system for contract employees, ensuring their inclusion in sharing in the community's appreciation.
- The financial audit of AFRH for the fiscal year ending September 30, 2015, was signed off by the auditing firm of Brown & Company CPAs, PLLC on November 13, 2015. This turnaround was within 43 days, which represents an incredibly short period of time. The organization is commended on the quick turnaround, which is an unusual achievement within the industry.

Areas for Improvement

AFRH-G should seek improvement in the following areas.

- Although the cultural diversity plan is comprehensive, it remains in draft format. Elements of the plan are being carried out through various compliance requirements. The organization is urged to finalize its draft plan and continue complete implementation of the plan. The plan should be reviewed at least annually for relevance and updated as needed.
- Staff members are aware of the prohibition of personal fundraising and the prohibition of witnessing documents; however, this is not included in written codes of conduct. The organization is urged to revise the written ethical codes of conduct to address personal fundraising and the witnessing of documents.

- Although some Advisory Council members completed an annual assessment, the procedure was not comprehensive of all members. An annual assessment form is available for the board, but self-assessment tools are not provided for self-assessment of individual members. The organization is urged to consistently complete an annual self-assessment of the entire board as well as periodic self-assessments of individual members.
- Advisory Council members are often required to complete annual written conflict-of-interest and ethical-code-of-conduct declarations in other aspects of their duties, but the process was not evident in the Advisory Council role. Governance policies should be implemented that address an annual written and signed conflict-of-interest declaration and ethical-code-of-conduct declaration.
- Currently, AFRH reviews a representative sampling of billing records on an annual basis, close to year end, to ensure accuracy and dates of services provided. The organization is urged to complete the review of a representative sampling of billing records at least quarterly.
- The net operating margin ratio, total excess margin ratio, and operating ratio are below the 25th quartile for multi-site communities that are accredited by CARF. AFRH utilizes a different approach for reporting and presenting its financials through a federal system. Other CARF-accredited CCRCs utilize generally accepted accounting principles (GAAP). The difference in accounting methods may affect comparisons to other CCRCs.
- AFRH is not allowed to carry any debt, and as a result of this practice, the capital structure ratios of cash to debt and the debt service coverage calculations are skewed. This results in these two ratios being rated as nonconformance when compared to other CCRCs. Based on this information, the organization does not need to develop an action plan for these two items.

Accreditation Decision

Armed Forces Retirement Home - Gulfport has earned a Five-Year Term of Accreditation. On balance, the organization is providing quality and culturally sensitive programs to the persons served and demonstrates substantial conformance to the CARF standards. The organization is commended on how it has incorporated its beautiful grounds and ocean views into the architecture of the facility, allowing the outdoors to come inside in many areas. Teamwork is evident across all levels of care, demonstrated through a collaborative approach of the interdisciplinary team, its extensive emergency response plans that are exercised routinely, the integration of resident art in common areas, and its focus on honoring the military contributions of its residents. Although a few opportunities for improvement have been identified, it is apparent that the organization has the resources and commitment to address these areas. AFRH-G is encouraged to continue to use the CARF standards to further enhance the provision of services and expand its performance improvement program by addressing the areas for improvement identified in this accreditation report.

Consultation

Section 1. ASPIRE to Excellence®

F. Financial Planning and Management

- Actual financial results are shared with staff that serve in a fiduciary capacity, but the organization might want to consider sharing financial performance with all staff beyond those who are in a fiduciary capacity to support of the organization's workforce growth by promoting open communication to help staff understand organizational goals.

H. Health and Safety

- It is suggested that water be included in the supplies in each transportation vehicle.

I. Human Resources

- Although the community has a comprehensive program for hiring new applicants, staff members expressed some frustration with the months-long process to fill open positions. The organization is encouraged to evaluate the process and seek ways to improve areas that may be in its control as well as to request the same from associated organizations.

K. Rights of Persons Served

- The organization has a detailed policy that addresses how an individual could have access to his/her own records. It is suggested that this policy be shared, in an abbreviated version, with the residents. This information could be shared in the Resident Handbook, or some other appropriate mechanism could be utilized.

Section 2. Care Process for the Persons Served

A. Program/Service Structure

- The organization has documented its exit criteria, but this documentation does not include discharge due to increased medical needs beyond what can be provided at AFRH-G. It is suggested that the organization further define and document this type of information in its exit criteria.
- The organization is providing appropriate competency-based training for medications, but it may want to consider engaging the current pharmacy system to assist with the provision of these inservice training sessions. Having the pharmacy assist may help the nursing staff to ensure that all personnel responsible for medication management/assistance have all of the information that they need and are able to ask any questions that might be particular to the pharmacy role in the medication management.
- To facilitate easier decision making about entrée choice, it is suggested that plated sample meals be utilized.

Consultation does not indicate nonconformance to standards but is offered as a suggestion for further quality improvement.

Standards Conformance

This section of the Accreditation Report displays the specific reasons for any partial or nonconformance to standards identified as a result of the survey. The standards listed in this section are addressed in the organization's Quality Improvement Plan, which can be accessed at *customerconnect.carf.org*.

Below are the possible reasons for partial or nonconformance to standards, along with an explanation of why each reason is cited.

To receive the information contained in this section in an alternate format, please contact editing@carf.org.

Reason for partial or nonconformance	Is cited:
Procedure/practice not developed	When a standard element requires a procedure/practice, it is not in existence.
Policy/plan not developed	When a standard element requires a policy/plan, it is not in existence.
Policy/plan/procedure/practice not implemented	When a standard element requires a policy/plan/procedure/practice, it exists but there is no actual performance.
Policy/plan/procedure/practice recently implemented	When a standard element requires a policy/plan/procedure/practice, it exists but the actual performance has not been in place for sufficient time to establish a track record.
Policy/plan/procedure/practice not consistently implemented	When a standard element requires a policy/plan/procedure/practice, it exists but the actual performance does not occur with sufficient regularity to be deemed standard operating procedure.
Frequency inadequate	When a standard element requires that an activity occur with a specific frequency or some unspecified regularity, the performance of the activity does not occur, occurs less frequently than required, or occurs less frequently than appropriate if regularity unspecified.
Documentation inadequate	When a standard element requires documentation or that documentation contain specific information, the documentation either does not exist or does not contain the specific information.
Training inadequate	When a standard element requires that certain training occur, it either does not occur or does not occur with sufficient regularity to be deemed standard operating procedure.
Involvement by appropriate person(s) inadequate	When a standard element requires the involvement of certain persons, those persons are either not involved or not involved in a sufficient manner.
Data or information necessary to address conformance not collected and/or evaluated	When the issue addressed by the standard element has not been considered and, consequently, the information necessary to address conformance has not been collected and/or evaluated in connection with the issue addressed.
Effort not comprehensive	When a standard element requires an activity to occur, the performance of the activity is insufficient to address the full scope of the activity.
Financial ratio calculation below the median	When the standard element rating is based on the calculation of a specific financial ratio, such ratio is below the 50th percentile.
Information not communicated understandably	When a standard element requires that information be shared with certain persons, the information is either not shared or not shared in a manner that allows for comprehension by the recipient.
Noncompliance with law, regulation, or other rule	When a standard element requires compliance with a legal requirement or a process for achieving legal compliance, sufficient evidence of compliance or the compliance process is not demonstrated.
Credentials inadequate	When a standard element requires that an individual possess a specific credential or level of credential, the specific credential is not possessed, or the credential possessed is below the specified level.
Evidence of conformance inadequate	When the requirement of a standard element is not satisfied, or is inconsistently satisfied and no other reasons apply.

Standard Number	Standard Text	Reasons for Partial or Nonconformance															
		Procedure/practice not developed	Policy/plan not developed	Policy/plan/procedure/practice not implemented	Policy/plan/procedure/practice recently implemented	Policy/plan/procedure/practice not consistently implemented	Frequency inadequate	Documentation inadequate	Training inadequate	Involvement by appropriate person(s) inadequate	Data or information necessary to address conformance not collected and/or evaluated	Effort not comprehensive	Financial ratio calculation below median	Information not communicated understandably	Noncompliance with law, regulation, or other rule	Credentials inadequate	Evidence of conformance inadequate
1.A.5.a.(1)	The organization implements a cultural competency and diversity plan that: Addresses: Persons served.				X												
1.A.5.a.(2)	The organization implements a cultural competency and diversity plan that: Addresses: Personnel.				X												
1.A.5.a.(3)	The organization implements a cultural competency and diversity plan that: Addresses: Other stakeholders.				X												
1.A.5.b.(1)	The organization implements a cultural competency and diversity plan that: Is based on the consideration of the following areas: Culture.				X												
1.A.5.b.(2)	The organization implements a cultural competency and diversity plan that: Is based on the consideration of the following areas: Age.				X												
1.A.5.b.(3)	The organization implements a cultural competency and diversity plan that: Is based on the consideration of the following areas: Gender.				X												
1.A.5.b.(4)	The organization implements a cultural competency and diversity plan that: Is based on the consideration of the following areas: Sexual orientation.				X												
1.A.5.b.(5)	The organization implements a cultural competency and diversity plan that: Is based on the consideration of the following areas: Spiritual beliefs.				X												
1.A.5.b.(6)	The organization implements a cultural competency and diversity plan that: Is based on the consideration of the following areas: Socioeconomic status.				X												
1.A.5.b.(7)	The organization implements a cultural competency and diversity plan that: Is based on the consideration of the following areas: Language.				X												
1.A.5.c.	The organization implements a cultural competency and diversity plan that: Is reviewed at least annually for relevance.				X		X										
1.A.5.d.	The organization implements a cultural competency and diversity plan that: Is updated as needed.				X												
1.A.6.a.(4)(c)	Corporate responsibility efforts include, at a minimum, the following: Written ethical codes of conduct in at least the following areas: Service delivery, including: Personal fundraising.	X						X									

Standard Number	Standard Text	Reasons for Partial or Nonconformance																
		Procedure/practice not developed	Policy/plan not developed	Policy/plan/procedure/practice not implemented	Policy/plan/procedure/practice recently implemented	Policy/plan/procedure/practice not consistently implemented	Frequency inadequate	Documentation inadequate	Training inadequate	Involvement by appropriate person(s) inadequate	Data or information necessary to address conformance not collected and/or evaluated	Effort not comprehensive	Financial ratio calculation below median	Information not communicated understandably	Noncompliance with law, regulation, or other rule	Credentials inadequate	Evidence of conformance inadequate
1.A.6.a.(4)(f)	Corporate responsibility efforts include, at a minimum, the following: Written ethical codes of conduct in at least the following areas: Service delivery, including: Witnessing of legal documents.	X						X									
1.B.2.g.(3)	Governance policies address: Board performance, including: Annual self-assessment of the entire board.					X											
1.B.2.g.(4)	Governance policies address: Board performance, including: Periodic self-assessment of individual members.	X															
1.B.2.g.(5)	Governance policies address: Board performance, including: Annual written and signed conflict of interest declaration.							X									
1.B.2.g.(6)	Governance policies address: Board performance, including: Annual written and signed ethical code of conduct declaration.							X									
1.F.7.a.	If the organization bills for services provided, a review of a representative sampling of records of the persons served is conducted: At least quarterly.						X										
1.F.13.a.(1)	The organization addresses: Margin/profitability, including: Revenue and expenses related to the persons served.												X				
1.F.13.a.(2)	The organization addresses: Margin/profitability, including: Earnings related to businesses not directly related to the persons served (ancillary revenue) and third-party sources of revenue, such as contributions, investment income, and financial support from a third party.												X				
1.F.13.a.(3)	The organization addresses: Margin/profitability, including: Expense management.												X				
1.F.13.c.(1)	The organization addresses: Capital structure to ensure: Financial flexibility.												X				
1.F.13.c.(2)	The organization addresses: Capital structure to ensure: Ability to meet the needs of persons served and other stakeholders.												X				

Benchmarking

This section of the Accreditation Report benchmarks your organization's conformance to standards. By comparing strengths and areas for improvement with various comparator groups, benchmarking encourages your organization to improve effectiveness, efficiency, satisfaction, and access. This information should also stimulate discussions among stakeholders focused on better meeting the needs and preferences of the persons served. In addition, benchmarking:

- Encourages a culture of continuous evaluation and improvement.
- Accelerates understanding of and agreement on areas for improvement.
- Helps prioritize improvement opportunities.
- Shifts internal thinking toward a focus on outcomes.
- Provides a reference to increase performance expectations.
- Motivates your team to work collaboratively to surpass benchmarks.

This report provides benchmarks (mean % of conformance) for each section of the ASPIRE to Excellence® quality framework.

[*] When available, benchmark comparison groups include:

- All surveyed organizations.
- All surveyed organizations in the same primary CARF customer service unit.
- Surveyed organizations with the same ownership type.
- Surveyed organizations in the same geographic region.
- Surveyed organizations with similar number of persons served annually.
- Surveyed organizations with similar staff size.

In addition, standards conformance for each organization undergoing resurvey is benchmarked against its previous survey in all standards areas.

Benchmark Comparison Groups

Primary area of accreditation: CARF–CCAC

Ownership type: Government Entity

Geographic region: US–South

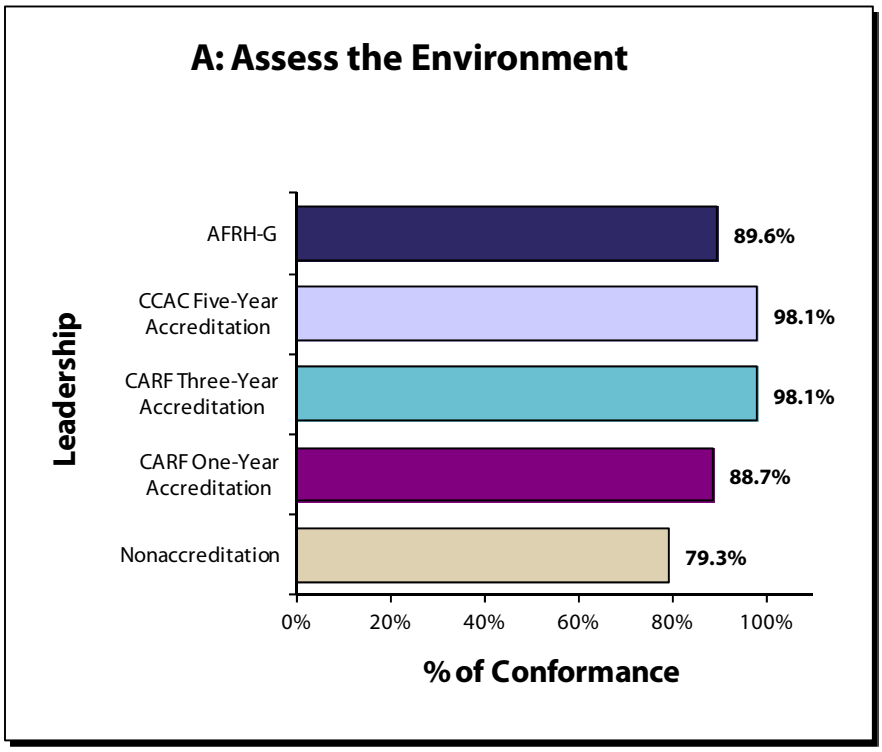
Staff size (FTEs): 100–499

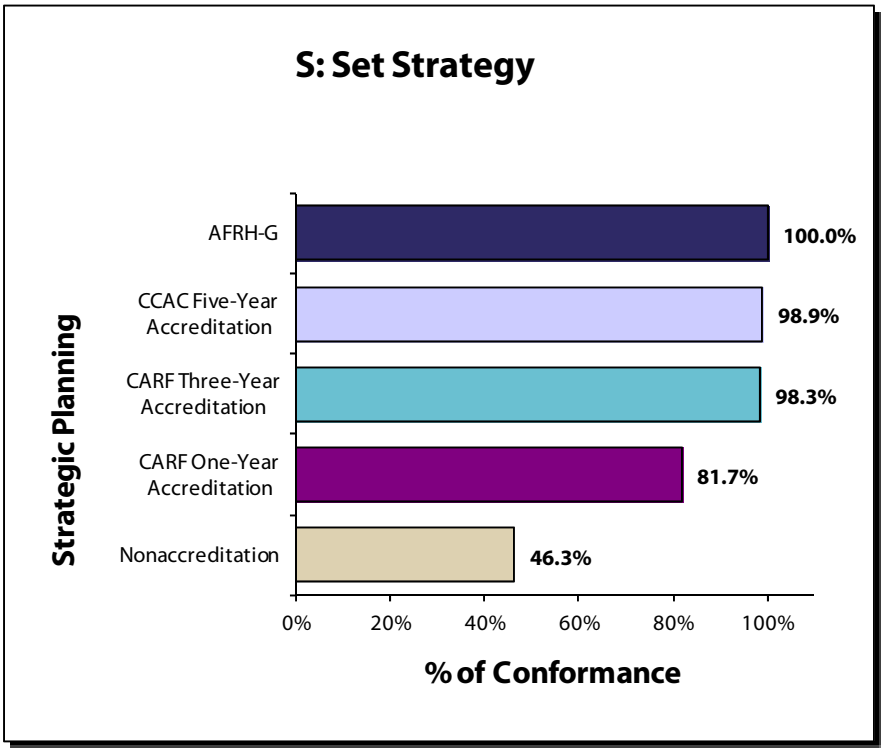
Persons served annually: 500-999

To receive the information contained in this section in an alternate format, please contact editing@carf.org.

[*] Excluding Governance.

All surveyed organizations





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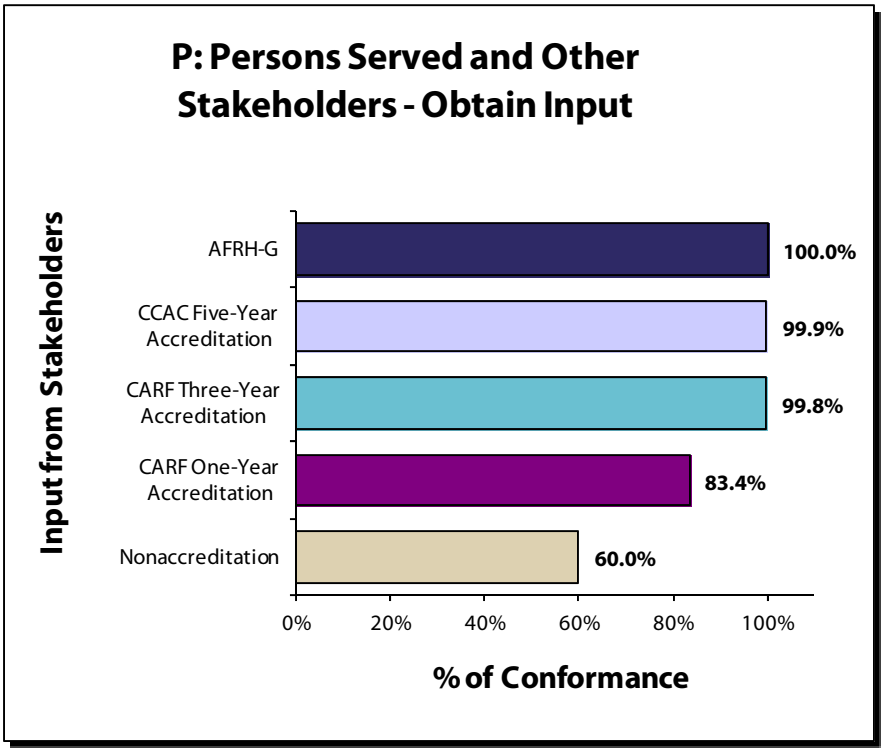

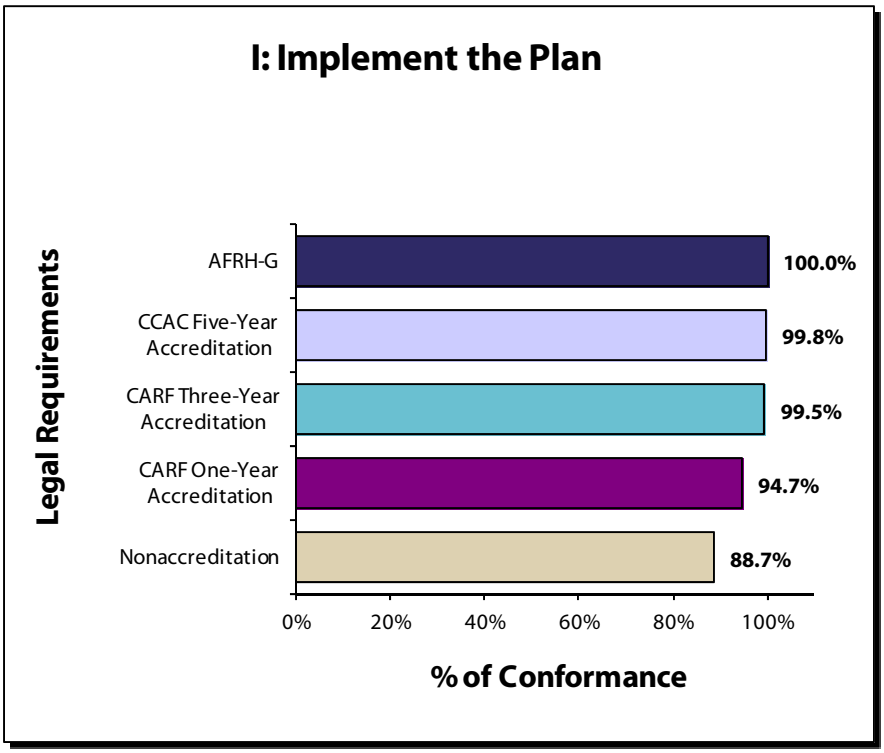

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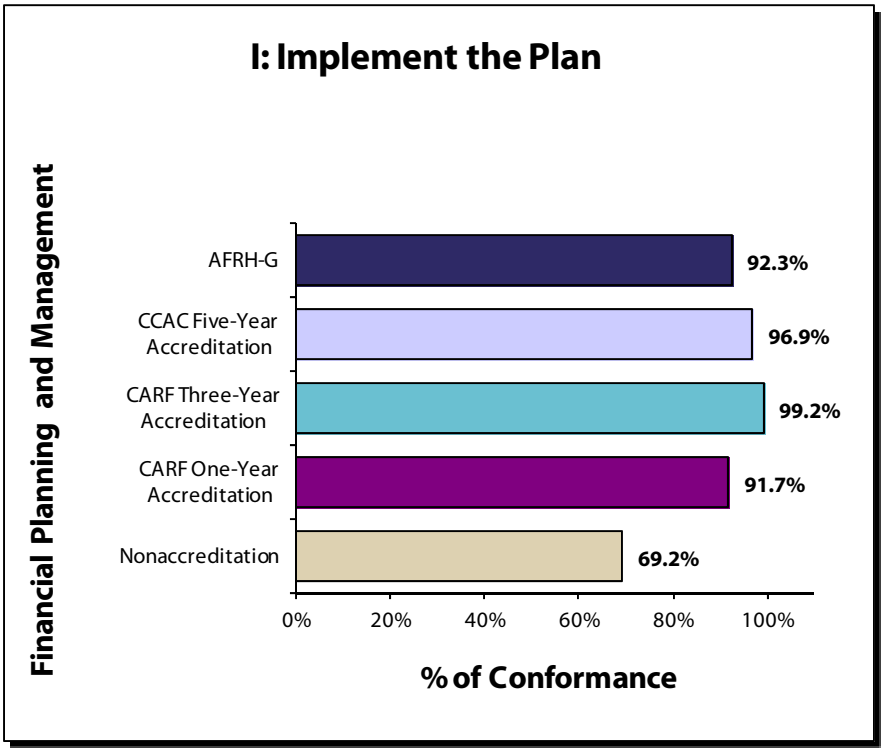

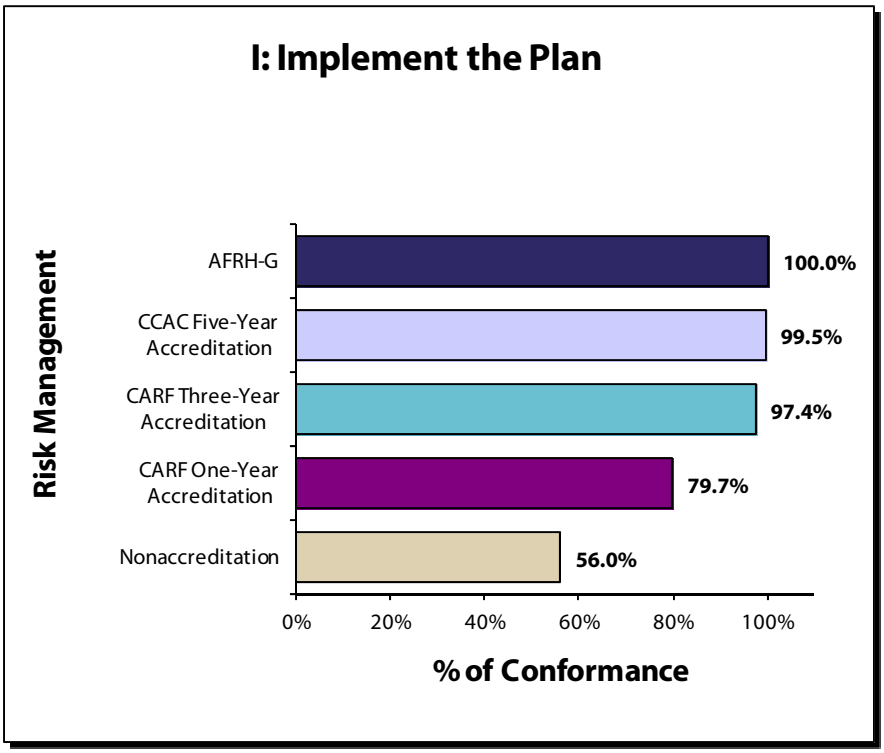

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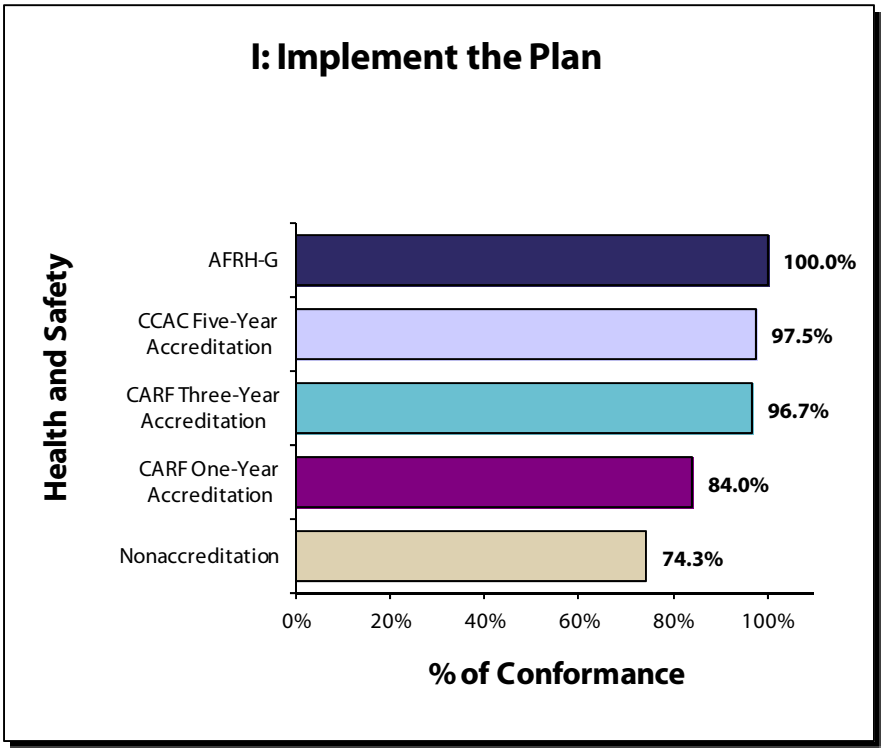

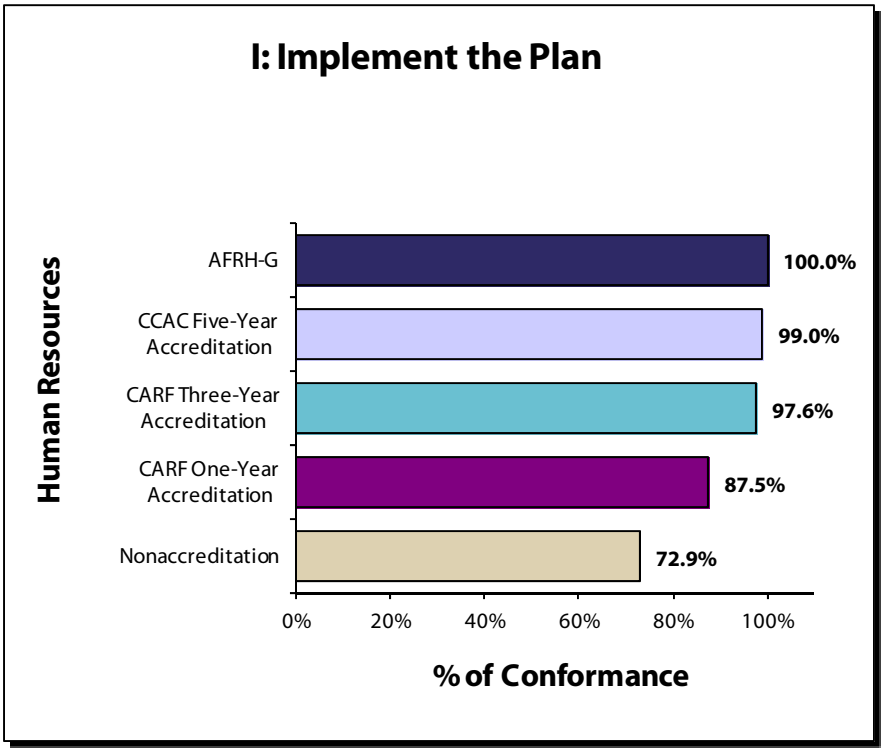

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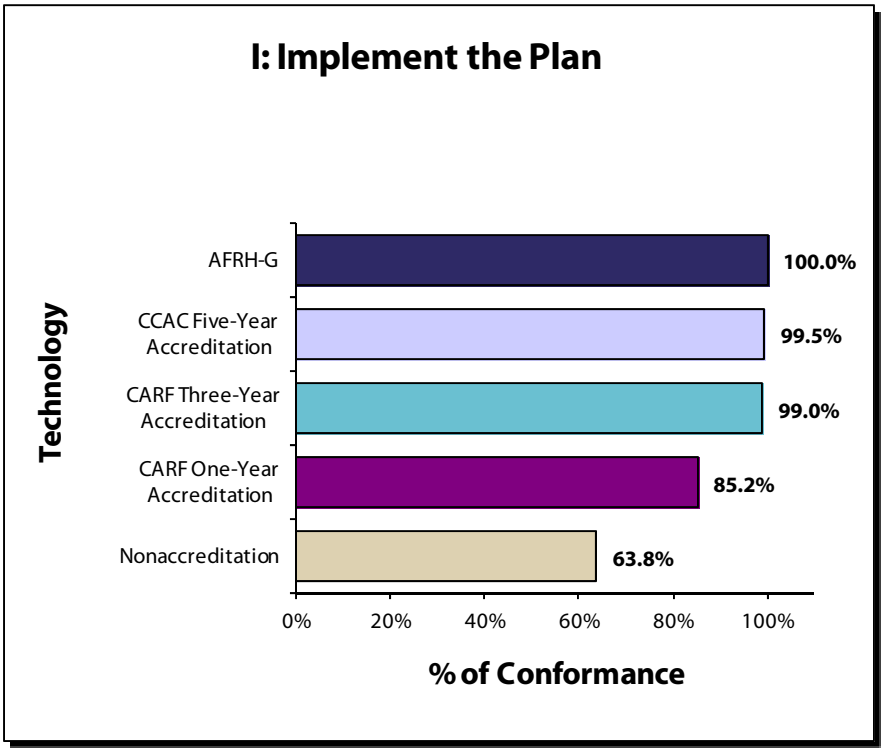

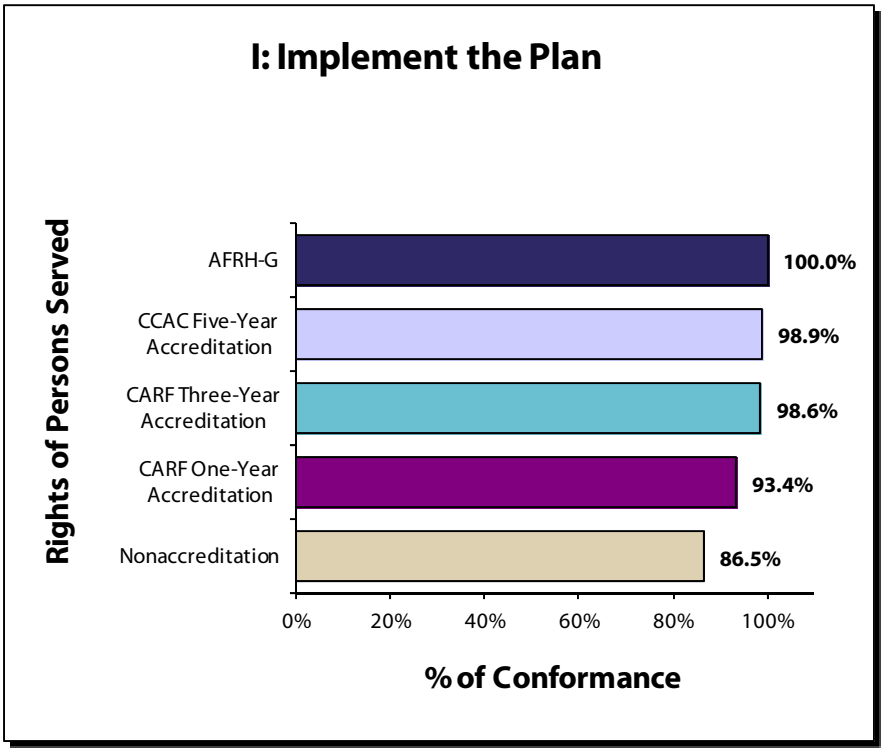

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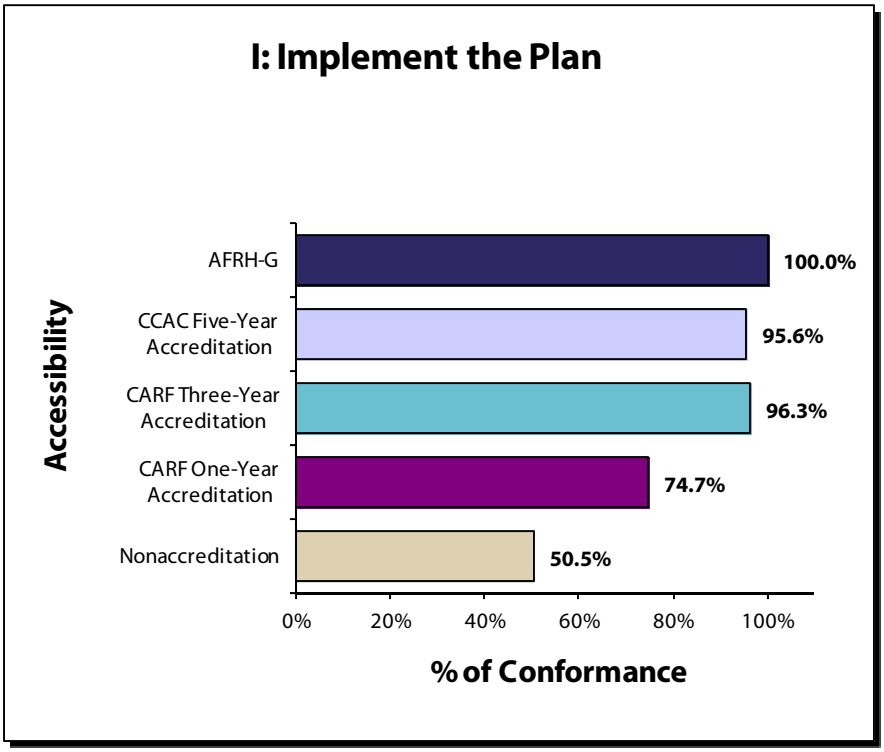

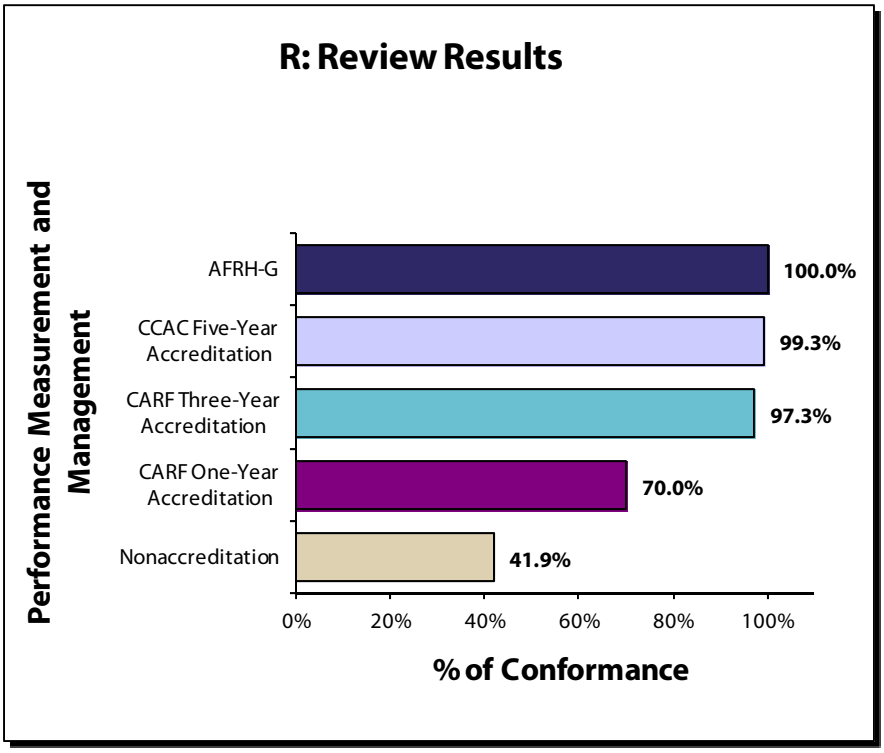

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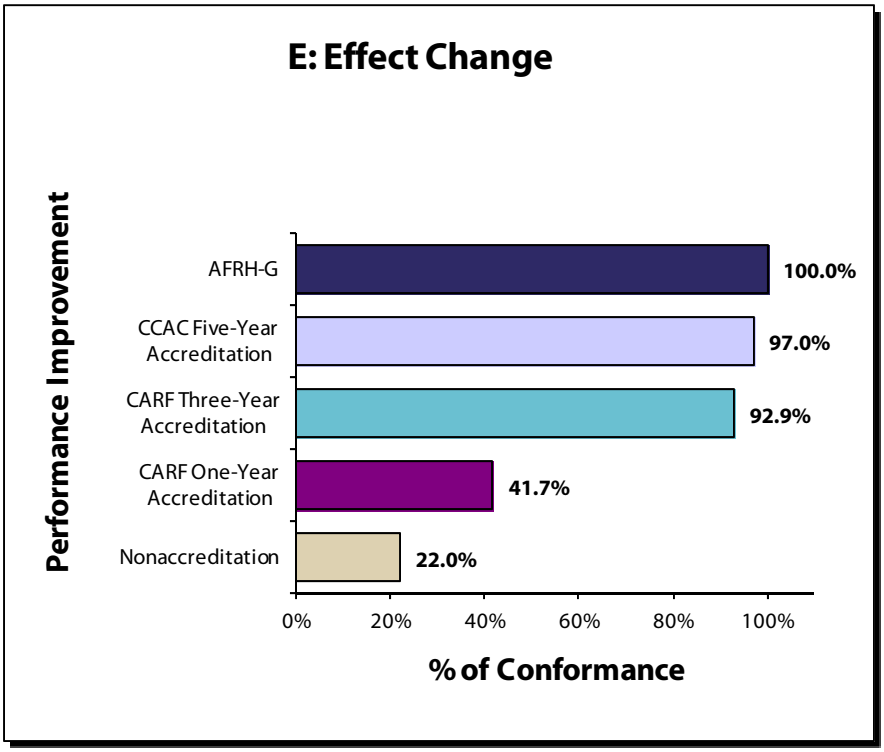
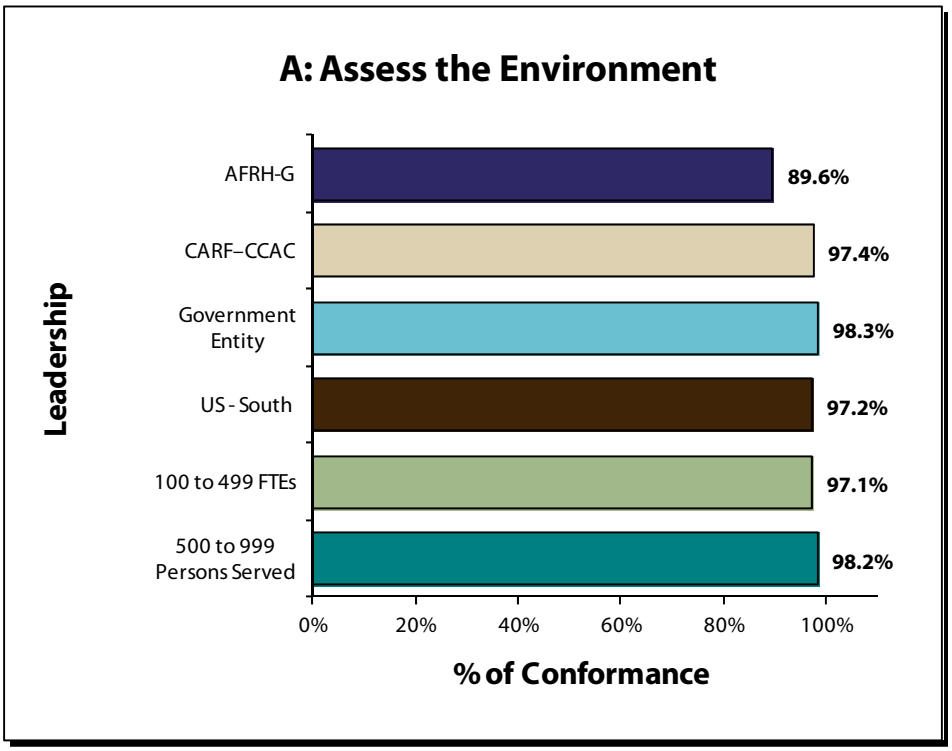
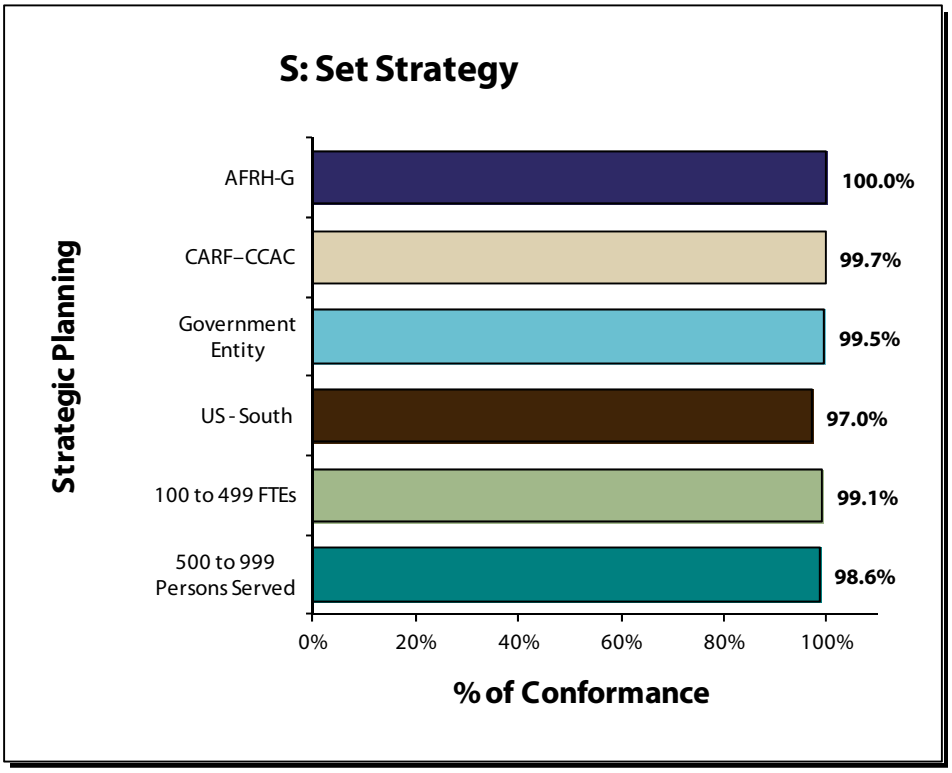


Other benchmarks





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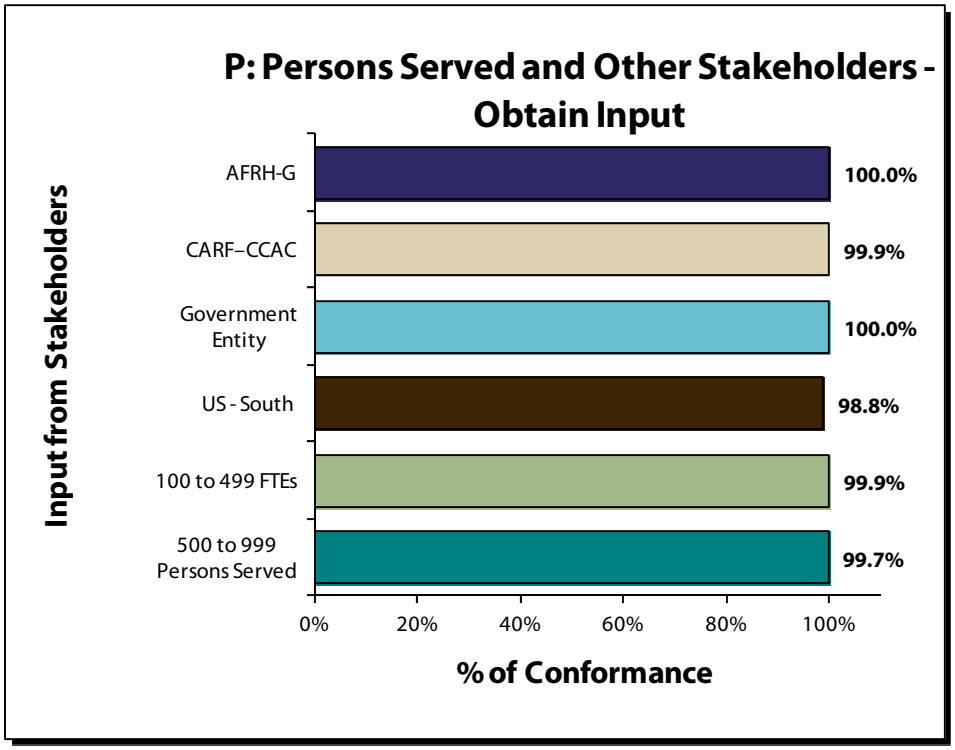

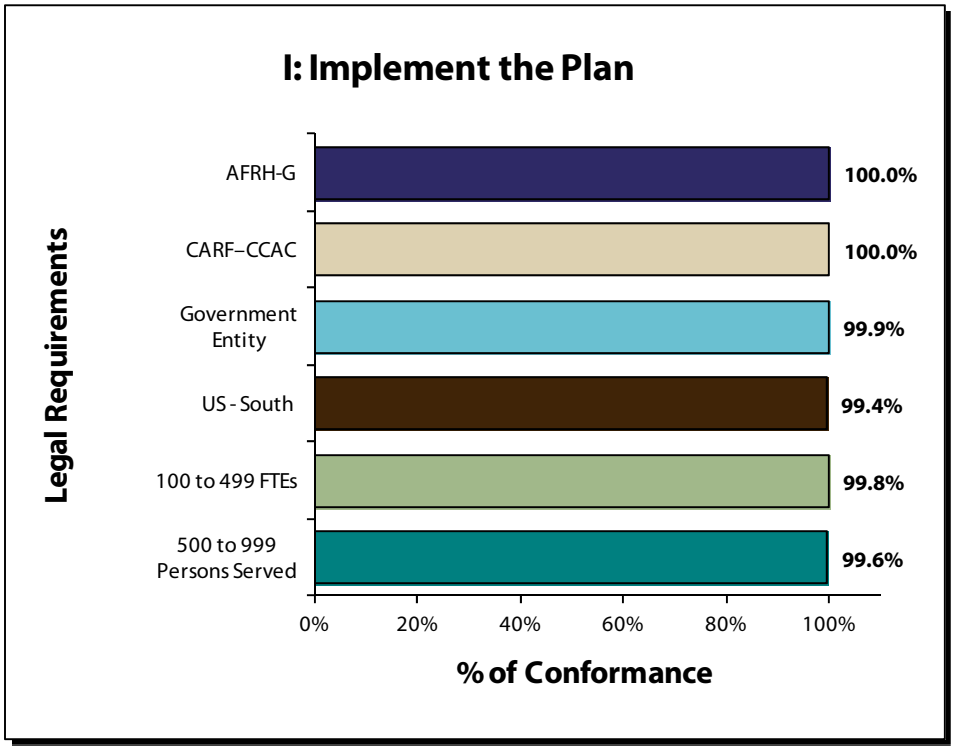

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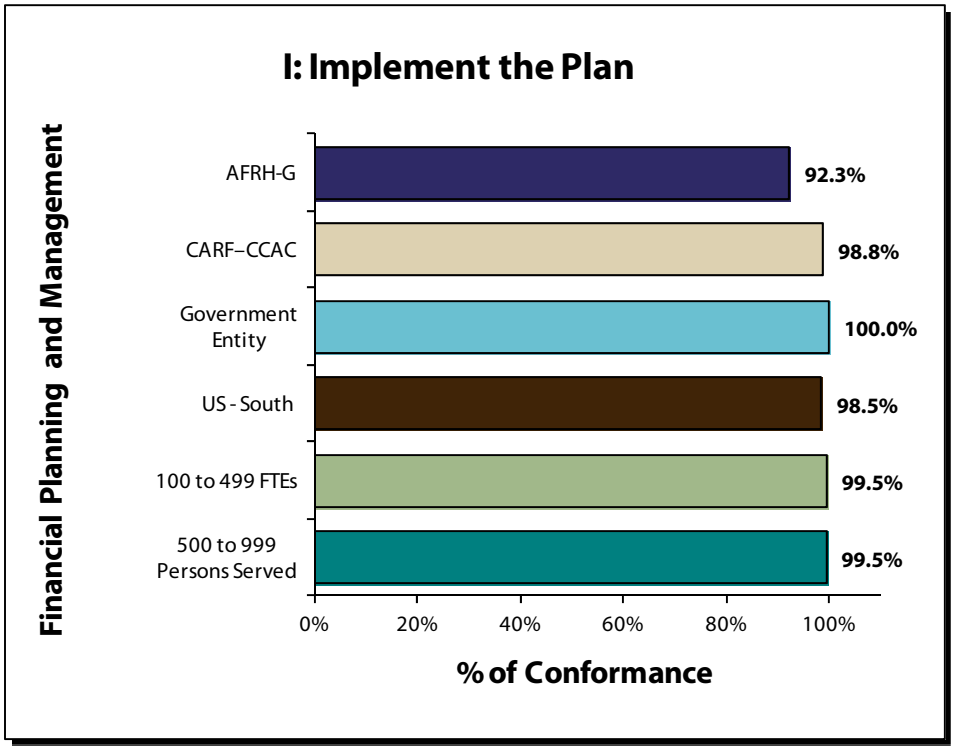

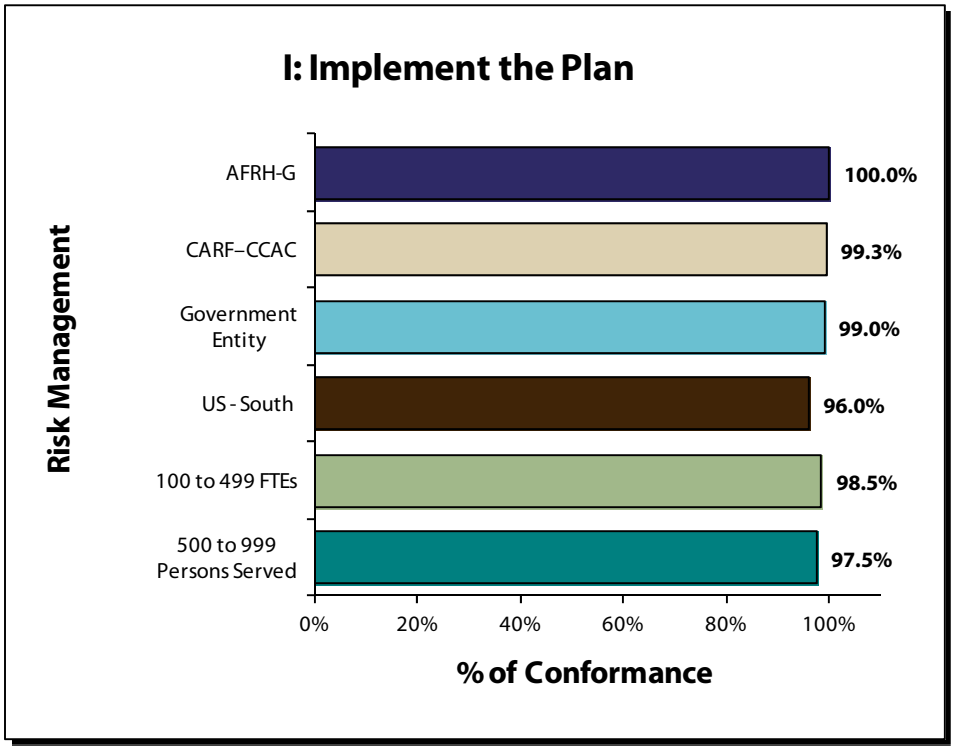

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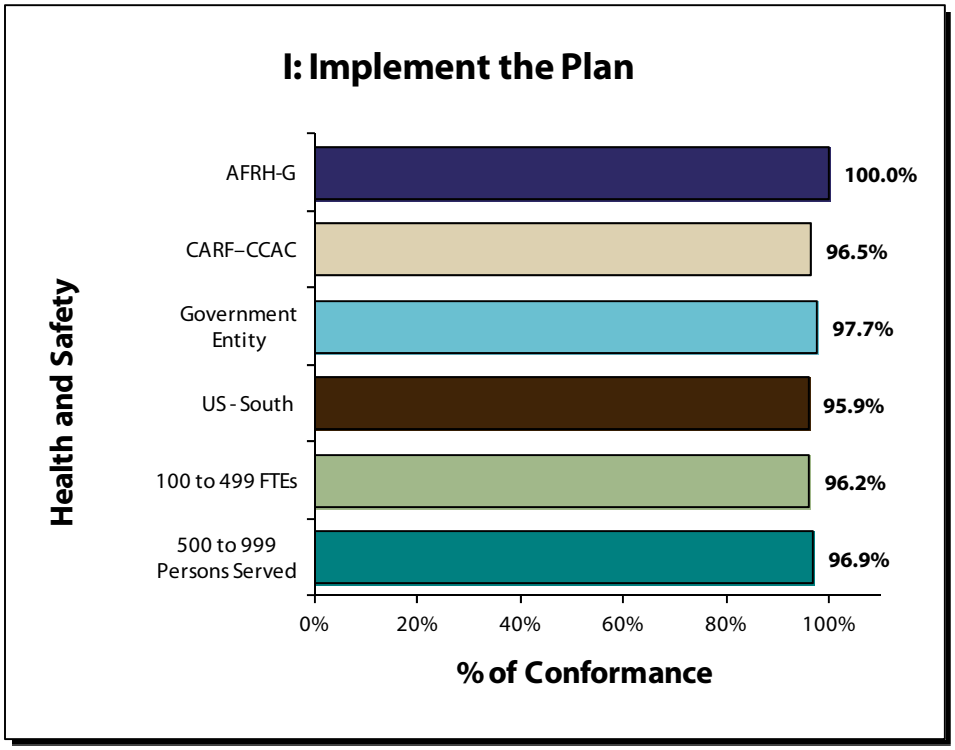

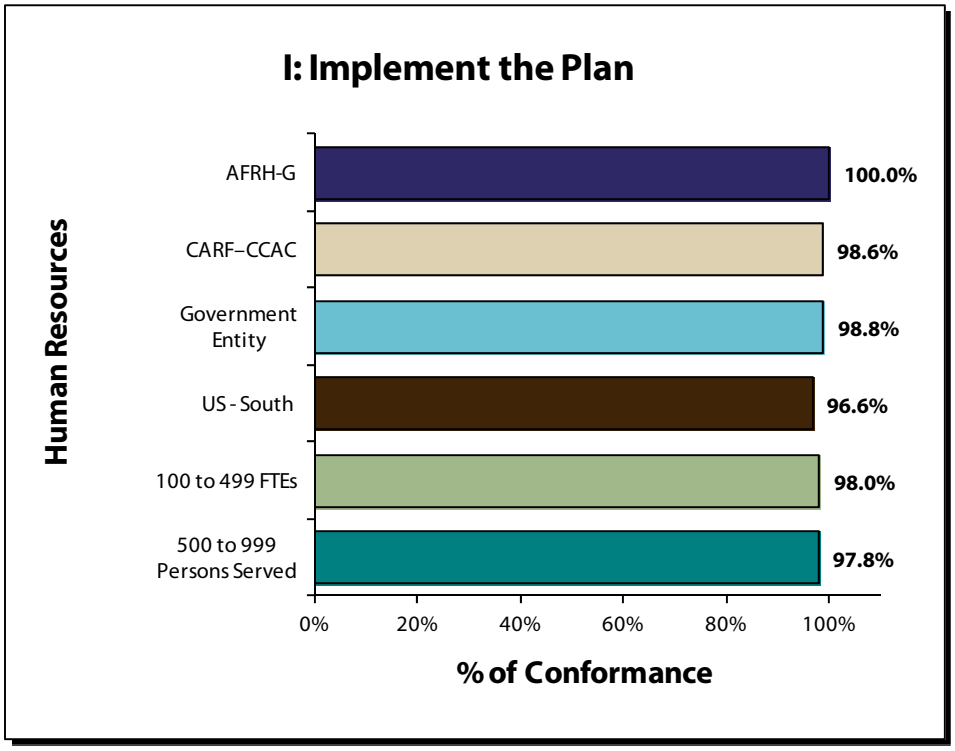

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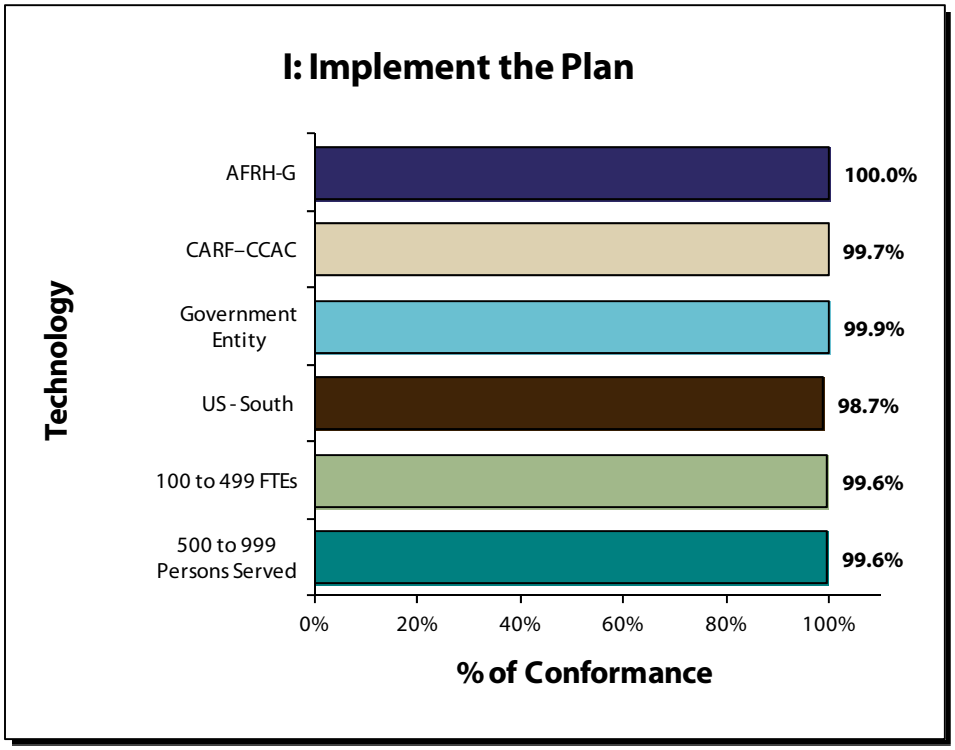
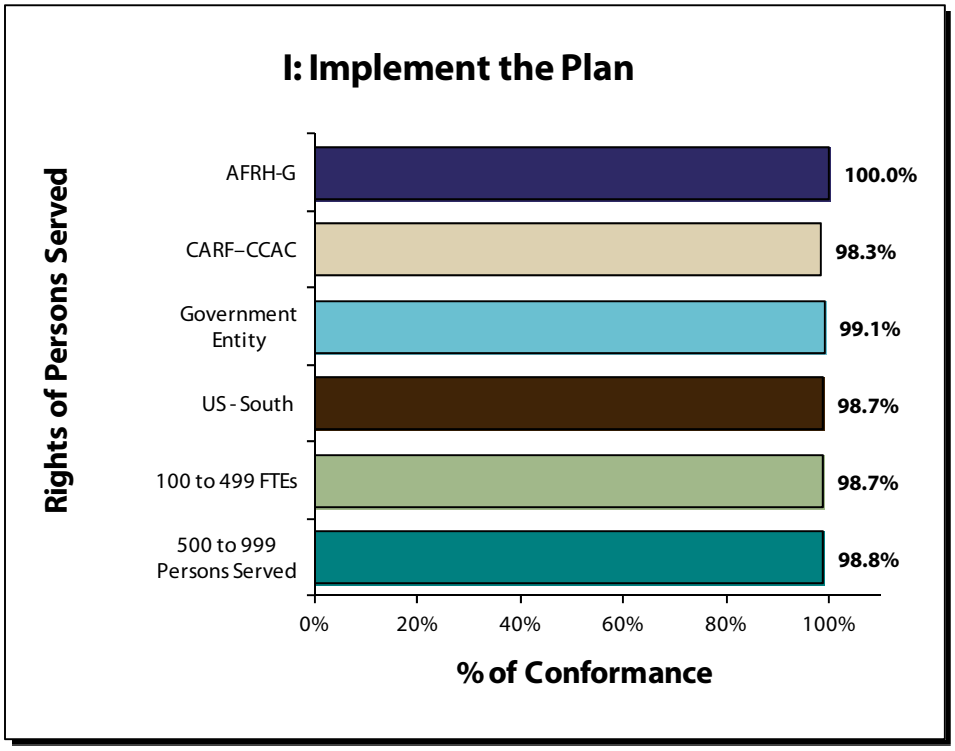
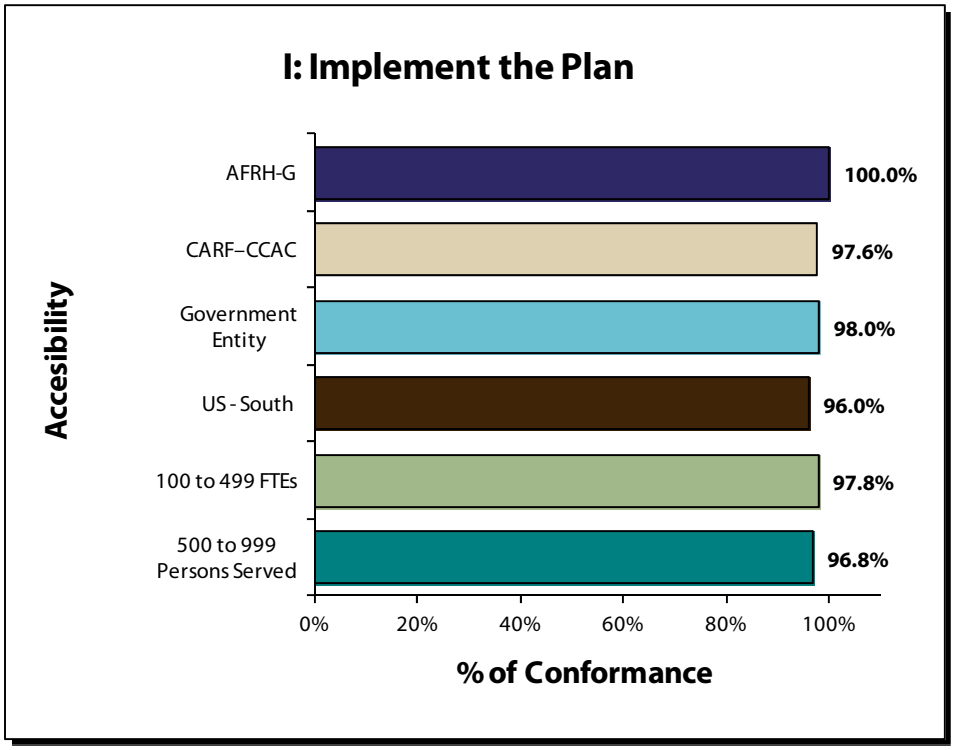
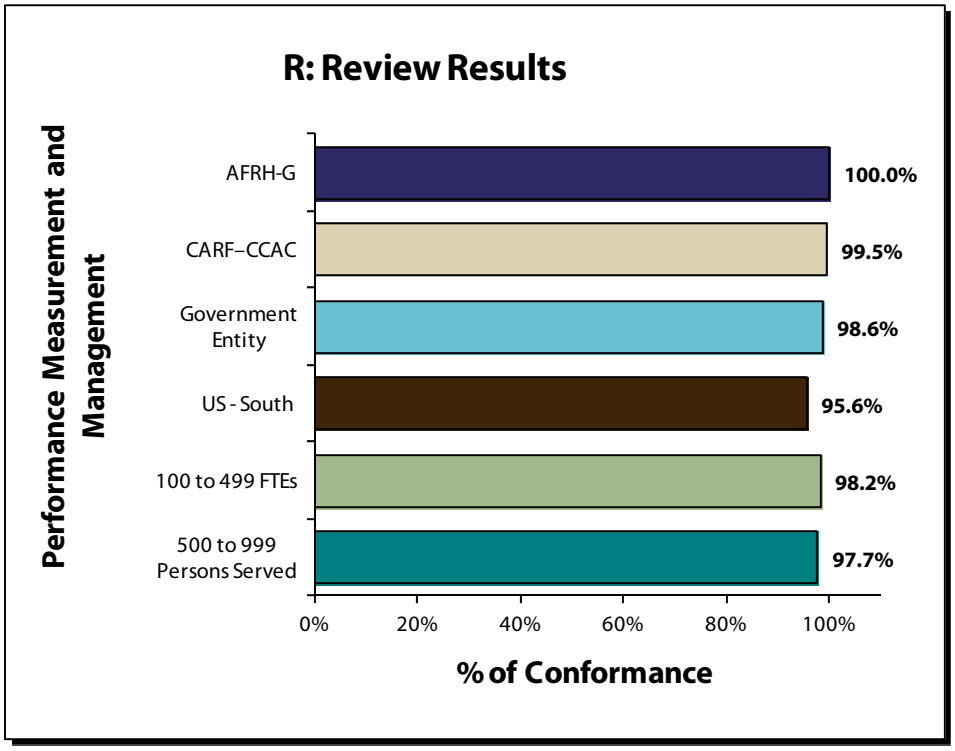


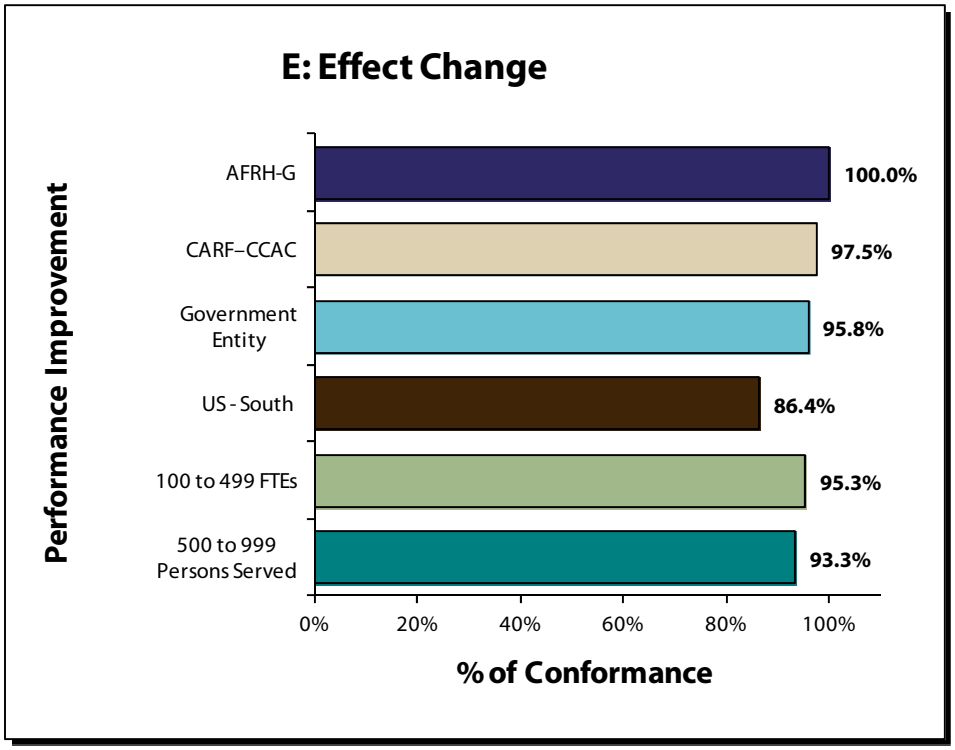


Other benchmarks — continued

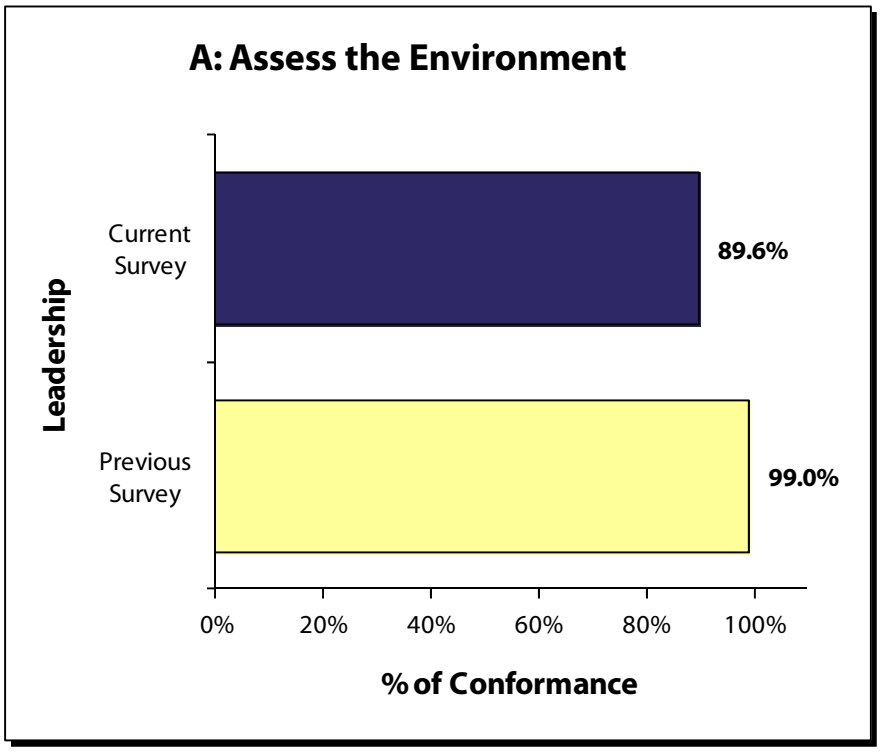


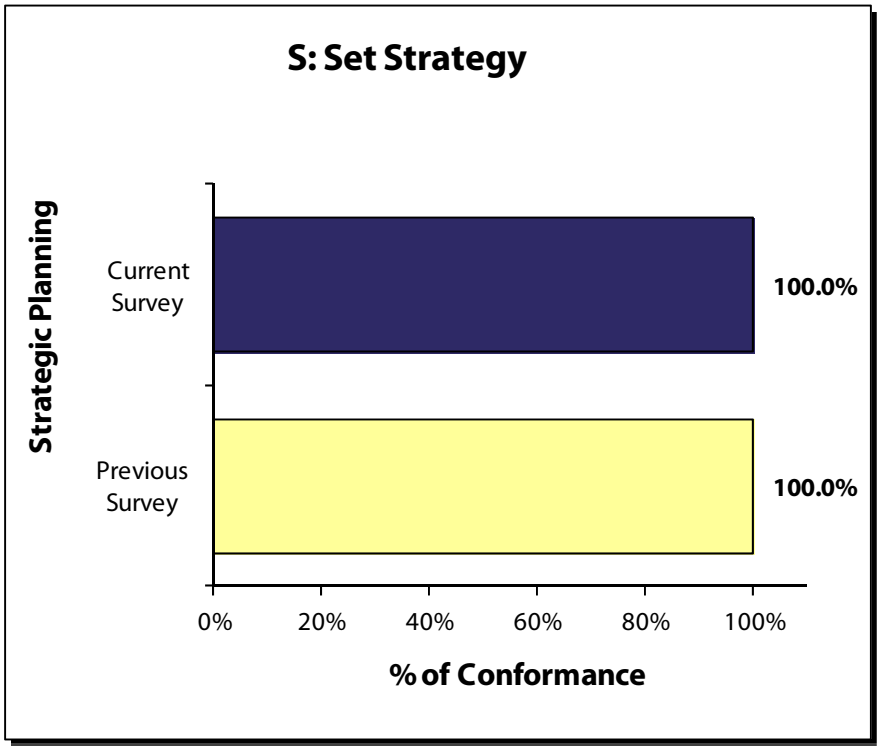


Other benchmarks — continued

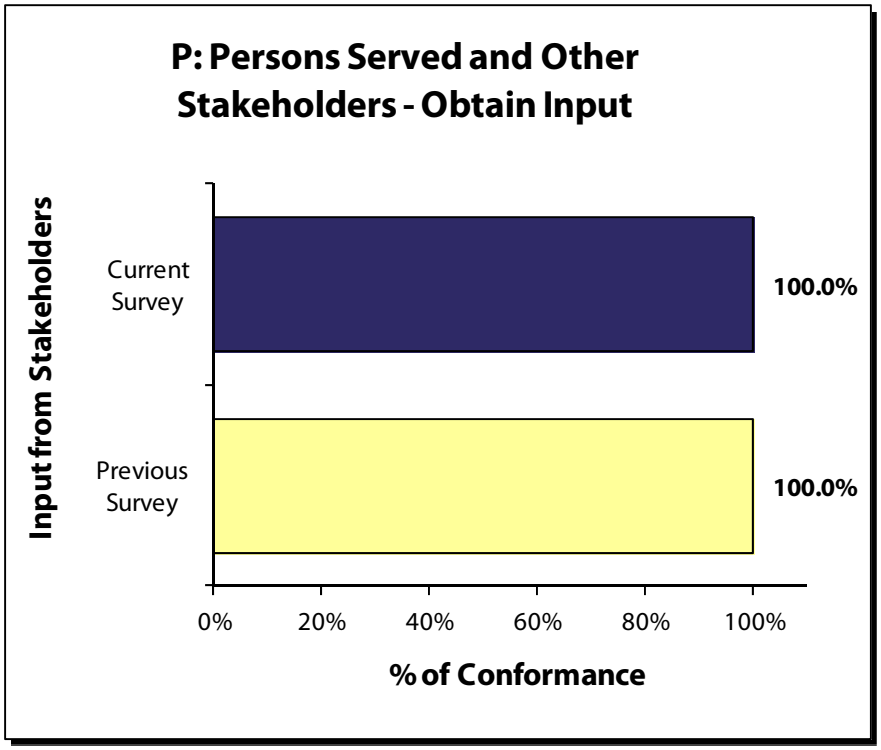


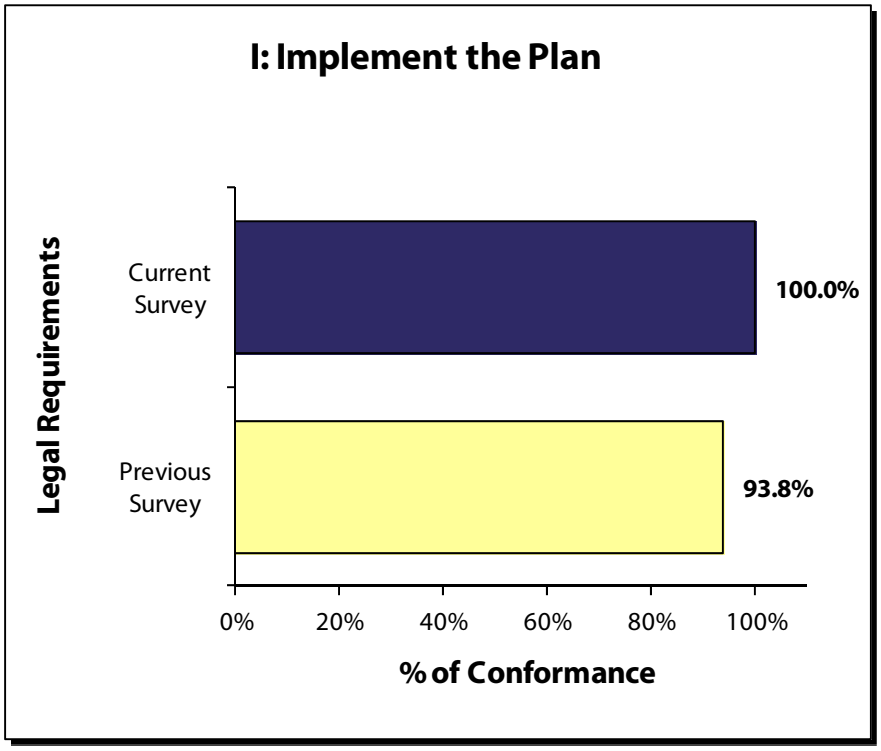
Previous survey



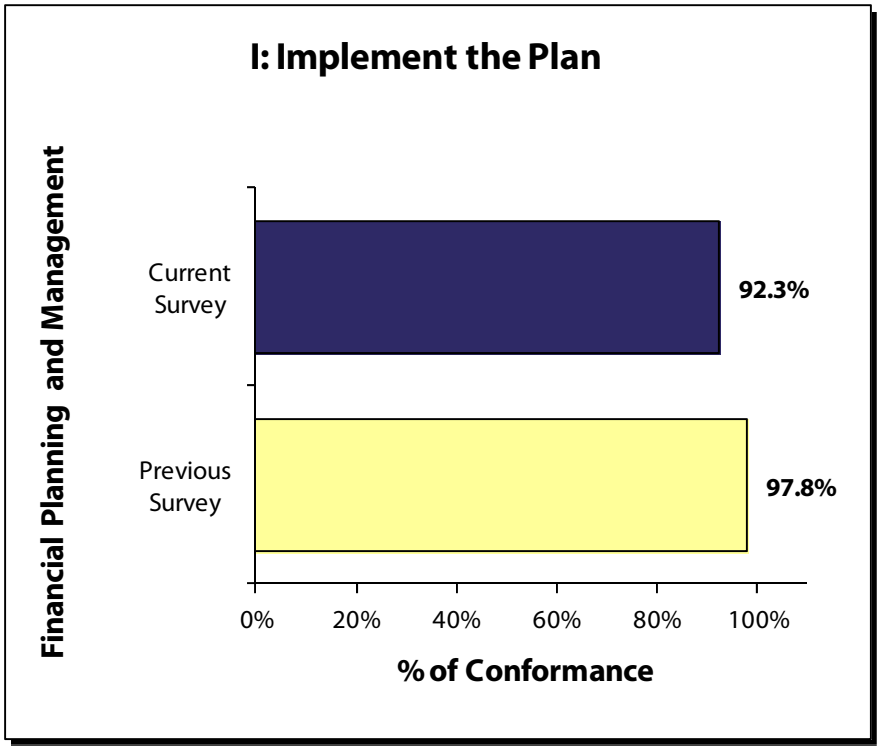


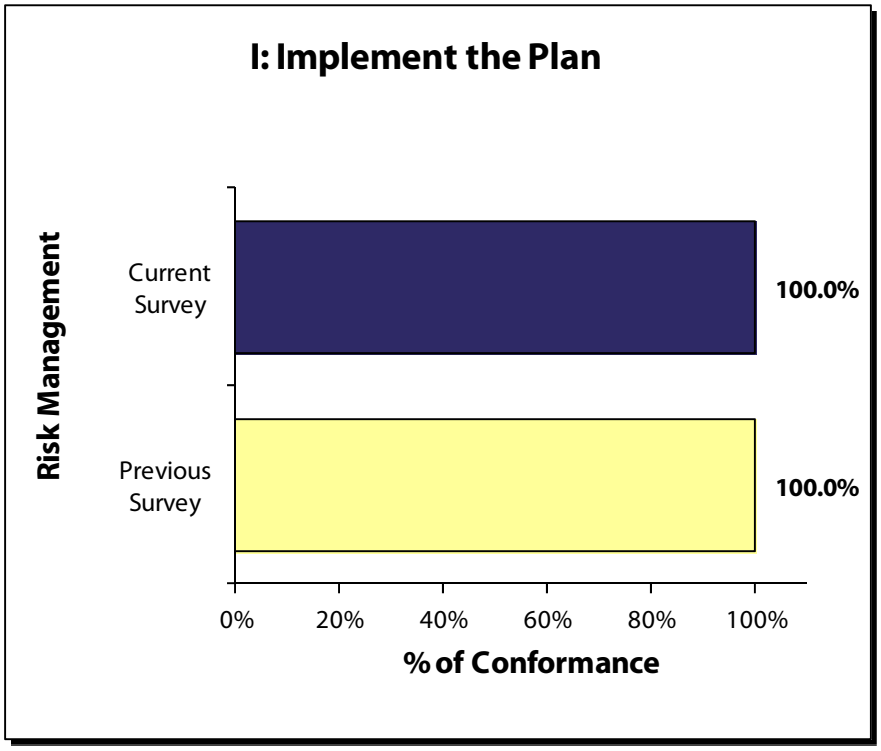
Previous survey — continued



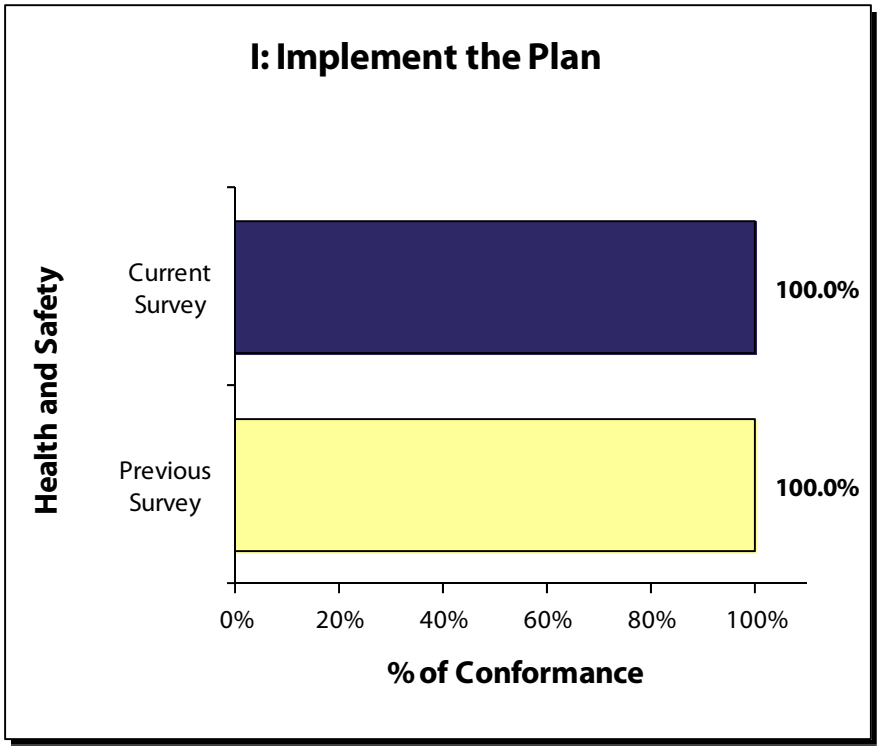


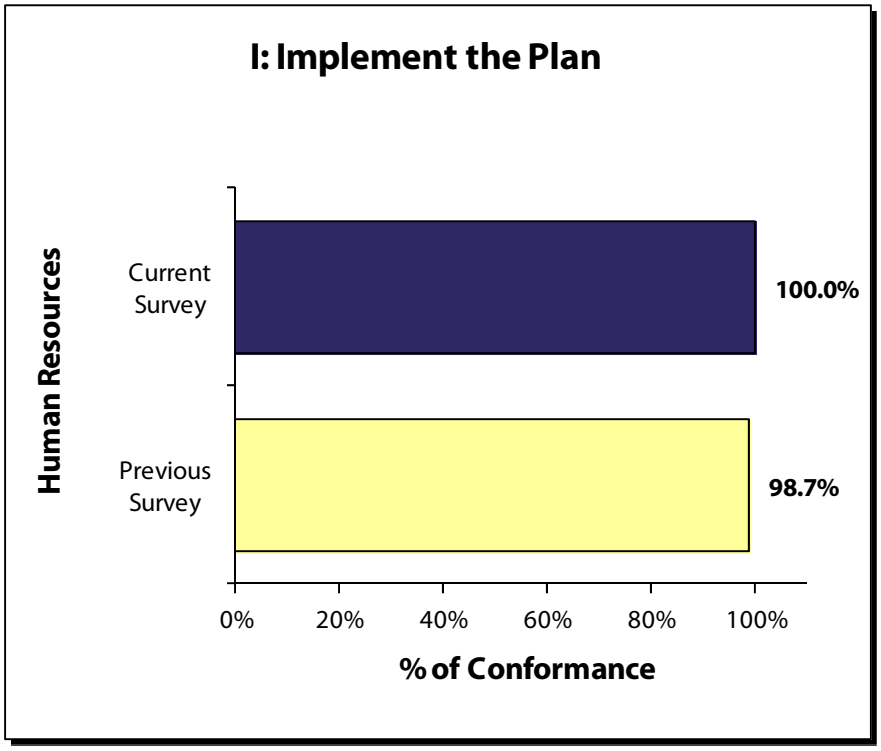
Previous survey — continued



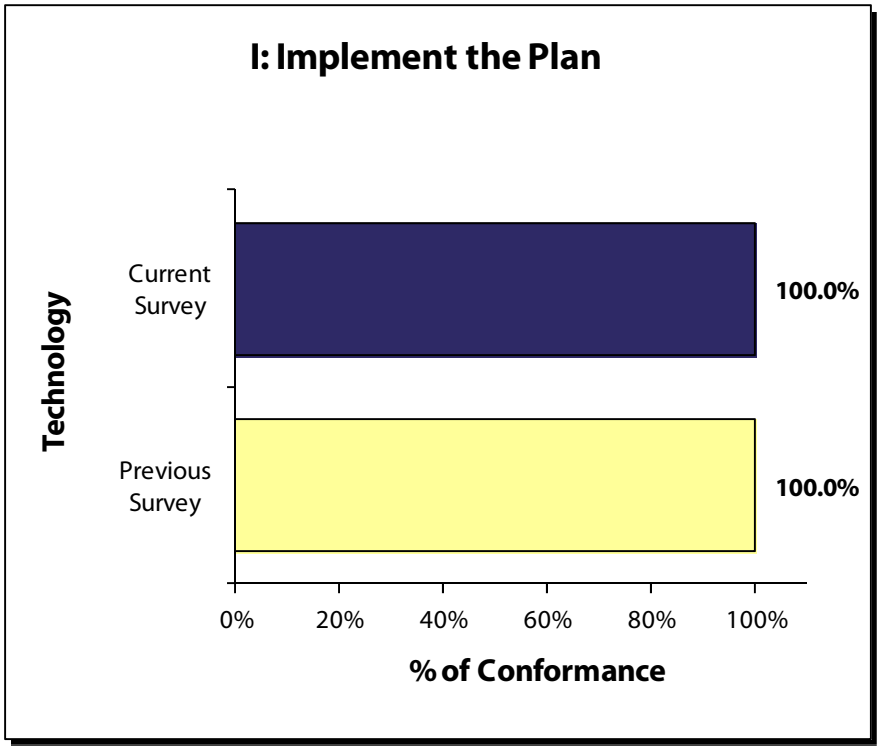


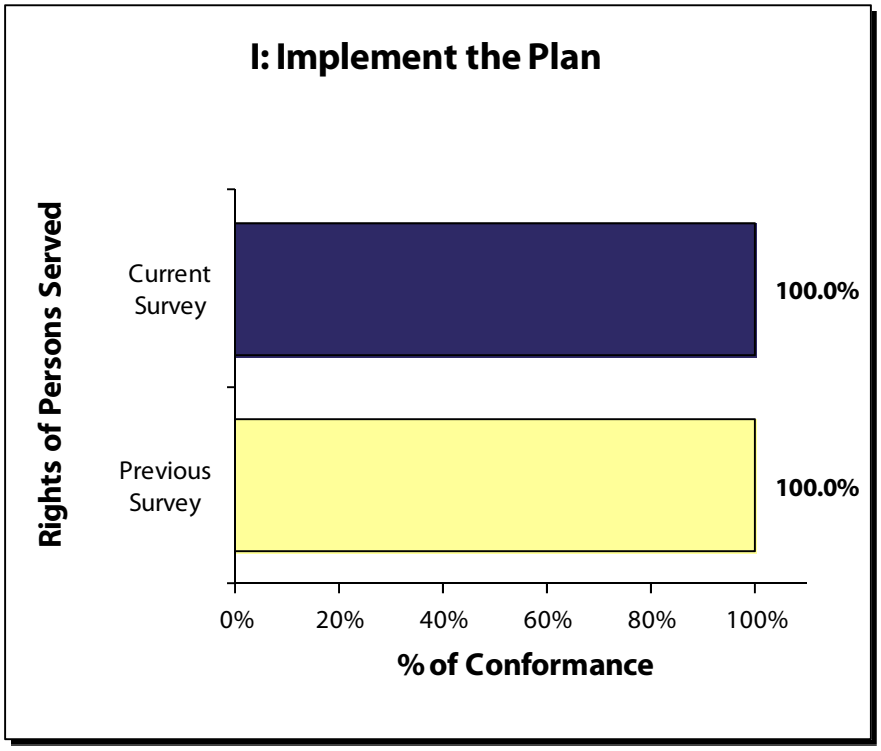
Previous survey — continued



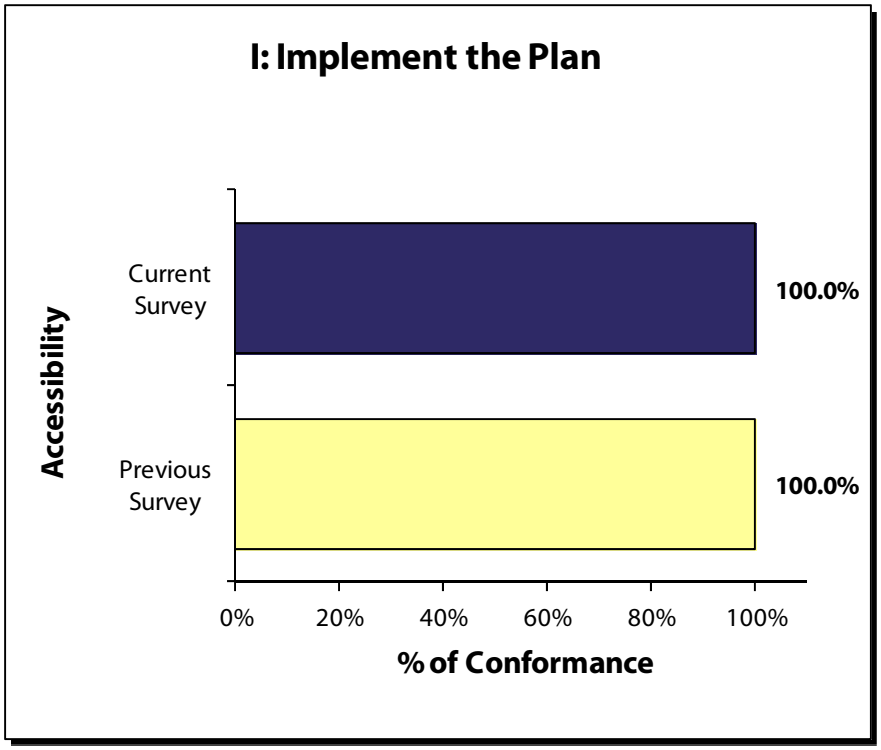


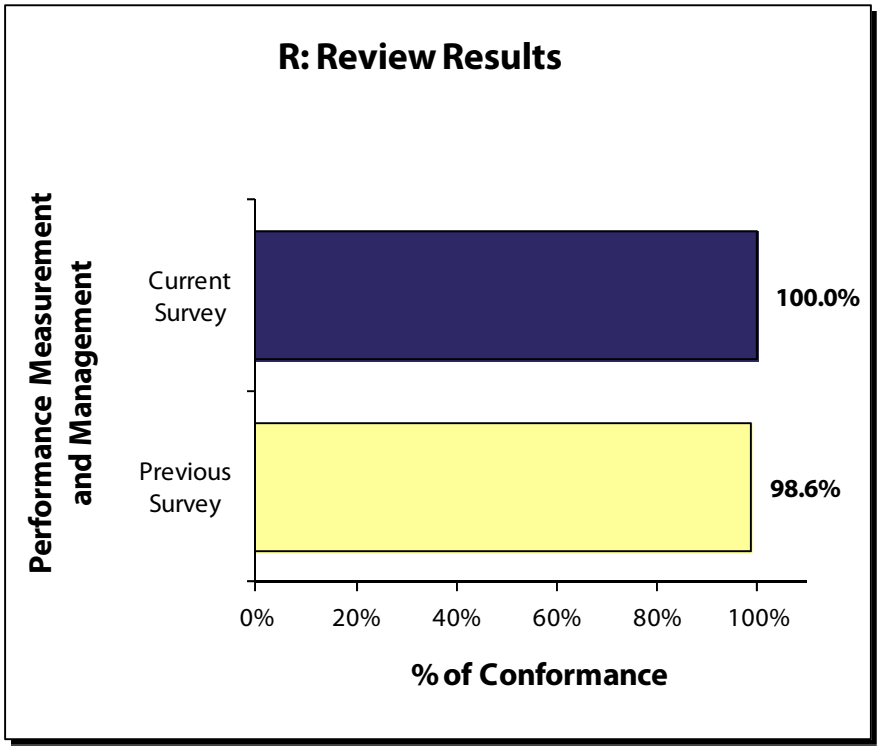
Previous survey — continued



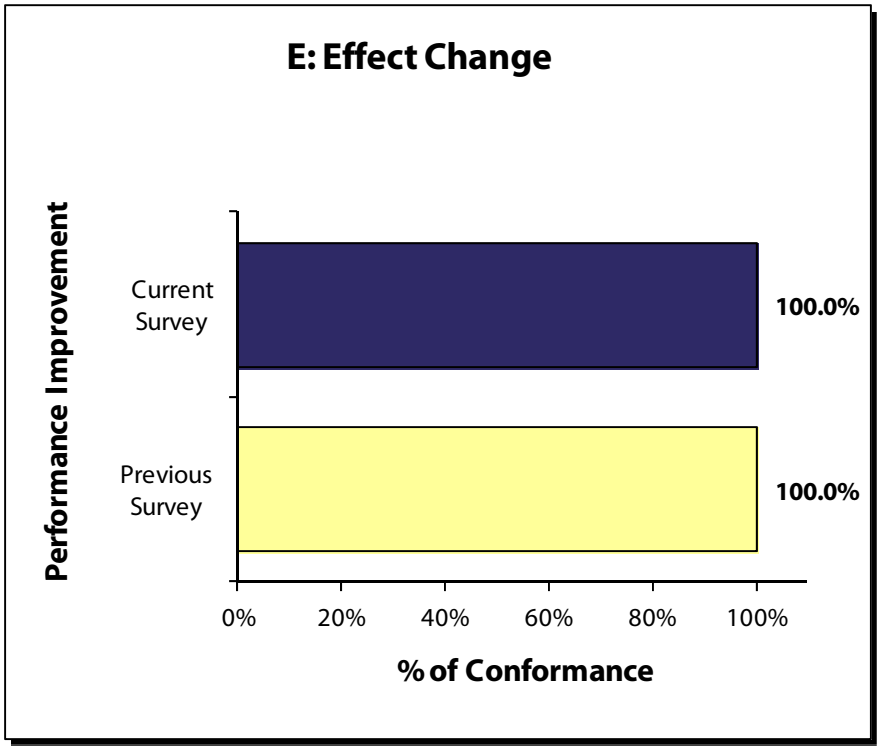


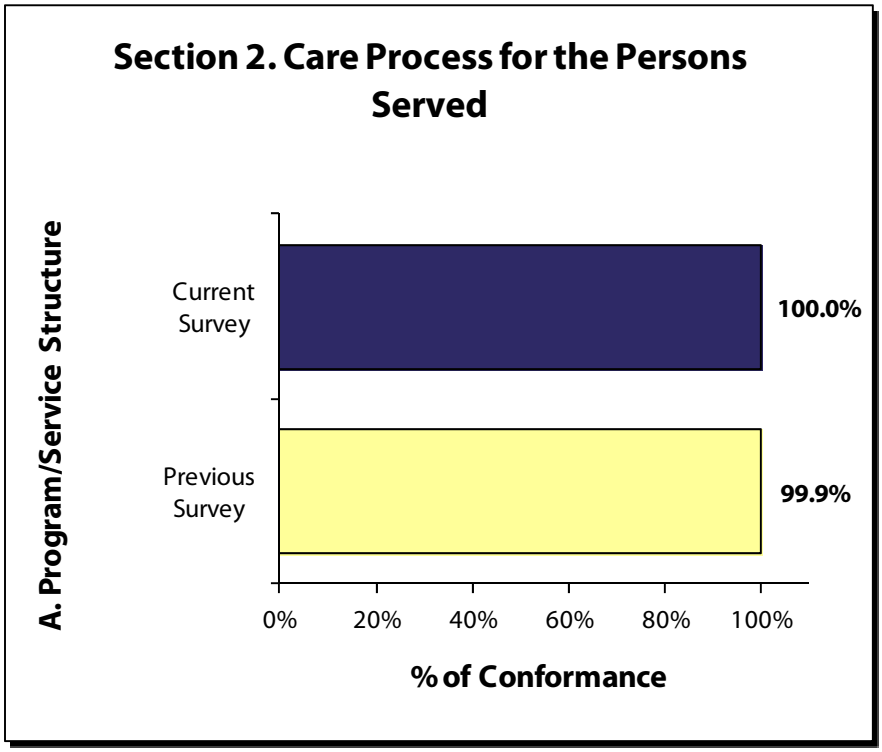
Previous survey — continued



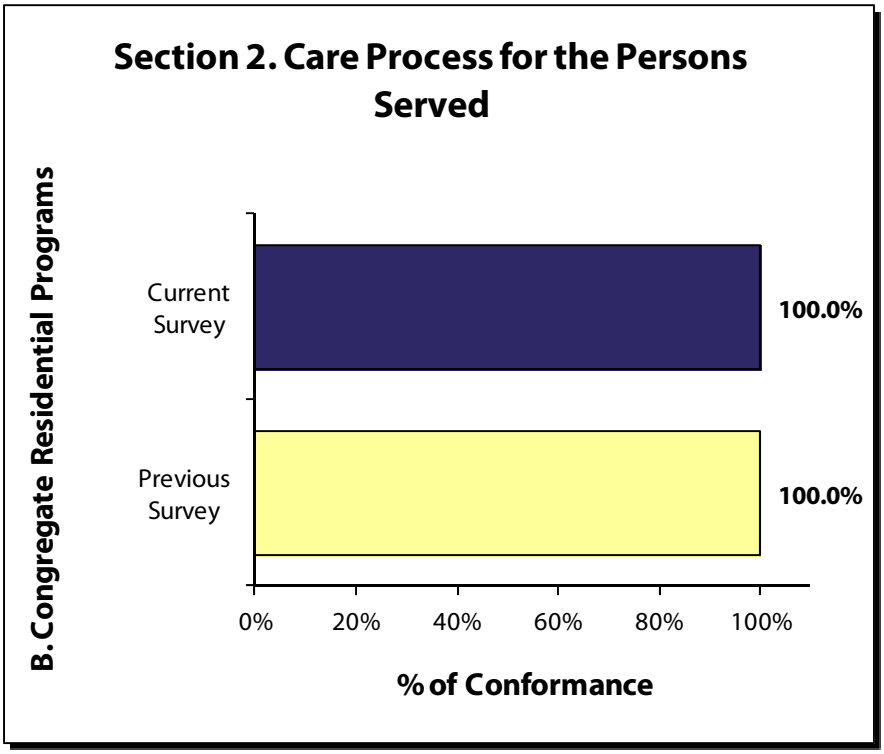


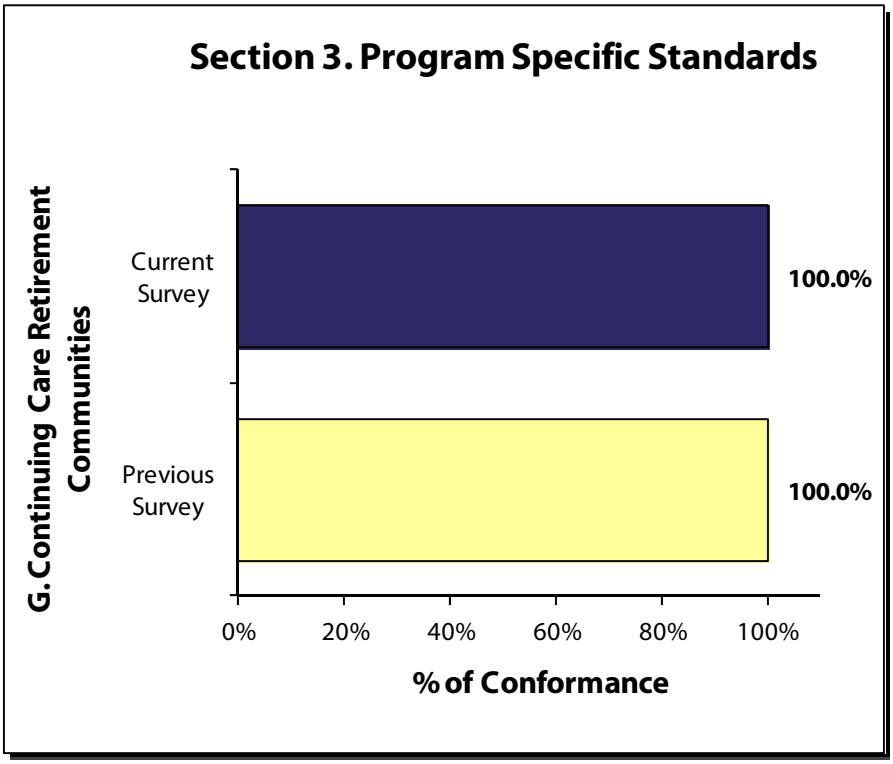
Previous survey — continued





Previous survey — continued





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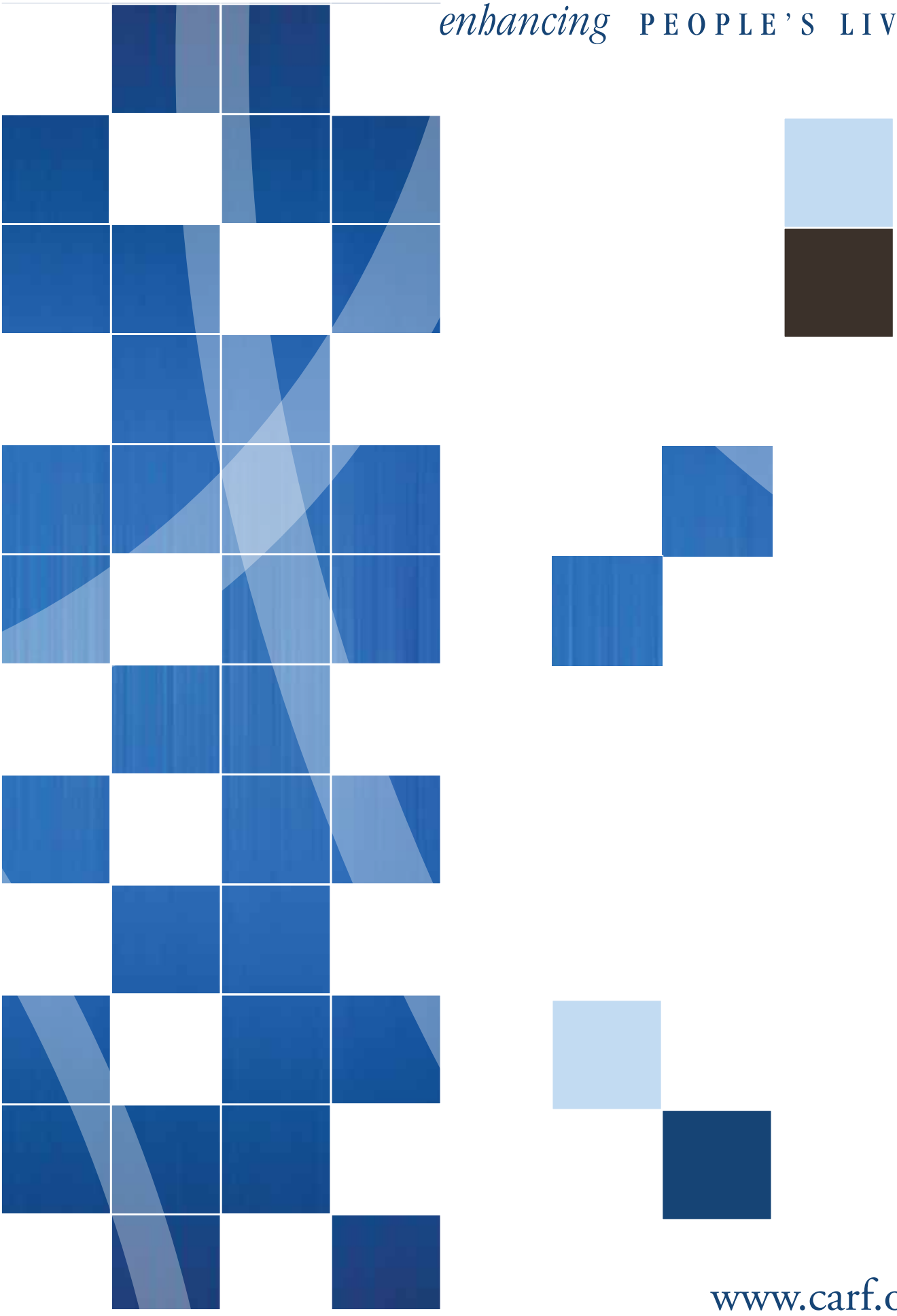

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