Select Year: 2004

# The 2004 Florida Statutes

## CHAPTER 400

## NURSING HOMES AND RELATED HEALTH CARE FACILITIES

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**PART I**

**LONG-TERM CARE FACILITIES: OMBUDSMAN PROGRAM**

400.0091 Training.

**400.0060 Definitions.**--When used in this part, unless the context otherwise requires, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Long-term care facility" means a skilled nursing facility, nursing facility, assisted living facility, adult family-care home, board and care facility, or any other similar adult care center.

(3) "Office" means the Office of State Long-Term Care Ombudsman.

(4) "Ombudsman" means the individual designated to head the Office of State Long-Term Care Ombudsman.

(5) "Resident" means an individual 60 years of age or older who resides in a long-term care facility.

(6) "Secretary" means the Secretary of Elderly Affairs.

**History.**--ss. 1, 30, ch. 93-177; s. 4, ch. 95-210.

**400.0061 Legislative findings and intent; long-term care facilities.**--

(1) The Legislature finds that conditions in long-term care facilities in this state are such that the rights, health, safety, and welfare of residents are not ensured by rules of the Department of Elderly Affairs or the Agency for Health Care Administration, or by the good faith of owners or operators of long-term care facilities. Furthermore, there is a need for a formal mechanism whereby a long-term care facility resident or his or her representative may make a complaint against the facility or its employees, or against other persons who are in a position to restrict, interfere with, or threaten the rights, health, safety, or welfare of the resident. The Legislature finds that concerned citizens are more effective advocates of the rights of others than governmental agencies. The Legislature further finds that in order to be eligible to receive an allotment of funds authorized and appropriated under the federal Older Americans Act, the state must establish and operate an Office of State Long-Term Care Ombudsman, to be headed by the State Long-Term Care Ombudsman, and carry out a long-term care ombudsman program.

(2) It is the intent of the Legislature, therefore, to utilize voluntary citizen ombudsman councils under the leadership of the ombudsman, and through them to operate an ombudsman program which shall, without interference by any executive agency, undertake to discover, investigate, and determine the presence of conditions or individuals which constitute a threat to the rights, health, safety, or welfare of the residents of long-term care facilities. To ensure that the effectiveness and efficiency of such investigations are not impeded by advance notice or delay, the Legislature intends that the ombudsman and ombudsman councils and their designated representatives not be required to obtain warrants in order to enter into or conduct administrative inspections of long-term care facilities. It is the further intent of the Legislature that the environment in long-term care facilities shall be conducive to the dignity and independence of residents and that investigations by ombudsman councils shall further the enforcement of laws, rules, and regulations that safeguard the health, safety, and welfare of residents.

**History.**--ss. 2, 30, ch. 93-177; s. 758, ch. 95-148; s. 111, ch. 99-8.

**400.0063 Establishment of Office of State Long-Term Care Ombudsman; designation of ombudsman and legal advocate.** --

(1) There is created an Office of State Long-Term Care Ombudsman in the Department of Elderly Affairs.

(2)(a) The Office of State Long-Term Care Ombudsman shall be headed by the State Long-Term Care Ombudsman who shall have expertise and experience in the fields of long-term care and advocacy, who shall serve on a full-time basis and shall personally, or through representatives of the office, carry out the purposes and functions of the Office of State Long-Term Care Ombudsman in accordance with state and federal law.

(b) The State Long-Term Care Ombudsman shall be appointed by and shall serve at the pleasure of the Secretary of Elderly Affairs. No person who has a conflict of interest, or has an immediate family member who has a conflict of interest, may be involved in the designation of the ombudsman.

(3)(a) There is created in the Office of State Long-Term Care Ombudsman the position of legal advocate, who shall be selected by and serve at the pleasure of the ombudsman, and who shall be a member in good standing of The Florida Bar.

(b) The duties of the legal advocate shall include, but not be limited to:

1. Assisting the ombudsman in carrying out the duties of the office with respect to the abuse, neglect, or violation of rights of residents of long-term care facilities.

2. Assisting the state and local ombudsman councils in carrying out their responsibilities under this part.

3. Initiating and prosecuting legal and equitable actions to enforce the rights of long-term care facility residents as defined in this chapter.

4. Serving as legal counsel to the state and local ombudsman councils, or individual members thereof, against whom any suit or other legal action is initiated in connection with the performance of the official duties of the councils or an individual member.

**History.**--ss. 3, 30, ch. 93-177; s. 41, ch. 95-196; s. 121, ch. 2000-349; s. 41, ch. 2000-367; s. 20, ch. 2002-223.

**400.0065 State Long-Term Care Ombudsman; duties and responsibilities; conflict of interest.**--

(1) The purpose of the Office of State Long-Term Care Ombudsman shall be to:

(a) Identify, investigate, and resolve complaints made by or on behalf of residents of long-term care facilities, relating to actions or omissions by providers or representatives of providers of long-term care services, other public or private agencies, guardians, or representative payees that may adversely affect the health, safety, welfare, or rights of the residents.

(b) Provide services to assist residents in protecting the health, safety, welfare, and rights of the residents.

(c) Inform residents about obtaining the services of the Office of State Long-Term Care Ombudsman and its representatives.

(d) Ensure that residents have regular and timely access to the services provided through the office and that residents and complainants receive timely responses from representatives of the office to their complaints.

(e) Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.

(f) Provide administrative and technical assistance to state and local ombudsman councils.

(g) Analyze, comment on, and monitor the development and implementation of federal, state, and local laws, rules, and regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the state, and recommend any changes in such laws, rules, regulations, policies, and actions as the office determines to be appropriate.

(h) Provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

(2) The State Long-Term Care Ombudsman shall have the duty and authority to:

(a) Assist and support the efforts of the State Long-Term Care Ombudsman Council in the establishment and coordination of local ombudsman councils throughout the state.

(b) Perform the duties specified in state and federal law, rules, and regulations.

(c) Within the limits of federal and state funding authorized and appropriated, employ such personnel, including staff for local ombudsman councils, as are necessary to perform adequately the functions of the office and provide or contract for legal services to assist the state and local ombudsman councils in the performance of their duties. Staff positions for each local ombudsman council may be established as career service positions, and shall be filled by the ombudsman after approval by the secretary.

(d) Contract for services necessary to carry out the activities of the office.

(e) Apply for, receive, and accept grants, gifts, or other payments, including, but not limited to, real property, personal property, and services from a governmental entity or other public or private entity or person, and make arrangements for the use of such grants, gifts, or payments.

(f) Coordinate, to the greatest extent possible, state and local ombudsman services with the protection and advocacy systems for individuals with developmental disabilities and mental illnesses and with legal assistance programs for the poor through adoption of memoranda of understanding and other means.

(g) Enter into a cooperative agreement with the statewide and district human rights advocacy committees for the purpose of coordinating advocacy services provided to residents of long-term care facilities.

[1](h) Enter into a cooperative agreement with the Medicaid Fraud Division as prescribed under s. 731(e)(2)(B) of the Older Americans Act.

(3) The State Long-Term Care Ombudsman shall not:

(a) Have a direct involvement in the licensing or certification of, or an ownership or investment interest in, a long-term care facility or a provider of a long-term care service.

(b) Be employed by, or participate in the management of, a long-term care facility.

(c) Receive, or have a right to receive, directly or indirectly, remuneration, in cash or in kind, under a compensation agreement with the owner or operator of a long-term care facility.

The Department of Elderly Affairs shall adopt rules to establish procedures to identify and eliminate conflicts of interest as described in this subsection.

**History.**--ss. 4, 30, ch. 93-177; s. 112, ch. 99-8; s. 122, ch. 2000-349; s. 42, ch. 2000-367; s. 21, ch. 2002-223.

**[1]Note.**--As amended by s. 122, ch. 2000-349. For a description of multiple acts in the same session affecting a statutory provision, *see* preface to the *Florida Statutes*, "Statutory Construction." Paragraph (2)(i), redesignated as paragraph (2)(h) incident to compiling the Florida Statutes 2002, was also amended by s. 42, ch. 2000-367, and that version reads:

(h) Enter into a cooperative agreement with the office of state government which is responsible for investigating Medicaid fraud.

**400.0066 Office of State Long-Term Care Ombudsman and departments of state government.**--

(1) The State Long-Term Care Ombudsman shall perform the duties specified in state and federal law.

(2) The Department of Elderly Affairs shall meet the costs associated with these functions from funds appropriated to the department.

(3) The Department of Elderly Affairs shall include the costs associated with support of the long-term care ombudsman program in developing its budget requests for consideration by the Governor and submittal to the Legislature.

[1](4) The Department of Elderly Affairs may divert from the federal ombudsman appropriation an amount equal to the department's administrative cost ratio, not to exceed 10 percent of the federal appropriation, for the ombudsman. The remaining 90 percent or more of the allotment from the Older Americans Act program shall be expended on direct ombudsman activities.

**History.**--s. 123, ch. 2000-349; s. 43, ch. 2000-367; s. 33, ch. 2002-223.

**[1]Note.**--As enacted by s. 123, ch. 2000-349. This material was also enacted by s. 43, ch. 2000-367, as subsection (5). The s. 43, ch. 2000-367, version reads:

(5) The department may divert from the federal ombudsman appropriation an amount not to exceed 10 percent of the federal appropriation for the ombudsman.

**400.0067 State Long-Term Care Ombudsman Council; duties; membership.**--

(1) There is created within the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council.

(2) The State Long-Term Care Ombudsman Council shall:

(a) Assist the ombudsman in reaching a consensus among local ombudsman councils on issues of statewide concern.

(b) Serve as an appellate body in receiving from the local ombudsman councils complaints not resolved at the local level. The state ombudsman council may enter any long-term care facility involved in an appeal, pursuant to the conditions specified in s. 400.0069(3).

(c) Assist the ombudsman to discover, investigate, and determine the existence of abuse or neglect in any long-term care facility. The Department of Elderly Affairs shall develop procedures relating to such investigations. Investigations may consist, in part, of one or more onsite administrative inspections.

(d) Assist the ombudsman in eliciting, receiving, responding to, and resolving complaints made by or on behalf of long-term care facility residents and in developing procedures relating to the receipt and resolution of such complaints. The secretary shall approve all such procedures.

(e) Elicit and coordinate state, local, and voluntary organizational assistance for the purpose of improving the care received by residents of a long-term care facility.

(f) Prepare an annual report describing the activities carried out by the ombudsman and the State Long-Term Care Ombudsman Council in the year for which the report is prepared. The State Long-Term Care Ombudsman Council shall submit the report to the Secretary of Elderly Affairs. The secretary shall in turn submit the report to the Commissioner of the United States Administration on Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the minority leaders of the House and Senate, the chairpersons of appropriate House and Senate committees, the Secretary of Children and Family Services, and the Secretary of Health Care Administration. The report shall be submitted by the Secretary of Elderly Affairs at least 30 days before the convening of the regular session of the Legislature and shall, at a minimum:

1. Contain and analyze data collected concerning complaints about and conditions in long-term care facilities.

2. Evaluate the problems experienced by residents of long-term care facilities.

3. Contain recommendations for improving the quality of life of the residents and for protecting the health, safety, welfare, and rights of the residents.

4. Analyze the success of the ombudsman program during the preceding year and identify the barriers that prevent the optimal operation of the program. The report of the program's successes shall also address the relationship between the state long-term care ombudsman program, the Department of Elderly Affairs, the Agency for Health Care Administration, and the Department of Children and Family Services, and an assessment of how successfully the state long-term care ombudsman program has carried out its responsibilities under the Older Americans Act.

5. Provide policy and regulatory and legislative recommendations to solve identified problems; resolve residents' complaints; improve the quality of care and life of the residents; protect the health, safety, welfare, and rights of the residents; and remove the barriers to the optimal operation of the state long-term care ombudsman program.

6. Contain recommendations from the local ombudsman councils regarding program functions and activities.

7. Include a report on the activities of the legal advocate and other legal advocates acting on behalf of the local and state councils.

(3)(a) The State Long-Term Care Ombudsman Council shall be composed of one active local council member designated by each local council plus three persons appointed by the Governor.

(b)1. The ombudsman, in consultation with the secretary, shall submit to the Governor a list of at least eight names of persons who are not serving on a local council.

2. The Governor shall appoint three members chosen from the list, at least one of whom must be over 60 years of age.

3. If the Governor's appointments are not made within 60 days after the ombudsman submits the list, the ombudsman, in consultation with the secretary, shall appoint three members, one of whom must be over 60 years of age.

(c) All members shall be appointed to serve 3-year terms. A member of the State Long-Term Care Ombudsman Council may not serve more than two consecutive terms. Any vacancy shall be filled in the same manner as the original appointment. The position of any member missing three consecutive regular meetings without cause shall be declared vacant. The findings of the ombudsman regarding cause shall be final and binding.

(d) The state ombudsman council shall elect a chairperson for a term of 1 year from among the members who have served for at least 1 year. The chairperson shall select a vice chairperson from among the members. The vice chairperson shall preside over the council in the absence of the chairperson.

(e) The state ombudsman council shall meet upon the call of the chairperson, at least quarterly or more frequently as needed.

(f) Members shall receive no compensation but shall be reimbursed for per diem and travel expenses as provided in s. 112.061.

(4) No officer, employee, or representative of the Office of State Long-Term Care Ombudsman or of the State Long-Term Care Ombudsman Council, nor any member of the immediate family of such officer, employee, or representative, may have a conflict of interest. The ombudsman shall adopt rules to identify and remove conflicts of interest.

(5) The Department of Elderly Affairs shall make a separate and distinct request for an appropriation for all expenses for the state and local ombudsman councils.

**History.**--ss. 5, 30, 31, ch. 93-177; s. 759, ch. 95-148; s. 113, ch. 99-8; s. 209, ch. 99-13; s. 15, ch. 2000-263; s. 11, ch. 2000-305; s. 124, ch. 2000-349; s. 44, ch. 2000-367; s. 22, ch. 2002-223.

**400.0069 Local long-term care ombudsman councils; duties; membership.** --

(1) There shall be at least one long-term care ombudsman council in each of the planning and service areas of the Department of Elderly Affairs, which shall function under the direction of the ombudsman and the state ombudsman council.

(2) The duties of the local ombudsman council are:

(a) To serve as a third-party mechanism for protecting the health, safety, welfare, and civil and human rights of residents of a long-term care facility.

(b) To discover, investigate, and determine the existence of abuse or neglect in any long-term care facility and to use the procedures provided for in ss. 415.101-415.113 when applicable. Investigations may consist, in part, of one or more onsite administrative inspections.

(c) To elicit, receive, investigate, respond to, and resolve complaints made by, or on behalf of, long-term care facility residents.

(d) To review and, if necessary, to comment on, for their effect on the rights of long-term care facility residents, all existing or proposed rules, regulations, and other governmental policies relating to long-term care facilities.

(e) To review personal property and money accounts of Medicaid residents pursuant to an investigation to obtain information regarding a specific complaint or problem.

(f) To represent the interests of residents before government agencies and to seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.

(g) To carry out other activities that the ombudsman determines to be appropriate.

(3) In order to carry out the duties specified in subsection (2), the local ombudsman council is authorized, pursuant to ss. 400.19(1) and 400.434, to enter any long-term care facility without notice or first obtaining a warrant, subject to the provisions of s. 400.0073(5).

(4) Each local ombudsman council shall be composed of no less than 15 members and no more than 40 members from the local planning and service area, to include the following: one medical or osteopathic physician whose practice includes or has included a substantial number of geriatric patients and who may have limited practice in a long-term care facility; one registered nurse who has geriatric experience, if possible; one licensed pharmacist; one registered dietitian; at least six nursing home residents or representative consumer advocates for nursing home residents; at least three residents of assisted living facilities or adult family-care homes or three representative consumer advocates for long-term care facility residents; one attorney; and one professional social worker. In no case shall the medical director of a long-term care facility or an employee of the Agency for Health Care Administration, the Department of Children and Family Services, or the Department of Elderly Affairs serve as a member or as an ex officio member of a council. Each member of the council shall certify that neither the council member nor any member of the council member's immediate family has any conflict of interest pursuant to subsection (10). Local ombudsman councils are encouraged to recruit council members who are 60 years of age or older.

(5) All members shall be appointed to serve 3-year terms. Upon expiration of a term and in case of any other vacancy, the council shall select a replacement by majority vote. The ombudsman shall review the selection of the council and recommend approval or disapproval to the Governor. If no action is taken by the Governor to approve or disapprove the replacement of a member within 30 days after the ombudsman has notified the Governor of his or her recommendation, the replacement shall be considered disapproved and the process for selection of a replacement shall be repeated.

(6) The local ombudsman council shall elect a chair for a term of 1 year from members who have served at least 1 year. The chair shall select a vice chair from among the members of the council. The vice chair shall preside over the council in the absence of the chair.

(7) The local ombudsman council shall meet upon the call of the chair or the ombudsman, at least once a month or more frequently as needed to handle emergency situations.

(8) A member of a local ombudsman council shall receive no compensation but shall be reimbursed for travel expenses both within and outside the county of residence in accordance with the provisions of s. 112.061.

(9) The local ombudsman councils are authorized to call upon appropriate agencies of state government for such professional assistance as may be needed in the discharge of their duties. All state agencies shall cooperate with the local ombudsman councils in providing requested information and agency representatives at council meetings.

(10) No officer, employee, or representative of a local long-term care ombudsman council, nor any member of the immediate family of such officer, employee, or representative, may have a conflict of interest. The ombudsman shall adopt rules to identify and remove conflicts of interest.

**History.**--s. 27, ch. 75-233; s. 3, ch. 76-168; s. 136, ch. 77-104; s. 8, ch. 77-401; s. 1, ch. 77-457; s. 4, ch. 78-323; s. 2, ch. 78-393; ss. 6, 12, ch. 80-198; ss. 2, 3, 5, ch. 81-184; ss. 2, 3, ch. 81-318; ss. 1, 4, ch. 82-46; ss. 15, 19, ch. 82-148; ss. 35, 79, 80, 83, 84, ch. 83-181; s. 39, ch. 86-220; s. 2, ch. 87-396; s. 7, ch. 89-294; s. 3, ch. 91-115; s. 27, ch. 92-33; ss. 6, 29, 30, 31, ch. 93-177; s. 49, ch. 93-217; s. 760, ch. 95-148; s. 5, ch. 95-210; s. 114, ch. 99-8; s. 125, ch. 2000-349; s. 45, ch. 2000-367; s. 23, ch. 2002-223.

**Note.**--Former s. 400.307.

**400.0071 Complaint procedures.**--

(1) The state ombudsman council shall recommend to the ombudsman and the secretary state and local procedures for receiving complaints against a nursing home or long-term care facility or its employee. The procedures shall be implemented after the approval of the ombudsman and the secretary.

(2) These procedures shall be posted in full view in every nursing home or long-term care facility. Every resident or representative of a resident shall receive, upon admission to a nursing home or long-term care facility, a printed copy of the procedures of the state and the local ombudsman councils.

**History.**--s. 28, ch. 75-233; s. 3, ch. 76-168; s. 9, ch. 77-401; s. 1, ch. 77-457; ss. 7, 12, ch. 80-198; ss. 4, 6, ch. 81-184; ss. 2, 3, ch. 81-318; s. 4, ch. 82-46; ss. 36, 79, 83, ch. 83-181; ss. 16, 29, 30, ch. 93-177; s. 49, ch. 93-217; s. 126, ch. 2000-349; s. 46, ch. 2000-367; s. 24, ch. 2002-223.

**Note.**--Former s. 400.311.

**400.0073 State and local ombudsman council investigations.**--

(1) A local ombudsman council shall investigate any complaint of a resident or representative of a resident based on an action by an administrator or employee of a nursing home or long-term care facility which might be:

(a) Contrary to law.

(b) Unreasonable, unfair, oppressive, or unnecessarily discriminatory, even though in accordance with law.

(c) Based on a mistake of fact.

(d) Based on improper or irrelevant grounds.

(e) Unaccompanied by an adequate statement of reasons.

(f) Performed in an inefficient manner.

(g) Otherwise erroneous.

(2) In an investigation, both the state and local ombudsman councils have the authority to hold hearings.

(3) Subsequent to an appeal from a local ombudsman council, the state ombudsman council may investigate any nursing home or long-term care facility.

(4) In addition to any specific investigation made pursuant to a complaint, the local ombudsman council shall conduct, at least annually, an investigation, which shall consist, in part, of an onsite administrative inspection, of each nursing home or long-term care facility within its jurisdiction. This inspection shall focus on the rights, health, safety, and welfare of the residents.

(5) Any onsite administrative inspection conducted by an ombudsman council shall be subject to the following:

(a) All inspections shall be at times and for durations necessary to produce the information required to carry out the duties of the council.

(b) No advance notice of an inspection shall be provided to any nursing home or long-term care facility, except that notice of followup inspections on specific problems may be provided.

(c) Inspections shall be conducted in a manner which will impose no unreasonable burden on nursing homes or long-term care facilities, consistent with the underlying purposes of this part. Unnecessary duplication of efforts among council members or the councils shall be reduced to the extent possible.

(d) Any ombudsman council member physically present for the inspection shall identify himself or herself and the statutory authority for his or her inspection of the facility.

(e) Inspections may not unreasonably interfere with the programs and activities of clients within the facility. Ombudsman council members shall respect the rights of residents.

(f) All inspections shall be limited to compliance with parts II, III, and VII of this chapter and 42 U.S.C. ss. 1396(a) et seq., and any rules or regulations promulgated pursuant to such laws.

(g) No ombudsman council member shall enter a single-family residential unit within a long-term care facility without the permission of the resident or the representative of the resident.

(h) Any inspection resulting from a specific complaint made to an ombudsman council concerning a facility shall be conducted within a reasonable time after the complaint is made.

(6) An inspection may not be accomplished by forcible entry. Refusal of a long-term care facility to allow entry of any ombudsman council member constitutes a violation of part II, part III, or part VII of this chapter.

**History.**--s. 29, ch. 75-233; s. 3, ch. 76-168; s. 10, ch. 77-401; s. 1, ch. 77-457; ss. 8, 12, ch. 80-198; ss. 4, 6, ch. 81-184; ss. 2, 3, ch. 81-318; s. 4, ch. 82-46; ss. 16, 19, ch. 82-148; ss. 37, 79, 83, ch. 83-181; ss. 7, 29, 30, ch. 93-177; s. 49, ch. 93-217; s. 761, ch. 95-148; s. 127, ch. 2000-349; s. 47, ch. 2000-367; s. 1, ch. 2001-45.

**Note.**--Former s. 400.314.

**400.0075 Complaint resolution procedures.**--

(1) Any complaint, including any problem identified by an ombudsman council as a result of an investigation, deemed valid and requiring remedial action by the local ombudsman council shall be identified and brought to the attention of the long-term care facility administrator in writing. Upon receipt of such document, the administrator, in concurrence with the local ombudsman council chair, shall establish target dates for taking appropriate remedial action. If, by the target date, the remedial action is not completed or forthcoming, the local ombudsman council may:

(a) Extend the target date if the council has reason to believe such action would facilitate the resolution of the complaint.

(b) In accordance with s. 400.0077, publicize the complaint, the recommendations of the council, and the response of the long-term care facility.

(c) Refer the complaint to the state ombudsman council.

If the health, safety, welfare, or rights of the resident are in imminent danger, the local long-term

care ombudsman council may seek immediate legal or administrative remedies to protect the resident.

(2) Upon referral from the local ombudsman council, the state ombudsman council shall assume the responsibility for the disposition of the complaint. If a long-term care facility fails to take action on a complaint found valid by the state ombudsman council, the state council may:

(a) In accordance with s. 400.0077, publicize the complaint, the recommendations of the council, and the response of the long-term care facility.

(b) Recommend to the agency a series of facility reviews pursuant to s. 400.19(4) to assure correction and nonrecurrence of conditions that give rise to complaints against a long-term care facility.

(c) Recommend to the agency changes in rules for inspecting and licensing or certifying long-term care facilities, and recommend to the Agency for Health Care Administration changes in rules for licensing and regulating long-term care facilities.

(d) Refer the complaint to the state attorney for prosecution if there is reason to believe the long-term care facility or its employee is guilty of a criminal act.

(e) Recommend to the Agency for Health Care Administration that the long-term care facility no longer receive payments under the State Medical Assistance Program (Medicaid).

(f) Recommend that the agency initiate procedures for revocation of license in accordance with chapter 120.

(g) Seek legal, administrative, or other remedies to protect the health, safety, welfare, or rights of the resident.

If the health, safety, welfare, or rights of the resident are in imminent danger, the State Long-Term Care Ombudsman Council shall seek immediate legal or administrative remedies to protect the resident.

(3) The state ombudsman council shall provide, as part of its annual report required pursuant to s. 400.0067(2)(f), information relating to the disposition of all complaints to the Department of Elderly Affairs.

**History.**--s. 30, ch. 75-233; s. 3, ch. 76-168; s. 244, ch. 77-147; s. 11, ch. 77-401; s. 1, ch. 77-457; s. 19, ch. 78-95; ss. 14, 18, ch. 80-186; ss. 9, 12, ch. 80-198; ss. 4, 6, ch. 81-184; ss. 2, 3, ch. 81-318; s. 4, ch. 82-46; ss. 17, 19, ch. 82-148; ss. 38, 79, 83, ch. 83-181; s. 17, ch. 90-347; ss. 8, 29, 30, ch. 93-177; s. 49, ch. 93-217; s. 762, ch. 95-148; s. 42, ch. 95-196; s. 115, ch. 99-8; s. 128, ch. 2000-349; s. 48, ch. 2000-367; s. 44, ch. 2004-5.

**Note.**--Former s. 400.317.

**400.0077 Confidentiality.**--

(1) The following are confidential and exempt from the provisions of s. 119.07(1):

(a) Resident records held by the ombudsman or by the state or a local ombudsman council.

(b) The names or identities of the complainants or residents involved in a complaint, including any problem identified by an ombudsman council as a result of an investigation, unless:

1. The complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure in writing;

2. The complainant or resident consents orally and the consent is documented contemporaneously in writing by the ombudsman council requesting such consent; or

3. The disclosure is required by court order.

(c) Any other information about a complaint, including any problem identified by an ombudsman council as a result of an investigation, unless an ombudsman council determines that the information does not meet any of the criteria specified in [1]s. 119.14(4)(b); or unless the information is to collect data for submission to those entities specified in s. 712(c) of the federal Older Americans Act for the purpose of identifying and resolving significant problems.

(2) That portion of an ombudsman council meeting in which an ombudsman council discusses information that is confidential and exempt from the provisions of s. 119.07(1) is closed to the public and exempt from the provisions of s. 286.011.

(3) All other matters before the council shall be open to the public and subject to chapter 119 and s. 286.011.

(4) Members of any state or local ombudsman council shall not be required to testify in any court with respect to matters held to be confidential under s. 400.414 except as may be necessary to enforce the provisions of this act.

(5) Subject to the provisions of this section, the Office of State Long-Term Care Ombudsman shall adopt rules for the disclosure by the ombudsman or local ombudsman councils of files maintained by the program.

(6) This section does not limit the subpoena power of the Attorney General pursuant to s. 409.920 (9)(b).

**History.**--ss. 31, 32, ch. 75-233; s. 3, ch. 76-168; s. 12, ch. 77-401; s. 1, ch. 77-457; ss. 10, 12, ch. 80-198; ss. 4, 6, ch. 81-184; ss. 2, 3, ch. 81-318; s. 4, ch. 82-46; ss. 39, 79, 83, ch. 83-181; s. 18, ch. 90-347; ss. 9, 29, 30, ch. 93-177; s. 49, ch. 93-217; s. 225, ch. 96-406; s. 3, ch. 2000-163; s. 129, ch. 2000-349; s. 49, ch. 2000-367; s. 18, ch. 2004-344.

**[1]Note.**--Repealed by s. 1, ch. 95-217.

**Note.**--Former s. 400.321.

**400.0078 Statewide toll-free telephone number.**--The Office of State Long-Term Care Ombudsman shall establish a statewide toll-free telephone number for receiving complaints concerning nursing facilities.

**History.**--s. 4, ch. 99-394.

**400.0079 Immunity.**--

(1) Any person making a complaint pursuant to this act who does so in good faith shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed.

(2) The ombudsman or any person acting on behalf of the Office of State Long-Term Care Ombudsman or the state or a local long-term care ombudsman council shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed, during the good faith

performance of official duties.

**History.**--s. 33, ch. 75-233; s. 3, ch. 76-168; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 10, 29, 30, ch. 93-177; s. 49, ch. 93-217; s. 130, ch. 2000-349; s. 50, ch. 2000-367.

**Note.**--Former s. 400.324.

**400.0081 Access.** --

(1) The Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council, and the local long-term care ombudsman councils, or their representatives, shall have access to:

(a) Long-term care facilities and residents.

(b) Medical and social records of a resident for review, if:

1. The office has the permission of the resident or the legal representative of the resident; or

2. The resident is unable to consent to the review and has no legal representative.

(c) Medical and social records of the resident as necessary to investigate a complaint, if:

1. A legal guardian of the resident refuses to give permission.

2. The office has reasonable cause to believe that the guardian is not acting in the best interests of the resident.

3. The representative obtains the approval of the ombudsman.

(d) The administrative records, policies, and documents to which the residents, or the general public, have access.

(e) Upon request, copies of all licensing and certification records maintained by the state with respect to a long-term care facility.

(2) Notwithstanding paragraph (1)(b), if, pursuant to a complaint investigation by the state ombudsman council or a local ombudsman council, the legal representative of the resident refuses to give permission for the release of the resident's records, and if the Office of State Long-Term Care Ombudsman has reasonable cause to find that the legal representative is not acting in the best interests of the resident, the medical and social records of the resident must be made available to the state or local council as is necessary for the members of the council to investigate the complaint.

(3) The Department of Elderly Affairs, in consultation with the ombudsman and the State Long-Term Care Ombudsman Council, shall adopt rules to establish procedures to ensure access as described in this section.

**History.**--ss. 11, 30, ch. 93-177; s. 131, ch. 2000-349; s. 51, ch. 2000-367.

**400.0083 Interference; retaliation; penalties.**--

(1) It shall be unlawful for any person, long-term care facility, or other entity to willfully interfere with a representative of the Office of State Long-Term Care Ombudsman, the State Long-Term

Care Ombudsman Council, or a local long-term care ombudsman council in the performance of official duties.

(2) It shall be unlawful for any person, long-term care facility, or other entity to retaliate against any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council, or a local long-term care ombudsman council.

(3)(a) Any person, long-term care facility, or other entity who violates this section shall be liable for damages and equitable relief as determined by law.

(b) Any person, long-term care facility, or other entity who violates this section commits a misdemeanor of the second degree, punishable as provided in s. 775.083.

**History.**--ss. 12, 30, ch. 93-177; s. 132, ch. 2000-349; s. 52, ch. 2000-367.

**400.0085 Penalty.**--Anyone knowingly or willfully taking action against a person making a complaint under this act is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083.

**History.**--s. 34, ch. 75-233; s. 3, ch. 76-168; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 16, 29, 30, ch. 93-177; s. 49, ch. 93-217.

**Note.**--Former s. 400.327.

**400.0087 Agency oversight.**--

(1) The Department of Elderly Affairs shall monitor the local ombudsman councils responsible for carrying out the duties delegated by s. 400.0069 and federal law. The department, in consultation with the ombudsman, shall adopt rules to establish the policies and procedures for the monitoring of local ombudsman councils.

(2) The department is responsible for ensuring that the Office of State Long-Term Care Ombudsman provides information to public and private agencies, legislators, and others; provides appropriate training to representatives of the office or of the state or local long-term care ombudsman councils; and coordinates ombudsman services with the Advocacy Center for Persons with Disabilities and with providers of legal services to residents of long-term care facilities in compliance with state and federal laws.

(3) The Department of Elderly Affairs is the designated state unit on aging for purposes of complying with the federal Older Americans Act. The Department of Elderly Affairs shall ensure that the ombudsman program has the objectivity and independence required to qualify it for funding under the federal Older Americans Act, and shall carry out the long-term care ombudsman program through the Office of State Long-Term Care Ombudsman. The Department of Elderly Affairs shall also:

(a) Receive and disburse state and federal funds for purposes that the state ombudsman council has formulated in accordance with the Older Americans Act.

(b) Act as liaison between the federal program representatives, the staffs of the state and local ombudsman councils, and members of the state and local ombudsman councils.

**History.**--ss. 13, 30, ch. 93-177; s. 43, ch. 95-196; s. 133, ch. 2000-349; s. 53, ch. 2000-367; s. 25, ch. 2002-223.

**400.0089 Agency reports.**--The Department of Elderly Affairs shall maintain a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities and to residents, for the purpose of identifying and resolving significant problems. The department and the State Long-Term Care Ombudsman Council shall submit such data as part of its annual report required pursuant to s. 400.0067(2)(f) to the Agency for Health Care Administration, the Department of Children and Family Services, the Florida Statewide Advocacy Council, the Advocacy Center for Persons with Disabilities, the Commissioner for the United States Administration on Aging, the National Ombudsman Resource Center, and any other state or federal entities that the ombudsman determines appropriate. The State Long-Term Care Ombudsman Council shall publish quarterly and make readily available information pertaining to the number and types of complaints received by the long-term care ombudsman program.

**History.**--ss. 14, 30, ch. 93-177; s. 44, ch. 95-196; s. 116, ch. 99-8; s. 16, ch. 2000-263; s. 134, ch. 2000-349; s. 54, ch. 2000-367; s. 26, ch. 2002-223; s. 37, ch. 2003-1.

**400.0091 Training.**--The ombudsman shall provide appropriate training to all employees of the Office of State Long-Term Care Ombudsman and to the state and local long-term care ombudsman councils, including all unpaid volunteers. All volunteers and appropriate employees of the Office of State Long-Term Care Ombudsman must be given a minimum of 20 hours of training upon employment or enrollment as a volunteer and 10 hours of continuing education annually thereafter. Training must cover, at a minimum, guardianships and powers of attorney, medication administration, care and medication of residents with dementia and Alzheimer's disease, accounting for residents' funds, discharge rights and responsibilities, and cultural sensitivity. No employee, officer, or representative of the office or of the state or local long-term care ombudsman councils, other than the ombudsman, may carry out any authorized ombudsman duty or responsibility unless the person has received the training required by this section and has been approved by the ombudsman as qualified to carry out ombudsman activities on behalf of the office or the state or local long-term care ombudsman councils.

**History.**--ss. 15, 30, ch. 93-177; s. 135, ch. 2000-349; s. 55, ch. 2000-367; s. 32, ch. 2001-62; s. 27, ch. 2002-223.

## PART II

## NURSING HOMES

**400.011 Purpose.** --The purpose of this part is to provide for the development, establishment, and enforcement of basic standards for:

(1) The health, care, and treatment of persons in nursing homes and related health care facilities; and

(2) The maintenance and operation of such institutions that will ensure safe, adequate, and appropriate care, treatment, and health of persons in such facilities.

**History.**--s. 1, ch. 69-309; s. 1, ch. 70-361; s. 3, ch. 76-168; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 3, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 1, 49, ch. 93-217; s. 28, ch. 2000-141; s. 34, ch. 2001-186; s. 3, ch. 2001-372.

**400.021 Definitions.**--When used in this part, unless the context otherwise requires, the term:

(1) "Administrator" means the licensed individual who has the general administrative charge of a facility.

(2) "Agency" means the Agency for Health Care Administration, which is the licensing agency under this part.

(3) "Bed reservation policy" means the number of consecutive days and the number of days per year that a resident may leave the nursing home facility for overnight therapeutic visits with family or friends or for hospitalization for an acute condition before the licensee may discharge the resident due to his or her absence from the facility.

(4) "Board" means the Board of Nursing Home Administrators.

(5) "Controlling interest" means:

(a) The applicant for licensure or a licensee;

(b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5 percent or greater ownership interest in the management company or other entity, related or unrelated, which the applicant or licensee may contract with to operate the facility; or

(c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5 percent or greater ownership interest in the applicant or licensee.

The term does not include a voluntary board member.

(6) "Custodial service" means care for a person which entails observation of diet and sleeping habits and maintenance of a watchfulness over the general health, safety, and well-being of the aged or infirm.

(7) "Department" means the Department of Children and Family Services.

(8) "Facility" means any institution, building, residence, private home, or other place, whether operated for profit or not, including a place operated by a county or municipality, which undertakes through its ownership or management to provide for a period exceeding 24-hour nursing care, personal care, or custodial care for three or more persons not related to the owner or manager by blood or marriage, who by reason of illness, physical infirmity, or advanced age require such services, but does not include any place providing care and treatment primarily for the acutely ill. A facility offering services for fewer than three persons is within the meaning of this definition if it holds itself out to the public to be an establishment which regularly provides such services.

(9) "Geriatric outpatient clinic" means a site for providing outpatient health care to persons 60 years of age or older, which is staffed by a registered nurse or a physician assistant.

(10) "Geriatric patient" means any patient who is 60 years of age or older.

(11) "Local ombudsman council" means a local long-term care ombudsman council established pursuant to s. 400.0069, located within the Older Americans Act planning and service areas.

(12) "Nursing home bed" means an accommodation which is ready for immediate occupancy, or is capable of being made ready for occupancy within 48 hours, excluding provision of staffing; and which conforms to minimum space requirements, including the availability of appropriate equipment and furnishings within the 48 hours, as specified by rule of the agency, for the provision of services specified in this part to a single resident.

(13) "Nursing home facility" means any facility which provides nursing services as defined in part I of chapter 464 and which is licensed according to this part.

(14) "Nursing service" means such services or acts as may be rendered, directly or indirectly, to and in behalf of a person by individuals as defined in s. 464.003.

(15) "Planning and service area" means the geographic area in which the Older Americans Act programs are administered and services are delivered by the Department of Elderly Affairs.

(16) "Respite care" means admission to a nursing home for the purpose of providing a short period of rest or relief or emergency alternative care for the primary caregiver of an individual receiving care at home who, without home-based care, would otherwise require institutional care.

(17) "Resident care plan" means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident; the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being; a listing of services provided within or outside the facility to meet those needs; and an explanation of service goals. The resident care plan must be signed by the director of nursing or another registered nurse employed by the facility to whom institutional responsibilities have been delegated and by the resident, the resident's designee, or the resident's legal representative. The facility may not use an agency or temporary registered nurse to satisfy the foregoing requirement and must document the institutional responsibilities that have been delegated to the registered nurse.

(18) "Resident designee" means a person, other than the owner, administrator, or employee of the facility, designated in writing by a resident or a resident's guardian, if the resident is adjudicated incompetent, to be the resident's representative for a specific, limited purpose.

(19) "State ombudsman council" means the State Long-Term Care Ombudsman Council established pursuant to s. 400.0067.

(20) "Voluntary board member" means a director of a not-for-profit corporation or organization who serves solely in a voluntary capacity for the corporation or organization, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization. The agency shall recognize a person as a voluntary board member following submission of a statement to the agency by the director and the not-for-profit corporation or organization which affirms that the director conforms to this definition. The statement affirming the status of the director must be submitted to the agency on a form provided by the agency.

**History.**--s. 2, ch. 69-309; ss. 19, 35, ch. 69-106; s. 2, ch. 70-361; s. 1, ch. 70-439; ss. 21, 25, ch. 75-233; s. 3, ch. 76-168; s. 234, ch. 77-147; s. 1, ch. 77-457; ss. 1, 18, ch. 80-186; ss. 1, 12, ch. 80-198; s. 249, ch. 81-259; ss. 2, 3, ch. 81-318; ss. 4, 79, 83, ch. 83-181; s. 1, ch. 90-330; ss. 20, 30, ch. 93-177; ss. 2, 49, ch. 93-217; s. 763, ch. 95-148; s. 117, ch. 99-8; s. 94, ch. 2000-318; s. 136, ch. 2000-349; s. 1, ch. 2000-350; s. 56, ch. 2000-367; s. 2, ch. 2001-45; s. 3, ch. 2004-298.

**400.022 Residents' rights.**--

(1) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:

(a) The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision, which will not be infringed upon, and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these rights.

(b) The right to private and uncensored communication, including, but not limited to, receiving and sending unopened correspondence, access to a telephone, visiting with any person of the resident's choice during visiting hours, and overnight visitation outside the facility with family and friends in accordance with facility policies, physician orders, and Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act regulations, without the resident's losing his or her bed. Facility visiting hours shall be flexible, taking into consideration special circumstances such as, but not limited to, out-of-town visitors and working relatives or friends. Unless otherwise indicated in the resident care plan, the licensee shall, with the consent of the resident and in accordance with policies approved by the agency, permit recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure programs, and members of the clergy access to the facility during visiting hours for the purpose of visiting with and providing services to any resident.

(c) Any entity or individual that provides health, social, legal, or other services to a resident has the right to have reasonable access to the resident. The resident has the right to deny or withdraw consent to access at any time by any entity or individual. Notwithstanding the visiting policy of the facility, the following individuals must be permitted immediate access to the resident:

1. Any representative of the federal or state government, including, but not limited to, representatives of the Department of Children and Family Services, the Department of Health, the Agency for Health Care Administration, the Office of the Attorney General, and the Department of Elderly Affairs; any law enforcement officer; members of the state or local ombudsman council; and the resident's individual physician.

2. Subject to the resident's right to deny or withdraw consent, immediate family or other relatives of the resident.

The facility must allow representatives of the State Long-Term Care Ombudsman Council to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.

(d) The right to present grievances on behalf of himself or herself or others to the staff or administrator of the facility, to governmental officials, or to any other person; to recommend changes in policies and services to facility personnel; and to join with other residents or individuals within or outside the facility to work for improvements in resident care, free from restraint, interference, coercion, discrimination, or reprisal. This right includes access to ombudsmen and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. The right also includes the right to prompt efforts by the facility to resolve resident grievances, including grievances with respect to the behavior of other residents.

(e) The right to organize and participate in resident groups in the facility and the right to have the resident's family meet in the facility with the families of other residents.

(f) The right to participate in social, religious, and community activities that do not interfere with the rights of other residents.

(g) The right to examine, upon reasonable request, the results of the most recent inspection of the

facility conducted by a federal or state agency and any plan of correction in effect with respect to the facility.

(h) The right to manage his or her own financial affairs or to delegate such responsibility to the licensee, but only to the extent of the funds held in trust by the licensee for the resident. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident or the person responsible for the resident. The facility may not require a resident to deposit personal funds with the facility. However, upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility as follows:

1. The facility must establish and maintain a system that ensures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

2. The accounting system established and maintained by the facility must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

3. A quarterly accounting of any transaction made on behalf of the resident shall be furnished to the resident or the person responsible for the resident.

4. Upon the death of a resident with personal funds deposited with the facility, the facility must convey within 30 days the resident's funds, including interest, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, or, if a personal representative has not been appointed within 30 days, to the resident's spouse or adult next of kin named in the beneficiary designation form provided for in s. 400.162(6).

5. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Title XVIII or Title XIX of the Social Security Act.

(i) The right to be fully informed, in writing and orally, prior to or at the time of admission and during his or her stay, of services available in the facility and of related charges for such services, including any charges for services not covered under Title XVIII or Title XIX of the Social Security Act or not covered by the basic per diem rates and of bed reservation and refund policies of the facility.

(j) The right to be adequately informed of his or her medical condition and proposed treatment, unless the resident is determined to be unable to provide informed consent under Florida law, or the right to be fully informed in advance of any nonemergency changes in care or treatment that may affect the resident's well-being; and, except with respect to a resident adjudged incompetent, the right to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to know the consequences of such actions.

(k) The right to refuse medication or treatment and to be informed of the consequences of such decisions, unless determined unable to provide informed consent under state law. When the resident refuses medication or treatment, the nursing home facility must notify the resident or the resident's legal representative of the consequences of such decision and must document the resident's decision in his or her medical record. The nursing home facility must continue to provide other services the resident agrees to in accordance with the resident's care plan.

(l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.

(m) The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated; and to security in storing and using personal possessions. Privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. Residents' personal and medical records shall be confidential and exempt from the provisions of s. 119.07(1).

(n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis.

(o) The right to be free from mental and physical abuse, corporal punishment, extended involuntary seclusion, and from physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, restraint may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, and, in the case of use of a chemical restraint, a physician shall be consulted immediately thereafter. Restraints may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.

(p) The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act. For nonpayment of a bill for care received, the resident shall be given 30 days' advance notice. A licensee certified to provide services under Title XIX of the Social Security Act may not transfer or discharge a resident solely because the source of payment for care changes. Admission to a nursing home facility operated by a licensee certified to provide services under Title XIX of the Social Security Act may not be conditioned upon a waiver of such right, and any document or provision in a document which purports to waive or preclude such right is void and unenforceable. Any licensee certified to provide services under Title XIX of the Social Security Act that obtains or attempts to obtain such a waiver from a resident or potential resident shall be construed to have violated the resident's rights as established herein and is subject to disciplinary action as provided in subsection (3). The resident and the family or representative of the resident shall be consulted in choosing another facility.

(q) The right to freedom of choice in selecting a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense or through Title XIX of the Social Security Act; and to obtain information about, and to participate in, community-based activities programs, unless medically contraindicated as documented by a physician in the resident's medical record. If a resident chooses to use a community pharmacy and the facility in which the resident resides uses a unit-dose system, the pharmacy selected by the resident shall be one that provides a compatible unit-dose system, provides service delivery, and stocks the drugs normally used by long-term care residents. If a resident chooses to use a community pharmacy and the facility in which the resident resides does not use a unit-dose system, the pharmacy selected by the resident shall be one that provides service delivery and stocks the drugs normally used by long-term care residents.

(r) The right to retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated as documented in the resident's medical record by a physician. If clothing is provided to the resident by the licensee, it shall be of reasonable fit.

(s) The right to have copies of the rules and regulations of the facility and an explanation of the responsibility of the resident to obey all reasonable rules and regulations of the facility and to respect the personal rights and private property of the other residents.

(t) The right to receive notice before the room of the resident in the facility is changed.

(u) The right to be informed of the bed reservation policy for a hospitalization. The nursing home shall inform a private-pay resident and his or her responsible party that his or her bed will be reserved for any single hospitalization for a period up to 30 days provided the nursing home receives reimbursement. Any resident who is a recipient of assistance under Title XIX of the Social Security Act, or the resident's designee or legal representative, shall be informed by the licensee that his or her bed will be reserved for any single hospitalization for the length of time for which Title XIX reimbursement is available, up to 15 days; but that the bed will not be reserved if it is medically determined by the agency that the resident will not need it or will not be able to return to the nursing home, or if the agency determines that the nursing home's occupancy rate ensures the availability of a bed for the resident. Notice shall be provided within 24 hours of the hospitalization.

(v) For residents of Medicaid or Medicare certified facilities, the right to challenge a decision by the facility to discharge or transfer the resident, as required under Title 42 C.F.R. part 483.13.

(2) The licensee for each nursing home shall orally inform the resident of the resident's rights and provide a copy of the statement required by subsection (1) to each resident or the resident's legal representative at or before the resident's admission to a facility. The licensee shall provide a copy of the resident's rights to each staff member of the facility. Each such licensee shall prepare a written plan and provide appropriate staff training to implement the provisions of this section. The written statement of rights must include a statement that a resident may file a complaint with the agency or local ombudsman council. The statement must be in boldfaced type and shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline where complaints may be lodged.

(3) Any violation of the resident's rights set forth in this section shall constitute grounds for action by the agency under the provisions of s. 400.102. In order to determine whether the licensee is adequately protecting residents' rights, the annual inspection of the facility shall include private informal conversations with a sample of residents to discuss residents' experiences within the facility with respect to rights specified in this section and general compliance with standards, and consultation with the ombudsman council in the local planning and service area of the Department of Elderly Affairs in which the nursing home is located.

(4) Any person who submits or reports a complaint concerning a suspected violation of the resident's rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint shall have immunity from any criminal or civil liability therefor, unless that person has acted in bad faith, with malicious purpose, or if the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

**History.**--s. 8, ch. 76-201; s. 1, ch. 77-174; ss. 1, 9, ch. 79-268; ss. 2, 18, ch. 80-186; s. 2, ch. 81-318; ss. 11, 19, ch. 82-148; ss. 5, 79, 83, ch. 83-181; s. 1, ch. 84-144; s. 15, ch. 90-347; s. 30, ch. 93-177; ss. 3, 49, ch. 93-217; s. 764, ch. 95-148; s. 226, ch. 96-406; s. 118, ch. 99-8; s. 5, ch. 99-394; ss. 70, 137, ch. 2000-349; s. 57, ch. 2000-367; s. 33, ch. 2001-62.

**400.023 Civil enforcement.**--

(1) Any resident whose rights as specified in this part are violated shall have a cause of action. The action may be brought by the resident or his or her guardian, by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death. If the action alleges a claim for the resident's rights or for negligence that caused the death of the resident, the claimant shall be required to elect either survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for the resident's rights or for negligence that did not cause the death of the resident, the personal representative of the estate

may recover damages for the negligence that caused injury to the resident. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for any violation of the rights of a resident or for negligence. Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action, and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 400.023-400.0238 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of rights specified in s. 400.022. This section does not preclude theories of recovery not arising out of negligence or s. 400.022 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 400.023-400.0238.

(2) In any claim brought pursuant to this part alleging a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

Nothing in this part shall be interpreted to create strict liability. A violation of the rights set forth in s. 400.022 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(3) In any claim brought pursuant to this section, a licensee, person, or entity shall have a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(4) In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse shall have the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(5) A licensee shall not be liable for the medical negligence of any physician rendering care or treatment to the resident except for the administrative services of a medical director as required in this part. Nothing in this subsection shall be construed to protect a licensee, person, or entity from liability for failure to provide a resident with appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff.

(6) The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the Agency for Health Care Administration at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The requirement of providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

(7) An action under this part for a violation of rights or negligence recognized herein is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death

of the resident.

**History.**--ss. 3, 18, ch. 80-186; s. 2, ch. 81-318; ss. 6, 79, 83, ch. 83-181; s. 51, ch. 83-218; s. 1, ch. 86-79; s. 30, ch. 93-177; ss. 4, 49, ch. 93-217; s. 765, ch. 95-148; s. 30, ch. 99-225; s. 4, ch. 2001-45; s. 34, ch. 2001-62.

**400.0233 Presuit notice; investigation; notification of violation of resident's rights or alleged negligence; claims evaluation procedure; informal discovery; review; settlement offer; mediation.**--

(1) As used in this section, the term:

(a) "Claim for resident's rights violation or negligence" means a negligence claim alleging injury to or the death of a resident arising out of an asserted violation of the rights of a resident under s. 400.022 or an asserted deviation from the applicable standard of care.

(b) "Insurer" means any self-insurer authorized under s. 627.357, liability insurance carrier, joint underwriting association, or uninsured prospective defendant.

(2) Prior to filing a claim for a violation of a resident's rights or a claim for negligence, a claimant alleging injury to or the death of a resident shall notify each prospective defendant by certified mail, return receipt requested, of an asserted violation of a resident's rights provided in s. 400.022 or deviation from the standard of care. Such notification shall include an identification of the rights the prospective defendant has violated and the negligence alleged to have caused the incident or incidents and a brief description of the injuries sustained by the resident which are reasonably identifiable at the time of notice. The notice shall contain a certificate of counsel that counsel's reasonable investigation gave rise to a good faith belief that grounds exist for an action against each prospective defendant.

(3)(a) No suit may be filed for a period of 75 days after notice is mailed to any prospective defendant. During the 75-day period, the prospective defendants or their insurers shall conduct an evaluation of the claim to determine the liability of each defendant and to evaluate the damages of the claimants. Each defendant or insurer of the defendant shall have a procedure for the prompt evaluation of claims during the 75-day period. The procedure shall include one or more of the following:

1. Internal review by a duly qualified facility risk manager or claims adjuster;

2. Internal review by counsel for each prospective defendant;

3. A quality assurance committee authorized under any applicable state or federal statutes or regulations; or

4. Any other similar procedure that fairly and promptly evaluates the claims.

Each defendant or insurer of the defendant shall evaluate the claim in good faith.

(b) At or before the end of the 75 days, the defendant or insurer of the defendant shall provide the claimant with a written response:

1. Rejecting the claim; or

2. Making a settlement offer.

(c) The response shall be delivered to the claimant if not represented by counsel or to the

claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer of the defendant to reply to the notice within 75 days after receipt shall be deemed a rejection of the claim for purposes of this section.

(4) The notification of a violation of a resident's rights or alleged negligence shall be served within the applicable statute of limitations period; however, during the 75-day period, the statute of limitations is tolled as to all prospective defendants. Upon stipulation by the parties, the 75-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving written notice by certified mail, return receipt requested, of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(5) No statement, discussion, written document, report, or other work product generated by presuit claims evaluation procedures under this section is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit claims evaluation procedure. Any licensed physician or registered nurse may be retained by either party to provide an opinion regarding the reasonable basis of the claim. The presuit opinions of the expert are not discoverable or admissible in any civil action for any purpose by the opposing party.

(6) Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery as provided in subsection (7).

(7) Informal discovery may be used by a party to obtain unsworn statements and the production of documents or things as follows:

(a) *Unsworn statements.*--Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(b) *Documents or things.*--Any party may request discovery of relevant documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce relevant and discoverable documents or things within that party's possession or control, if in good faith it can reasonably be done within the timeframe of the claims evaluation process.

(8) Each request for and notice concerning informal discovery pursuant to this section must be in writing, and a copy thereof must be sent to all parties. Such a request or notice must bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice, and the manner of service thereof.

(9) If a prospective defendant makes a written settlement offer, the claimant shall have 15 days from the date of receipt to accept the offer. An offer shall be deemed rejected unless accepted by delivery of a written notice of acceptance.

(10) To the extent not inconsistent with this part, the provisions of the Florida Mediation Code, Florida Rules of Civil Procedure, shall be applicable to such proceedings.

(11) Within 30 days after the claimant's receipt of the defendant's response to the claim, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with the mediation rules of practice and procedures adopted by the Supreme Court. Upon stipulation of the parties, this 30-day period may be extended and the statute of limitations is tolled during the mediation and any such extension. At the conclusion of mediation, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

**History.**--s. 5, ch. 2001-45.

**400.0234 Availability of facility records for investigation of resident's rights violations and defenses; penalty.**--

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility in accordance with s. 400.145 shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

(2) No facility shall be held liable for any civil damages as a result of complying with this section.

**History.**--s. 6, ch. 2001-45.

**400.0235 Certain provisions not applicable to actions under this part.**--An action under this part for a violation of rights or negligence recognized under this part is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

**History.**--s. 7, ch. 2001-45.

**400.0236 Statute of limitations.**--

(1) Any action for damages brought under this part shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued.

(2) In those actions covered by this subsection in which it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event for more than 6 years from the date the incident giving rise to the injury occurred.

(3) This section shall apply to causes of action that have accrued prior to the effective date of this section; however, any such cause of action that would not have been barred under prior law may be brought within the time allowed by prior law or within 2 years after the effective date of this section, whichever is earlier, and will be barred thereafter. In actions where it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event more than 4 years from the effective date of this section.

**History.**--s. 8, ch. 2001-45.

**400.0237 Punitive damages; pleading; burden of proof.**--

(1) In any action for damages brought under this part, no claim for punitive damages shall be permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. No discovery of financial worth shall proceed until after the pleading concerning punitive damages is permitted.

(2) A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of an employer, principal, corporation, or other legal entity, punitive damages may be imposed for the conduct of an employee or agent only if the conduct of the employee or agent meets the criteria specified in subsection (2) and:

(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;

(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or

(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.

(4) The plaintiff must establish at trial, by clear and convincing evidence, its entitlement to an award of punitive damages. The "greater weight of the evidence" burden of proof applies to a determination of the amount of damages.

(5) This section is remedial in nature and shall take effect upon becoming a law.

**History.**--s. 9, ch. 2001-45.

**400.0238 Punitive damages; limitation.**--

(1)(a) Except as provided in paragraphs (b) and (c), an award of punitive damages may not exceed the greater of:

1. Three times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $1 million.

(b) Where the fact finder determines that the wrongful conduct proven under this section was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant, it may award an amount of punitive damages not to exceed the greater of:

1. Four times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $4 million.

(c) Where the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there shall be no cap on punitive damages.

(d) This subsection is not intended to prohibit an appropriate court from exercising its jurisdiction under s. 768.74 in determining the reasonableness of an award of punitive damages that is less than three times the amount of compensatory damages.

(e) In any case in which the findings of fact support an award of punitive damages pursuant to paragraph (b) or paragraph (c), the clerk of the court shall refer the case to the appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and, for multijurisdictional facility owners, to the Office of the Statewide Prosecutor; and such agencies, state attorney, or Office of the Statewide Prosecutor shall initiate a criminal investigation into the conduct giving rise to the award of punitive damages. All findings by the trier of fact which support an award of punitive damages under this paragraph shall be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages under this paragraph.

(2) The claimant's attorney's fees, if payable from the judgment, are, to the extent that the fees are based on the punitive damages, calculated based on the final judgment for punitive damages. This subsection does not limit the payment of attorney's fees based upon an award of damages other than punitive damages.

(3) The jury may neither be instructed nor informed as to the provisions of this section.

(4) Notwithstanding any other law to the contrary, the amount of punitive damages awarded pursuant to this section shall be equally divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund, in accordance with the following provisions:

(a) The clerk of the court shall transmit a copy of the jury verdict to the Chief Financial Officer by certified mail. In the final judgment, the court shall order the percentages of the award, payable as provided herein.

(b) A settlement agreement entered into between the original parties to the action after a verdict has been returned must provide a proportionate share payable to the Quality of Long-Term Care Facility Improvement Trust Fund specified herein. For purposes of this paragraph, a proportionate share is a 50-percent share of that percentage of the settlement amount which the punitive damages portion of the verdict bore to the total of the compensatory and punitive damages in the verdict.

(c) The Department of Financial Services shall collect or cause to be collected all payments due the state under this section. Such payments are made to the Chief Financial Officer and deposited in the appropriate fund specified in this subsection.

(d) If the full amount of punitive damages awarded cannot be collected, the claimant and the other recipient designated pursuant to this subsection are each entitled to a proportionate share of the punitive damages collected.

(5) This section is remedial in nature and shall take effect upon becoming a law.

**History.**--s. 10, ch. 2001-45; s. 415, ch. 2003-261.

**400.0239 Quality of Long-Term Care Facility Improvement Trust Fund.** --

(1) There is created within the Agency for Health Care Administration a Quality of Long-Term Care Facility Improvement Trust Fund to support activities and programs directly related to improvement of the care of nursing home and assisted living facility residents. The trust fund shall be funded through proceeds generated pursuant to ss. 400.0238 and 400.4298, through funds specifically appropriated by the Legislature, through gifts, endowments, and other charitable contributions allowed under federal and state law, and through federal nursing home civil monetary penalties collected by the Centers for Medicare and Medicaid Services and returned to the state. These funds must be utilized in accordance with federal requirements.

(2) Expenditures from the trust fund shall be allowable for direct support of the following:

(a) Development and operation of a mentoring program, in consultation with the Department of Health and the Department of Elderly Affairs, for increasing the competence, professionalism, and career preparation of long-term care facility direct care staff, including nurses, nursing assistants, and social service and dietary personnel.

(b) Development and implementation of specialized training programs for long-term care facility personnel who provide direct care for residents with Alzheimer's disease and other dementias, residents at risk of developing pressure sores, and residents with special nutrition and hydration needs.

(c) Addressing areas of deficient practice identified through regulation or state monitoring.

(d) Provision of economic and other incentives to enhance the stability and career development of the nursing home direct care workforce, including paid sabbaticals for exemplary direct care career staff to visit facilities throughout the state to train and motivate younger workers to commit to careers in long-term care.

(e) Promotion and support for the formation and active involvement of resident and family councils in the improvement of nursing home care.

(f) Evaluation of special residents' needs in long-term care facilities, including challenges in meeting special residents' needs, appropriateness of placement and setting, and cited deficiencies related to caring for special needs.

(g) Other initiatives authorized by the Centers for Medicare and Medicaid Services for the use of federal civil monetary penalties, including projects recommended through the Medicaid "Up-or-Out" Quality of Care Contract Management Program pursuant to s. 400.148.

(3) The agency shall carry out through the trust fund the priorities and directives specified in legislative appropriations.

(4) Notwithstanding the provisions of s. 216.301, and pursuant to s. 216.351, any balance in the trust fund at the end of any fiscal year shall remain in the trust fund at the end of the year and shall be available for carrying out the purposes of the trust fund.

**History.**--s. 1, ch. 2001-205; s. 22, ch. 2003-57; s. 2, ch. 2004-229.

**400.0255 Resident transfer or discharge; requirements and procedures; hearings.**--

(1) As used in this section, the term:

(a) "Discharge" means to move a resident to a noninstitutional setting when the releasing facility ceases to be responsible for the resident's care.

(b) "Transfer" means to move a resident from the facility to another legally responsible institutional setting.

(2) Each facility licensed under this part must comply with subsection (9) and s. 400.022(1)(p) when deciding to discharge or transfer a resident.

(3) When a discharge or transfer is initiated by the nursing home, the nursing home administrator employed by the nursing home that is discharging or transferring the resident, or an individual employed by the nursing home who is designated by the nursing home administrator to act on behalf of the administration, must sign the notice of discharge or transfer. Any notice indicating a medical reason for transfer or discharge must either be signed by the resident's attending physician or the medical director of the facility, or include an attached written order for the discharge or transfer. The notice or the order must be signed by the resident's physician, medical director, treating physician, nurse practitioner, or physician assistant.

(4)(a) Each facility must notify the agency of any proposed discharge or transfer of a resident when such discharge or transfer is necessitated by changes in the physical plant of the facility that make the facility unsafe for the resident.

(b) Upon receipt of such a notice, the agency shall conduct an onsite inspection of the facility to verify the necessity of the discharge or transfer.

(5) A resident of any Medicaid or Medicare certified facility may challenge a decision by the facility to discharge or transfer the resident.

(6) A facility that has been reimbursed for reserving a bed and, for reasons other than those permitted under this section, refuses to readmit a resident within the prescribed timeframe shall refund the bed reservation payment.

(7) At least 30 days prior to any proposed transfer or discharge, a facility must provide advance notice of the proposed transfer or discharge to the resident and, if known, to a family member or the resident's legal guardian or representative, except, in the following circumstances, the facility shall give notice as soon as practicable before the transfer or discharge:

(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility, and the circumstances are documented in the resident's medical records by the resident's physician; or

(b) The health or safety of other residents or facility employees would be endangered, and the circumstances are documented in the resident's medical records by the resident's physician or the medical director if the resident's physician is not available.

(8) The notice required by subsection (7) must be in writing and must contain all information required by state and federal law, rules, or regulations applicable to Medicaid or Medicare cases. The agency shall develop a standard document to be used by all facilities licensed under this part for purposes of notifying residents of a discharge or transfer. Such document must include a means

for a resident to request the local long-term care ombudsman council to review the notice and request information about or assistance with initiating a fair hearing with the department's Office of Appeals Hearings. In addition to any other pertinent information included, the form shall specify the reason allowed under federal or state law that the resident is being discharged or transferred, with an explanation to support this action. Further, the form shall state the effective date of the discharge or transfer and the location to which the resident is being discharged or transferred. The form shall clearly describe the resident's appeal rights and the procedures for filing an appeal, including the right to request the local ombudsman council to review the notice of discharge or transfer. A copy of the notice must be placed in the resident's clinical record, and a copy must be transmitted to the resident's legal guardian or representative and to the local ombudsman council within 5 business days after signature by the resident or resident designee.

(9) A resident may request that the local ombudsman council review any notice of discharge or transfer given to the resident. When requested by a resident to review a notice of discharge or transfer, the local ombudsman council shall do so within 7 days after receipt of the request. The nursing home administrator, or the administrator's designee, must forward the request for review contained in the notice to the local ombudsman council within 24 hours after such request is submitted. Failure to forward the request within 24 hours after the request is submitted shall toll the running of the 30-day advance notice period until the request has been forwarded.

(10)(a) A resident is entitled to a fair hearing to challenge a facility's proposed transfer or discharge. The resident, or the resident's legal representative or designee, may request a hearing at any time within 90 days after the resident's receipt of the facility's notice of the proposed discharge or transfer.

(b) If a resident requests a hearing within 10 days after receiving the notice from the facility, the request shall stay the proposed transfer or discharge pending a hearing decision. The facility may not take action, and the resident may remain in the facility, until the outcome of the initial fair hearing, which must be completed within 90 days after receipt of a request for a fair hearing.

(c) If the resident fails to request a hearing within 10 days after receipt of the facility notice of the proposed discharge or transfer, the facility may transfer or discharge the resident after 30 days from the date the resident received the notice.

(11) Notwithstanding paragraph (10)(b), an emergency discharge or transfer may be implemented as necessary pursuant to state or federal law during the period of time after the notice is given and before the time a hearing decision is rendered. Notice of an emergency discharge or transfer to the resident, the resident's legal guardian or representative, and the local ombudsman council if requested pursuant to subsection (9) must be by telephone or in person. This notice shall be given before the transfer, if possible, or as soon thereafter as practicable. A local ombudsman council conducting a review under this subsection shall do so within 24 hours after receipt of the request. The resident's file must be documented to show who was contacted, whether the contact was by telephone or in person, and the date and time of the contact. If the notice is not given in writing, written notice meeting the requirements of subsection (8) must be given the next working day.

(12) After receipt of any notice required under this section, the local ombudsman council may request a private informal conversation with a resident to whom the notice is directed, and, if known, a family member or the resident's legal guardian or designee, to ensure that the facility is proceeding with the discharge or transfer in accordance with the requirements of this section. If requested, the local ombudsman council shall assist the resident with filing an appeal of the proposed discharge or transfer.

(13) The following persons must be present at all hearings authorized under this section:

(a) The resident, or the resident's legal representative or designee.

(b) The facility administrator, or the facility's legal representative or designee.

A representative of the local long-term care ombudsman council may be present at all hearings authorized by this section.

(14) In any hearing under this section, the following information concerning the parties shall be confidential and exempt from the provisions of s. 119.07(1):

(a) Names and addresses.

(b) Medical services provided.

(c) Social and economic conditions or circumstances.

(d) Evaluation of personal information.

(e) Medical data, including diagnosis and past history of disease or disability.

(f) Any information received verifying income eligibility and amount of medical assistance payments. Income information received from the Social Security Administration or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data.

The exemption created by this subsection does not prohibit access to such information by a local long-term care ombudsman council upon request, by a reviewing court if such information is required to be part of the record upon subsequent review, or as specified in s. 24(a), Art. I of the State Constitution.

(15)(a) The department's Office of Appeals Hearings shall conduct hearings under this section. The office shall notify the facility of a resident's request for a hearing.

(b) The department shall, by rule, establish procedures to be used for fair hearings requested by residents. These procedures shall be equivalent to the procedures used for fair hearings for other Medicaid cases, chapter 10-2, part VI, Florida Administrative Code. The burden of proof must be clear and convincing evidence. A hearing decision must be rendered within 90 days after receipt of the request for hearing.

(c) If the hearing decision is favorable to the resident who has been transferred or discharged, the resident must be readmitted to the facility's first available bed.

(d) The decision of the hearing officer shall be final. Any aggrieved party may appeal the decision to the district court of appeal in the appellate district where the facility is located. Review procedures shall be conducted in accordance with the Florida Rules of Appellate Procedure.

(16) The department may adopt rules necessary to administer this section.

(17) The provisions of this section apply to transfers or discharges that are initiated by the nursing home facility, and not by the resident or by the resident's physician or legal guardian or representative.

**History.**--s. 6, ch. 93-217; s. 4, ch. 95-407; s. 34, ch. 96-169; s. 227, ch. 96-406; s. 8, ch. 99-394; s. 138, ch. 2000-349; s. 3, ch. 2000-350; s. 58, ch. 2000-367; ss. 13, 53, ch. 2001-45.

**400.051 Homes or institutions exempt from the provisions of this part.**--

(1) The following shall be exempt from the provisions of this part:

(a) Any facility, institution, or other place operated by the Federal Government or a federal agency.

(b) Any hospital, as defined in s. 395.002(11), that is licensed under chapter 395.

(c) Any facility, together with improvements or additions thereto, which has existed and operated continuously in this state for at least 60 years on or before July 1, 1989, and is directly or indirectly owned and operated by a nationally recognized fraternal organization, is not open to the public, and accepts only its own members and their spouses as residents.

(2) Any facility or institution operated by and for persons who rely exclusively upon treatment by spiritual means through prayer, in accordance with the creed or tenets of any organized church or religious denomination, shall be exempt from the provisions of this part. However, such facility or institution shall comply with all applicable laws and rules relating to sanitation and safety.

**History.**--s. 4, ch. 69-309; s. 4, ch. 70-361; s. 3, ch. 76-168; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 8, 79, 83, ch. 83-181; s. 1, ch. 88-411; s. 30, ch. 93-177; ss. 7, 49, ch. 93-217; s. 5, ch. 94-206; s. 2, ch. 94-317; s. 34, ch. 98-89; s. 40, ch. 98-171; s. 210, ch. 99-13.

**400.062 License required; fee; disposition; display; transfer.**--

(1) It is unlawful to operate or maintain a facility without first obtaining from the agency a license authorizing such operation.

(2) Separate licenses shall be required for facilities maintained in separate premises, even though operated under the same management. However, a separate license shall not be required for separate buildings on the same grounds.

(3) The annual license fee required for each license issued under this part shall be comprised of two parts. Part I of the license fee shall be the basic license fee. The rate per bed for the basic license fee shall be established annually and shall be $50 per bed. The agency may adjust the per bed licensure fees by the Consumer Price Index based on the 12 months immediately preceding the increase to cover the cost of regulation under this part. Part II of the license fee shall be the resident protection fee, which shall be at the rate of not less than 25 cents per bed. The rate per bed shall be the minimum rate per bed, and such rate shall remain in effect until the effective date of a rate per bed adopted by rule by the agency pursuant to this part. At such time as the amount on deposit in the Resident Protection Trust Fund is less than $1 million, the agency may adopt rules to establish a rate which may not exceed $10 per bed. The rate per bed shall revert back to the minimum rate per bed when the amount on deposit in the Resident Protection Trust Fund reaches $1 million, except that any rate established by rule shall remain in effect until such time as the rate has been equally required for each license issued under this part. Any amount in the fund in excess of $2 million shall revert to the Health Care Trust Fund and may not be expended without prior approval of the Legislature. The agency may prorate the annual license fee for those licenses which it issues under this part for less than 1 year. Funds generated by license fees collected in accordance with this section shall be deposited in the following manner:

(a) The basic license fee collected shall be deposited in the Health Care Trust Fund, established for the sole purpose of carrying out this part. When the balance of the account established in the Health Care Trust Fund for the deposit of fees collected as authorized under this section exceeds one-third of the annual cost of regulation under this part, the excess shall be used to reduce the licensure fees in the next year.

(b) The resident protection fee collected shall be deposited in the Resident Protection Trust Fund for the sole purpose of paying, in accordance with the provisions of s. 400.063, for the appropriate

alternate placement, care, and treatment of a resident removed from a nursing home facility on a temporary, emergency basis or for the maintenance and care of residents in a nursing home facility pending removal and alternate placement.

(4) Counties or municipalities applying for licenses under this part are exempt from license fees authorized under this section.

(5) The license shall be displayed in a conspicuous place inside the facility.

(6) A license shall be valid only in the hands of the individual, firm, partnership, association, or corporation to whom it is issued and shall not be subject to sale, assignment, or other transfer, voluntary or involuntary, nor shall a license be valid for any premises other than those for which originally issued.

**History.**--s. 5, ch. 70-361; s. 3, ch. 76-168; s. 235, ch. 77-147; s. 1, ch. 77-457; ss. 2, 9, ch. 79-268; ss. 2, 3, ch. 81-318; ss. 1, 19, ch. 82-148; ss. 9, 79, 83, ch. 83-181; s. 8, ch. 91-282; s. 30, ch. 93-177; ss. 8, 49, ch. 93-217; s. 14, ch. 2001-45.

**400.0625 Minimum standards for clinical laboratory test results and diagnostic X-ray results.** --

(1) Each nursing home, as a requirement for issuance or renewal of its license, shall require that all clinical laboratory tests performed for the nursing home be performed by a clinical laboratory licensed under the provisions of chapter 483, except for such self-testing procedures as are approved by the agency by rule. Results of clinical laboratory tests performed prior to admission which meet the minimum standards provided in s. 483.181(3) shall be accepted in lieu of routine examinations required upon admission and clinical laboratory tests which may be ordered by a physician for residents of the nursing home.

(2) Each nursing home, as a requirement for issuance or renewal of its license, shall establish minimum standards for acceptance of results of diagnostic X rays performed by or for the nursing home. Such minimum standards shall require licensure or registration of the source of ionizing radiation under the provisions of chapter 404. Diagnostic X-ray results which meet the minimum standards shall be accepted in lieu of routine examinations required upon admission and in lieu of diagnostic X rays which may be ordered by a physician for residents of the nursing home.

**History.**--ss. 22, 28, ch. 82-182; ss. 10, 79, 81, 83, ch. 83-181; s. 26, ch. 83-215; s. 30, ch. 93-177; ss. 9, 49, ch. 93-217.

**Note.**--Former s. 400.4175.

**400.063 Resident Protection Trust Fund.**--

(1) A Resident Protection Trust Fund shall be established for the purpose of collecting and disbursing funds generated from the license fees and administrative fines as provided for in ss. 393.0673(2), 400.062(3)(b), 400.111(1), 400.121(2), and 400.23(8). Such funds shall be for the sole purpose of paying for the appropriate alternate placement, care, and treatment of residents who are removed from a facility licensed under this part or a facility specified in s. 393.0678(1) in which the agency determines that existing conditions or practices constitute an immediate danger to the health, safety, or security of the residents. If the agency determines that it is in the best interest of the health, safety, or security of the residents to provide for an orderly removal of the residents from the facility, the agency may utilize such funds to maintain and care for the residents in the facility pending removal and alternative placement. The maintenance and care of the residents shall be under the direction and control of a receiver appointed pursuant to s. 393.0678(1) or s. 400.126(1). However, funds may be expended in an emergency upon a filing of a petition for a receiver, upon the declaration of a state of local emergency pursuant to s. 252.38(3)(a)5., or upon a duly authorized local order of evacuation of a facility by emergency personnel to

protect the health and safety of the residents.

(2) The agency is authorized to establish for each facility, subject to intervention by the agency, a separate bank account for the deposit to the credit of the agency of any moneys received from the Resident Protection Trust Fund or any other moneys received for the maintenance and care of residents in the facility, and the agency is authorized to disburse moneys from such account to pay obligations incurred for the purposes of this section. The agency is authorized to requisition moneys from the Resident Protection Trust Fund in advance of an actual need for cash on the basis of an estimate by the agency of moneys to be spent under the authority of this section. Any bank account established under this section need not be approved in advance of its creation as required by s. 17.58, but shall be secured by depository insurance equal to or greater than the balance of such account or by the pledge of collateral security in conformance with criteria established in [1]s. 18.11. The agency shall notify the Chief Financial Officer of any such account so established and shall make a quarterly accounting to the Chief Financial Officer for all moneys deposited in such account.

(3) Funds authorized under this section shall be expended on behalf of all residents transferred to an alternate placement, at the usual and customary charges of the facility used for the alternate placement, provided no other source of private or public funding is available. However, such funds may not be expended on behalf of a resident who is eligible for Title XIX of the Social Security Act, if the alternate placement accepts Title XIX of the Social Security Act. Funds shall be utilized for maintenance and care of residents in a facility in receivership only to the extent private or public funds, including funds available under Title XIX of the Social Security Act, are not available or are not sufficient to adequately manage and operate the facility, as determined by the agency. The existence of the Resident Protection Trust Fund shall not make the agency liable for the maintenance of any resident in any facility. The state shall be liable for the cost of alternate placement of residents removed from a deficient facility, or for the maintenance of residents in a facility in receivership, only to the extent that funds are available in the Resident Protection Trust Fund.

(4) The agency is authorized to adopt rules necessary to implement this section.

**History.**--ss. 3, 9, ch. 79-268; ss. 4, 18, ch. 80-186; s. 2, ch. 81-318; ss. 11, 79, 83, ch. 83-181; s. 51, ch. 83-218; s. 14, ch. 83-230; s. 1, ch. 87-371; s. 30, ch. 93-177; ss. 10, 49, ch. 93-217; s. 211, ch. 99-13; s. 23, ch. 99-394; s. 416, ch. 2003-261.

**[1]Note.**--Repealed by s. 11, ch. 81-285; confirmed by s. 1, ch. 83-85.

**400.071 Application for license.**--

(1) An application for a license as required by s. 400.062 shall be made to the agency on forms furnished by it and shall be accompanied by the appropriate license fee.

(2) The application shall be under oath and shall contain the following:

(a) The name, address, and social security number of the applicant if an individual; if the applicant is a firm, partnership, or association, its name, address, and employer identification number (EIN), and the name and address of any controlling interest; and the name by which the facility is to be known.

(b) The name of any person whose name is required on the application under the provisions of paragraph (a) and who owns at least a 10-percent interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, and the name and address of the professional service, firm, association, partnership, or corporation in which such interest is held.

(c) The location of the facility for which a license is sought and an indication, as in the original application, that such location conforms to the local zoning ordinances.

(d) The name of the person or persons under whose management or supervision the facility will be conducted and the name of the administrator.

(e) A signed affidavit disclosing any financial or ownership interest that a person or entity described in paragraph (a) or paragraph (d) has held in the last 5 years in any entity licensed by this state or any other state to provide health or residential care which has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason any such entity was closed, whether voluntarily or involuntarily.

(f) The total number of beds and the total number of Medicare and Medicaid certified beds.

(g) Information relating to the number, experience, and training of the employees of the facility and of the moral character of the applicant and employees which the agency requires by rule, including the name and address of any nursing home with which the applicant or employees have been affiliated through ownership or employment within 5 years of the date of the application for a license and the record of any criminal convictions involving the applicant and any criminal convictions involving an employee if known by the applicant after inquiring of the employee. The applicant must demonstrate that sufficient numbers of qualified staff, by training or experience, will be employed to properly care for the type and number of residents who will reside in the facility.

(h) Copies of any civil verdict or judgment involving the applicant rendered within the 10 years preceding the application, relating to medical negligence, violation of residents' rights, or wrongful death. As a condition of licensure, the licensee agrees to provide to the agency copies of any new verdict or judgment involving the applicant, relating to such matters, within 30 days after filing with the clerk of the court. The information required in this paragraph shall be maintained in the facility's licensure file and in an agency database which is available as a public record.

(3) The applicant shall submit evidence which establishes the good moral character of the applicant, manager, supervisor, and administrator. No applicant, if the applicant is an individual; no member of a board of directors or officer of an applicant, if the applicant is a firm, partnership, association, or corporation; and no licensed nursing home administrator shall have been convicted, or found guilty, regardless of adjudication, of a crime in any jurisdiction which affects or may potentially affect residents in the facility.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator, or similarly titled individual who is responsible for the day-to-day operation of the licensed facility, and the facility financial officer, or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency has probable cause to believe that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or

assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Financial Services Commission and the Office of Insurance Regulation pursuant to chapter 651 as part of an application for a certificate of authority to operate a continuing care retirement community is acceptable in fulfillment of the Department of Law Enforcement and Federal Bureau of Investigation background check.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation; however, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement shall not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) An application for license renewal must contain the information required under paragraphs (e) and (f).

(5) The applicant shall furnish satisfactory proof of financial ability to operate and conduct the nursing home in accordance with the requirements of this part and all rules adopted under this part, and the agency shall establish standards for this purpose, including information reported under paragraph (2)(e). The agency also shall establish documentation requirements, to be completed by each applicant, that show anticipated facility revenues and expenditures, the basis for financing the anticipated cash-flow requirements of the facility, and an applicant's access to contingency financing.

(6) If the applicant offers continuing care agreements as defined in chapter 651, proof shall be furnished that such applicant has obtained a certificate of authority as required for operation under that chapter.

(7) As a condition of licensure, each licensee, except one offering continuing care agreements as defined in chapter 651, must agree to accept recipients of Title XIX of the Social Security Act on a temporary, emergency basis. The persons whom the agency may require such licensees to accept

are those recipients of Title XIX of the Social Security Act who are residing in a facility in which existing conditions constitute an immediate danger to the health, safety, or security of the residents of the facility.

(8) The agency may not issue a license to a nursing home that fails to receive a certificate of need under the provisions of ss. 408.031-408.045. It is the intent of the Legislature that, in reviewing a certificate-of-need application to add beds to an existing nursing home facility, preference be given to the application of a licensee who has been awarded a Gold Seal as provided for in s. 400.235, if the applicant otherwise meets the review criteria specified in s. 408.035.

(9) The agency may develop an abbreviated survey for licensure renewal applicable to a licensee that has continuously operated as a nursing facility since 1991 or earlier, has operated under the same management for at least the preceding 30 months, and has had during the preceding 30 months no class I or class II deficiencies.

(10) As a condition of licensure, each facility must establish and submit with its application a plan for quality assurance and for conducting risk management.

(11) The applicant must provide the agency with proof of a legal right to occupy the property before a license may be issued. Proof may include, but is not limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, or quitclaim deeds.

**History.**--s. 6, ch. 69-309; ss. 19, 35, ch. 69-106; ss. 5, 6, ch. 70-361; s. 1, ch. 70-439; s. 3, ch. 76-168; s. 2, ch. 76-201; s. 236, ch. 77-147; s. 2, ch. 77-323; s. 1, ch. 77-457; ss. 4, 9, ch. 79-268; ss. 5, 18, ch. 80-186; ss. 2, 3, ch. 81-318; ss. 12, 79, 83, ch. 83-181; s. 44, ch. 87-92; s. 30, ch. 93-177; ss. 11, 49, ch. 93-217; s. 11, ch. 97-87; s. 1, ch. 98-85; ss. 41, 71, ch. 98-171; s. 9, ch. 99-394; s. 71, ch. 2000-349; s. 15, ch. 2001-45; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 18, ch. 2001-377; s. 18, ch. 2003-57; s. 417, ch. 2003-261; s. 46, ch. 2004-267; s. 2, ch. 2004-298.

**400.0712 Application for inactive license.** --

(1) As specified in this section, the agency may issue an inactive license to a nursing home facility for all or a portion of its beds. Any request by a licensee that a nursing home or portion of a nursing home become inactive must be submitted to the agency in the approved format. The facility may not initiate any suspension of services, notify residents, or initiate facility closure before receiving approval from the agency; and a facility that violates this provision shall not be issued an inactive license. Upon agency approval of an inactive license, the nursing home shall notify residents of any necessary discharge or transfer as provided in s. 400.0255.

(2) The agency may issue an inactive license to a nursing home that chooses to use an unoccupied contiguous portion of the facility for an alternative use to meet the needs of elderly persons through the use of less restrictive, less institutional services.

(a) An inactive license issued under this subsection may be granted for a period not to exceed 12 months but may be renewed annually by the agency for 12 months.

(b) A request to extend the inactive license must be submitted to the agency in the approved format and approved by the agency in writing.

(c) Nursing homes that receive an inactive license to provide alternative services shall not receive preference for participation in the Assisted Living for the Elderly Medicaid waiver.

(3) The agency may issue an inactive license to a nursing home that will be temporarily unable to provide services but is reasonably expected to resume services.

(a) An inactive license issued under this subsection may be issued for a period not to exceed 12 months and may be renewed by the agency for an additional 6 months upon demonstration of progress toward reopening.

(b) All licensure fees must be current and paid in full, and may be prorated as provided by agency rule, before the inactive license is issued.

(c) Reactivation of an inactive license requires that the applicant pay all licensure fees and be inspected by the agency to confirm that all of the requirements of this part and applicable rules are met.

(4) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 necessary to implement this section.

**History.**--s. 1, ch. 2004-298.

**400.102 Action by agency against licensee; grounds.**--

(1) Any of the following conditions shall be grounds for action by the agency against a licensee:

(a) An intentional or negligent act materially affecting the health or safety of residents of the facility;

(b) Misappropriation or conversion of the property of a resident of the facility;

(c) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a nursing home resident;

(d) Violation of provisions of this part or rules adopted under this part;

(e) Fraudulent altering, defacing, or falsifying any medical or nursing home records, or causing or procuring any of these offenses to be committed; or

(f) Any act constituting a ground upon which application for a license may be denied.

(2) If the agency has reasonable belief that any of such conditions exist, it shall take the following action:

(a) In the case of an applicant for original licensure, denial action as provided in s. 400.121.

(b) In the case of an applicant for relicensure or a current licensee, administrative action as provided in s. 400.121 or injunctive action as authorized by s. 400.125.

(c) In the case of a facility operating without a license, injunctive action as authorized in s. 400.125.

**History.**--s. 8, ch. 70-361; s. 1, ch. 70-439; s. 3, ch. 76-168; s. 237, ch. 77-147; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 13, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 12, 49, ch. 93-217; s. 35, ch. 96-169; s. 16, ch. 2001-45.

**400.111 Expiration of license; renewal.**--

(1) A license issued for the operation of a facility, unless sooner suspended or revoked, shall expire on the date set forth by the agency on the face of the license or 1 year from the date of issuance,

whichever occurs first. Ninety days prior to the expiration date, an application for renewal shall be submitted to the agency. A license shall be renewed upon the filing of an application on forms furnished by the agency if the applicant has first met the requirements established under this part and all rules adopted under this part. The failure to file an application within the period established in this subsection shall result in a late fee charged to the licensee by the agency in an amount equal to 50 percent of the fee in effect on the last preceding regular renewal date. A late fee shall be levied for each and every day the filing of the license application is delayed, but in no event shall such fine aggregate more than $5,000. If an application is received after the required filing date and exhibits a hand-canceled postmark obtained from a United States Post Office dated on or before the required filing date, no fine will be levied.

(2) A licensee against whom a revocation or suspension proceeding, or any judicial proceeding instituted by the agency under this part, is pending at the time of license renewal may be issued a temporary license effective until final disposition by the agency of such proceeding. If judicial relief is sought from the aforesaid administrative order, the court having jurisdiction may issue such orders regarding the issuance of a temporary permit during the pendency of the judicial proceeding.

(3) The agency may not renew a license if the applicant has failed to pay any fines assessed by final order of the agency or final order of the Health Care Financing Administration under requirements for federal certification. The agency may renew the license of an applicant following the assessment of a fine by final order if such fine has been paid into an escrow account pending an appeal of a final order.

(4) The licensee shall submit a signed affidavit disclosing any financial or ownership interest that a licensee has held within the last 5 years in any entity licensed by the state or any other state to provide health or residential care which entity has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason such entity was closed, whether voluntarily or involuntarily.

**History.**--s. 10, ch. 69-309; ss. 19, 35, ch. 69-106; s. 7, ch. 70-361; s. 1, ch. 70-439; s. 3, ch. 76-168; s. 238, ch. 77-147; s. 1, ch. 77-457; ss. 5, 9, ch. 79-268; ss. 6, 18, ch. 80-186; ss. 2, 3, ch. 81-318; ss. 2, 19, ch. 82-148; ss. 14, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 13, 49, ch. 93-217; s. 17, ch. 2001-45.

**400.118 Quality assurance; early warning system; monitoring; rapid response teams.**--

(1) The agency shall establish an early warning system to detect conditions in nursing facilities that could be detrimental to the health, safety, and welfare of residents. The early warning system shall include, but not be limited to, analysis of financial and quality-of-care indicators that would predict the need for the agency to take action pursuant to the authority set forth in this part.

(2)(a) The agency shall establish within each district office one or more quality-of-care monitors, based on the number of nursing facilities in the district, to monitor all nursing facilities in the district on a regular, unannounced, aperiodic basis, including nights, evenings, weekends, and holidays. Quality-of-care monitors shall visit each nursing facility at least quarterly. Priority for additional monitoring visits shall be given to nursing facilities with a history of resident care deficiencies. Quality-of-care monitors shall be registered nurses who are trained and experienced in nursing facility regulation, standards of practice in long-term care, and evaluation of patient care. Individuals in these positions shall not be deployed by the agency as a part of the district survey team in the conduct of routine, scheduled surveys, but shall function solely and independently as quality-of-care monitors. Quality-of-care monitors shall assess the overall quality of life in the nursing facility and shall assess specific conditions in the facility directly related to resident care, including the operations of internal quality improvement and risk management programs and adverse incident reports. The quality-of-care monitor shall include in an assessment visit observation of the care and services rendered to residents and formal and informal interviews

with residents, family members, facility staff, resident guests, volunteers, other regulatory staff, and representatives of a long-term care ombudsman council or Florida advocacy council.

(b) Findings of a monitoring visit, both positive and negative, shall be provided orally and in writing to the facility administrator or, in the absence of the facility administrator, to the administrator on duty or the director of nursing. The quality-of-care monitor may recommend to the facility administrator procedural and policy changes and staff training, as needed, to improve the care or quality of life of facility residents. Conditions observed by the quality-of-care monitor which threaten the health or safety of a resident shall be reported immediately to the agency area office supervisor for appropriate regulatory action and, as appropriate or as required by law, to law enforcement, adult protective services, or other responsible agencies.

(c) Any record, whether written or oral, or any written or oral communication generated pursuant to paragraph (a) or paragraph (b) shall not be subject to discovery or introduction into evidence in any civil or administrative action against a nursing facility arising out of matters which are the subject of quality-of-care monitoring, and a person who was in attendance at a monitoring visit or evaluation may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the monitoring visits or evaluations. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during monitoring visits or evaluations, and any person who participates in such activities may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her participation in such activities. The exclusion from the discovery or introduction of evidence in any civil or administrative action provided for herein shall not apply when the quality-of-care monitor makes a report to the appropriate authorities regarding a threat to the health or safety of a resident.

(3) The agency shall also create teams of experts that can function as rapid response teams to visit nursing facilities identified through the agency's early warning system. Rapid response teams may visit facilities that request the agency's assistance. The rapid response teams shall not be deployed for the purpose of helping a facility prepare for a regular survey.

**History.**--s. 10, ch. 99-394; s. 17, ch. 2000-263; s. 18, ch. 2001-45.

**400.1183 Resident grievance procedures.**--

(1) Every nursing home must have a grievance procedure available to its residents and their families. The grievance procedure must include:

(a) An explanation of how to pursue redress of a grievance.

(b) The names, job titles, and telephone numbers of the employees responsible for implementing the facility's grievance procedure. The list must include the address and the toll-free telephone numbers of the ombudsman and the agency.

(c) A simple description of the process through which a resident may, at any time, contact the toll-free telephone hotline of the ombudsman or the agency to report the unresolved grievance.

(d) A procedure for providing assistance to residents who cannot prepare a written grievance without help.

(2) Each facility shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

(3) Each facility must respond to the grievance within a reasonable time after its submission.

(4) The agency may investigate any grievance at any time.

(5) The agency may impose an administrative fine, in accordance with s. 400.121, against a nursing home facility for noncompliance with this section.

**History.**--s. 19, ch. 2001-45.

**400.119 Confidentiality of records and meetings of risk management and quality assurance committees.** --

(1) Records of meetings of the risk management and quality assurance committee of a long-term care facility licensed under this part or part III of this chapter, as well as incident reports filed with the facility's risk manager and administrator, notifications of the occurrence of an adverse incident, and adverse incident reports from the facility are confidential and exempt from s. 119.07 (1) and s. 24(a), Art. I of the State Constitution. However, if the Agency for Health Care Administration has a reasonable belief that conduct by a staff member or employee of a facility is criminal activity or grounds for disciplinary action by a regulatory board, the agency may disclose such records to the appropriate law enforcement agency or regulatory board.

(2) Records that are confidential and exempt under subsection (1) and that are obtained by a regulatory board are not available to the public as part of the record of investigation and prosecution in a disciplinary proceeding made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon request by a health care professional against whom probable cause has been found, any such records that form the basis of the determination of probable cause.

(3) Records disclosed to a law enforcement agency pursuant to subsection (1) remain confidential and exempt until criminal charges are filed.

(4) The meetings of an internal risk management and quality assurance committee of a long-term care facility licensed under this part or part III of this chapter are exempt from s. 286.011 and s. 24 (b), Art. I of the State Constitution and are not open to the public.

(5) This section is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2006, unless reviewed and saved from repeal through reenactment by the Legislature.

**History.**--s. 1, ch. 2001-44; s. 59, ch. 2002-1.

**400.121 Denial, suspension, revocation of license; moratorium on admissions; administrative fines; procedure; order to increase staffing.** --

(1) The agency may deny an application, revoke or suspend a license, or impose an administrative fine, not to exceed $500 per violation per day, against any applicant or licensee for the following violations by the applicant, licensee, or other controlling interest:

(a) A violation of any provision of s. 400.102(1);

(b) A demonstrated pattern of deficient practice;

(c) Failure to pay any outstanding fines assessed by final order of the agency or final order of the Health Care Financing Administration pursuant to requirements for federal certification. The agency may renew or approve the license of an applicant following the assessment of a fine by final order if such fine has been paid into an escrow account pending an appeal of a final order;

(d) Exclusion from the Medicare or Medicaid program; or

(e) An adverse action by a regulatory agency against any other licensed facility that has a common controlling interest with the licensee or applicant against whom the action under this section is being brought. If the adverse action involves solely the management company, the applicant or licensee shall be given 30 days to remedy before final action is taken. If the adverse action is based solely upon actions by a controlling interest, the applicant or licensee may present factors in mitigation of any proposed penalty based upon a showing that such penalty is inappropriate under the circumstances.

All hearings shall be held within the county in which the licensee or applicant operates or applies for a license to operate a facility as defined herein.

(2) Except as provided in s. 400.23(8), a $500 fine shall be imposed for each violation. Each day a violation of this part occurs constitutes a separate violation and is subject to a separate fine, but in no event may any fine aggregate more than $5,000. A fine may be levied pursuant to this section in lieu of and notwithstanding the provisions of s. 400.23. Fines paid shall be deposited in the Resident Protection Trust Fund and expended as provided in s. 400.063.

(3) The agency shall revoke or deny a nursing home license if the licensee or controlling interest operates a facility in this state that:

(a) Has had two moratoria imposed by final order for substandard quality of care, as defined by 42 C.F.R. part 483, within any 30-month period;

(b) Is conditionally licensed for 180 or more continuous days;

(c) Is cited for two class I deficiencies arising from unrelated circumstances during the same survey or investigation; or

(d) Is cited for two class I deficiencies arising from separate surveys or investigations within a 30-month period.

The licensee may present factors in mitigation of revocation, and the agency may make a determination not to revoke a license based upon a showing that revocation is inappropriate under the circumstances.

(4) The agency may issue an order immediately suspending or revoking a license when it determines that any condition in the facility presents a danger to the health, safety, or welfare of the residents in the facility.

(5)(a) The agency may impose an immediate moratorium on admissions to any facility when the agency determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility.

(b) Where the agency has placed a moratorium on admissions on any facility two times within a 7-year period, the agency may suspend the license of the nursing home and the facility's management company, if any. During the suspension, the agency shall take the facility into receivership and shall operate the facility.

(6) An action taken by the agency to deny, suspend, or revoke a facility's license under this part shall be heard by the Division of Administrative Hearings of the Department of Management Services within 60 days after the assignment of an administrative law judge, unless the time limitation is waived by both parties. The administrative law judge must render a decision within 30 days after receipt of a proposed recommended order.

(7) The agency is authorized to require a facility to increase staffing beyond the minimum required by law, if the agency has taken administrative action against the facility for care-related deficiencies directly attributable to insufficient staff. Under such circumstances, the facility may request an expedited interim rate increase. The agency shall process the request within 10 days after receipt of all required documentation from the facility. A facility that fails to maintain the required increased staffing is subject to a fine of $500 per day for each day the staffing is below the level required by the agency.

(8) An administrative proceeding challenging an action taken by the agency pursuant to this section shall be reviewed on the basis of the facts and conditions that resulted in such agency action.

(9) Notwithstanding any other provision of law to the contrary, agency action in an administrative proceeding under this section may be overcome by the licensee upon a showing by a preponderance of the evidence to the contrary.

(10) In addition to any other sanction imposed under this part, in any final order that imposes sanctions, the agency may assess costs related to the investigation and prosecution of the case. Payment of agency costs shall be deposited into the Health Care Trust Fund.

**History.**--s. 11, ch. 69-309; s. 1, ch. 69-267; ss. 19, 35, ch. 69-106; s. 9, ch. 70-361; s. 1, ch. 70-439; s. 3, ch. 76-168; s. 239, ch. 77-147; s. 1, ch. 77-457; s. 19, ch. 78-95; ss. 6, 9, ch. 79-268; ss. 7, 18, ch. 80-186; ss. 2, 3, ch. 81-318; ss. 15, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 14, 49, ch. 93-217; s. 36, ch. 96-169; s. 1, ch. 98-248; s. 11, ch. 99-394; s. 20, ch. 2001-45.

**400.125 Injunction proceedings authorized.**--

(1) The agency may institute injunction proceedings in a court of competent jurisdiction to:

(a) Enforce the provisions of this part or any minimum standard, rule, or order issued or entered into pursuant thereto; or

(b) Terminate the operation of a home where any of the following exist:

1. Failure to take preventive or corrective measures in accordance with any order of the agency.

2. Failure to abide by any final order of the agency once it has become effective and binding.

3. Any violation as provided in s. 400.121 constituting an emergency requiring immediate action.

(2) Such injunctive relief may include temporary and permanent injunction.

**History.**--s. 10, ch. 70-361; s. 1, ch. 70-439; s. 3, ch. 76-168; s. 240, ch. 77-147; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 16, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 15, 49, ch. 93-217.

**400.126 Receivership proceedings.**--

(1) As an alternative to or in conjunction with an injunctive proceeding, the agency may petition a court of competent jurisdiction for the appointment of a receiver, when any of the following conditions exist:

(a) Any person is operating a facility without a license and refuses to make application for a license as required by s. 400.062.

(b) The licensee is closing the facility or has informed the agency that it intends to close the

facility and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the facility. However, the failure on the part of the agency, after receiving notice of the closing of a facility that is certified to provide services under Title XIX of the Social Security Act, a minimum of 90 days prior to the closing date, to make adequate arrangement for relocating those residents who are receiving assistance under the Medicaid program shall in and of itself not be grounds to petition for the appointment of a receiver. Under these circumstances, if a facility remains open beyond the closing date, the agency shall reimburse the facility for all costs incurred, up to the cap, for those residents who are receiving assistance under the Medicaid program, provided the facility continues to be licensed pursuant to this part and certified to provide services under Title XIX of the Social Security Act.

(c) The agency determines that conditions exist in the facility which present an imminent danger to the health, safety, or welfare of the residents of the facility or a substantial probability that death or serious physical harm would result therefrom.

(d) The licensee cannot meet its financial obligation for providing food, shelter, care, and utilities. Evidence such as the issuance of bad checks or an accumulation of delinquent bills for such items as personnel salaries, food, drugs, or utilities shall constitute prima facie evidence that the ownership of the facility lacks the financial ability to operate the home.

(2) Petitions for receivership shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, shall have priority. A hearing shall be conducted within 5 days of the filing of the petition, at which time all interested parties shall have the opportunity to present evidence pertaining to the petition. The agency shall notify the owner or administrator of the facility named in the petition of the filing of the petition and the date set for the hearing. The court may grant the petition only upon finding that the health, safety, or welfare of residents of the facility would be threatened if a condition existing at the time the petition was filed is permitted to continue. A receiver may not be appointed when the owner or administrator, or a representative of the owner or administrator, is not present at the hearing on the petition, unless the court determines that one or more of the conditions in subsection (1) exist; that the facility owner or administrator cannot be found; that all reasonable means of locating the owner or the administrator and notifying him or her of the petition and hearing have been exhausted; or that the owner or administrator, after notification of the hearing, chooses not to attend. After such findings, the court may appoint any person qualified by education, training, or experience to carry out the responsibilities of a receiver pursuant to this section, who must either be qualified pursuant to s. 400.20 or who must employ a licensed nursing home administrator in compliance with s. 400.20, except that the court may not appoint any owner or affiliate of the facility which is in receivership. The receiver may be selected from a list of persons qualified to act as receivers developed by the agency and presented to the court with each petition for receivership. Under no circumstances shall the agency or designated agency employee be appointed as a receiver for more than 60 days; however, the receiver may petition the court, one time only, for a 30-day extension. The court shall grant the extension upon a showing of good cause.

(3) The receiver shall make provisions for the continued health, safety, and welfare of all residents of the facility and:

(a) Shall exercise those powers and perform those duties set out by the court.

(b) Shall operate the facility in such a manner as to assure safety and adequate health care for the residents.

(c) Shall take such action as is reasonably necessary to protect or conserve the assets or property of the facility for which the receiver is appointed, or the proceeds from any transfer thereof, and may use them only in the performance of the powers and duties set forth in this section and by order of the court.

(d) May use the building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the facility at the time the petition for receivership was filed. The receiver shall collect payments for all goods and services provided to residents or others during the period of the receivership at the same rate of payment charged by the owners at the time the petition for receivership was filed, or at a fair and reasonable rate otherwise approved by the court for private-pay residents. The receiver may apply to the agency for a rate increase for Title XIX of the Social Security Act residents if the facility is not receiving the "state reimbursement cap" and expenditures justify an increase in the rate.

(e) May correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety or health of residents while they remain in the facility, provided the total cost of correction does not exceed $10,000. The court may order expenditures for this purpose in excess of $10,000 on application from the receiver after notice to the owner and a hearing.

(f) May let contracts and hire agents and employees to carry out the powers and duties of the receiver under this section.

(g) Shall honor all leases, mortgages, and secured transactions governing the building in which the facility is located and all goods and fixtures in the building of which the receiver has taken possession, but only to the extent of payments which, in the case of a rental agreement, are for the use of the property during the period of receivership, or which, in the case of a purchase agreement, become due during the period of receivership.

(h) Shall have full power to direct and manage and to discharge employees of the facility, subject to any contract rights they may have. The receiver shall pay employees at the rate of compensation, including benefits, approved by the court. A receivership does not relieve the owner of any obligation to employees made prior to the appointment of a receiver and not carried out by the receiver.

(i) Shall be entitled to take possession of all property or assets of residents which are in the possession of a facility or its owner. The receiver shall preserve all property or assets and all resident records of which the receiver takes possession and shall provide for the prompt transfer of the property, assets, and records to the new placement of any transferred resident. An inventory list certified by the owner and receiver shall be made at the time the receiver takes possession of the facility.

(4)(a) A person who is served with notice of an order of the court appointing a receiver and of the receiver's name and address shall be liable to pay the receiver for any goods or services provided by the receiver after the date of the order if the person would have been liable for the goods or services as supplied by the owner. The receiver shall give a receipt for each payment and shall keep a copy of each receipt on file. The receiver shall deposit accounts received in a separate account and shall use this account for all disbursements.

(b) The receiver may bring an action to enforce the liability created by paragraph (a).

(c) A payment to the receiver of any sum owing to the facility or its owner shall discharge any obligation to the facility to the extent of the payment.

(5)(a) A receiver may petition the court that he or she not be required to honor any lease, mortgage, secured transaction, or other wholly or partially executory contract entered into by the owner of the facility if the rent, price, or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rent, price, or rate of interest at the time the contract was entered into, or if any material provision of the agreement was unreasonable, when compared to contracts negotiated under similar conditions. Any relief in this form provided by the court shall be limited to the life of the receivership, unless otherwise determined by the court.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage, or security interest which the receiver has obtained a court order to avoid under paragraph (a), and if the real estate or goods are necessary for the continued operation of the facility under this section, the receiver may apply to the court to set a reasonable rental, price, or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing on the application within 15 days. The receiver shall send notice of the application to any known persons who own the property involved or mortgage holders at least 10 days prior to the hearing. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or for possession of the goods or real estate subject to the lease, security interest, or mortgage involved by any person who received such notice, but the payment does not relieve the owner of the facility of any liability for the difference between the amount paid by the receiver and the amount due under the original lease, security interest, or mortgage involved.

(6) The court shall set the compensation of the receiver, which will be considered a necessary expense of a receivership.

(7) A receiver may be held liable in a personal capacity only for the receiver's own gross negligence, intentional acts, or breach of fiduciary duty.

(8) The court may require a receiver to post a bond.

(9) The court may terminate a receivership when:

(a) The court determines that the receivership is no longer necessary because the conditions which gave rise to the receivership no longer exist; or

(b) All of the residents in the facility have been transferred or discharged.

(10) Within 30 days after the termination, unless this time period is extended by the court, the receiver shall give the court a complete accounting of all property of which the receiver has taken possession, of all funds collected and disbursed, and of the expenses of the receivership.

(11) Nothing in this section shall be deemed to relieve any owner, administrator, or employee of a facility placed in receivership of any civil or criminal liability incurred, or of any duty imposed by law, by reason of acts or omissions of the owner, administrator, or employee prior to the appointment of a receiver; nor shall anything contained in this section be construed to suspend during the receivership any obligation of the owner, administrator, or employee for payment of taxes or other operating and maintenance expenses of the facility, or of the owner, administrator, employee, or any other person for the payment of mortgages or liens. The owner shall retain the right to sell or mortgage any facility under receivership, subject to approval of the court which ordered the receivership. A licensee that is placed in receivership by the court is liable for all expenses and costs incurred by the Resident Protection Trust Fund that are related to capital improvement and operating costs and are no more than 10 percent above the facility's Medicaid rate which occur as a result of the receivership.

(12) Concurrently with the appointment of a receiver, the agency and the Department of Elderly Affairs shall coordinate an assessment of each resident in the facility by the Comprehensive Assessment and Review for Long-Term-Care (CARES) Program for the purpose of evaluating each resident's need for the level of care provided in a nursing facility and the potential for providing such care in alternative settings. If the CARES assessment determines that a resident could be cared for in a less restrictive setting or does not meet the criteria for skilled or intermediate care in a nursing home, the department and agency shall refer the resident for such care, as is appropriate for the resident. Residents referred pursuant to this subsection shall be given primary consideration for receiving services under the community care for the elderly program in the same manner as persons classified to receive such services pursuant to s. 430.205.

**History.**--ss. 8, 18, ch. 80-186; s. 2, ch. 81-318; ss. 17, 79, 83, ch. 83-181; s. 51, ch. 83-218; s. 57, ch. 91-282; s. 30, ch. 93-177; ss. 16, 49, ch. 93-217; s. 766, ch. 95-148; s. 21, ch. 2001-45.

**400.141 Administration and management of nursing home facilities.**--Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(1) Be under the administrative direction and charge of a licensed administrator.

(2) Appoint a medical director licensed pursuant to chapter 458 or chapter 459. The agency may establish by rule more specific criteria for the appointment of a medical director.

(3) Have available the regular, consultative, and emergency services of physicians licensed by the state.

(4) Provide for resident use of a community pharmacy as specified in s. 400.022(1)(q). Any other law to the contrary notwithstanding, a registered pharmacist licensed in Florida, that is under contract with a facility licensed under this chapter, shall repackage a nursing facility resident's bulk prescription medication which has been packaged by another pharmacist licensed in any state in the United States into a unit dose system compatible with the system used by the nursing facility, if the pharmacist is requested to offer such service. In order to be eligible for the repackaging, a resident or the resident's spouse must receive prescription medication benefits provided through a former employer as part of his or her retirement benefits, a qualified pension plan as specified in s. 4972 of the Internal Revenue Code, a federal retirement program as specified under 5 C.F.R. s. 831, or a long-term care policy as defined in s. 627.9404(1). A pharmacist who correctly repackages and relabels the medication and the nursing facility which correctly administers such repackaged medication under the provisions of this subsection shall not be held liable in any civil or administrative action arising from the repackaging. In order to be eligible for the repackaging, a nursing facility resident for whom the medication is to be repackaged shall sign an informed consent form provided by the facility which includes an explanation of the repackaging process and which notifies the resident of the immunities from liability provided herein. A pharmacist who repackages and relabels prescription medications, as authorized under this subsection, may charge a reasonable fee for costs resulting from the implementation of this provision.

(5) Provide for the access of the facility residents to dental and other health-related services, recreational services, rehabilitative services, and social work services appropriate to their needs and conditions and not directly furnished by the licensee. When a geriatric outpatient nurse clinic is conducted in accordance with rules adopted by the agency, outpatients attending such clinic shall not be counted as part of the general resident population of the nursing home facility, nor shall the nursing staff of the geriatric outpatient clinic be counted as part of the nursing staff of the facility, until the outpatient clinic load exceeds 15 a day.

(6) Be allowed and encouraged by the agency to provide other needed services under certain conditions. If the facility has a standard licensure status, and has had no class I or class II deficiencies during the past 2 years or has been awarded a Gold Seal under the program established in s. 400.235, it may be encouraged by the agency to provide services, including, but not limited to, respite and adult day services, which enable individuals to move in and out of the facility. A facility is not subject to any additional licensure requirements for providing these services. Respite care may be offered to persons in need of short-term or temporary nursing home services. Respite care must be provided in accordance with this part and rules adopted by the agency. However, the agency shall, by rule, adopt modified requirements for resident assessment, resident care plans, resident contracts, physician orders, and other provisions, as appropriate, for short-term or temporary nursing home services. The agency shall allow for shared programming and staff in a facility which meets minimum standards and offers services pursuant to this subsection, but, if the facility is cited for deficiencies in patient care, may require additional staff and programs appropriate to the needs of service recipients. A person who receives respite care may not be counted as a resident of the facility for purposes of the facility's licensed capacity unless

that person receives 24-hour respite care. A person receiving either respite care for 24 hours or longer or adult day services must be included when calculating minimum staffing for the facility. Any costs and revenues generated by a nursing home facility from nonresidential programs or services shall be excluded from the calculations of Medicaid per diems for nursing home institutional care reimbursement.

(7) If the facility has a standard license or is a Gold Seal facility, exceeds the minimum required hours of licensed nursing and certified nursing assistant direct care per resident per day, and is part of a continuing care facility licensed under chapter 651 or a retirement community that offers other services pursuant to part III, part IV, or part V on a single campus, be allowed to share programming and staff. At the time of inspection and in the semiannual report required pursuant to subsection (15), a continuing care facility or retirement community that uses this option must demonstrate through staffing records that minimum staffing requirements for the facility were met. Licensed nurses and certified nursing assistants who work in the nursing home facility may be used to provide services elsewhere on campus if the facility exceeds the minimum number of direct care hours required per resident per day and the total number of residents receiving direct care services from a licensed nurse or a certified nursing assistant does not cause the facility to violate the staffing ratios required under s. 400.23(3)(a). Compliance with the minimum staffing ratios shall be based on total number of residents receiving direct care services, regardless of where they reside on campus. If the facility receives a conditional license, it may not share staff until the conditional license status ends. This subsection does not restrict the agency's authority under federal or state law to require additional staff if a facility is cited for deficiencies in care which are caused by an insufficient number of certified nursing assistants or licensed nurses. The agency may adopt rules for the documentation necessary to determine compliance with this provision.

(8) Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.

(9) If the licensee furnishes food service, provide a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by attending physicians. In making rules to implement this subsection, the agency shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics.

(10) Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the residents; and individual resident care plans including, but not limited to, prescribed services, service frequency and duration, and service goals. The records shall be open to inspection by the agency.

(11) Keep such fiscal records of its operations and conditions as may be necessary to provide information pursuant to this part.

(12) Furnish copies of personnel records for employees affiliated with such facility, to any other facility licensed by this state requesting this information pursuant to this part. Such information contained in the records may include, but is not limited to, disciplinary matters and any reason for termination. Any facility releasing such records pursuant to this part shall be considered to be acting in good faith and may not be held liable for information contained in such records, absent a showing that the facility maliciously falsified such records.

(13) Publicly display a poster provided by the agency containing the names, addresses, and telephone numbers for the state's abuse hotline, the State Long-Term Care Ombudsman, the Agency for Health Care Administration consumer hotline, the Advocacy Center for Persons with Disabilities, the Florida Statewide Advocacy Council, and the Medicaid Fraud Control Unit, with a clear description of the assistance to be expected from each.

(14) Submit to the agency the information specified in s. 400.071(2)(e) for a management company

within 30 days after the effective date of the management agreement.

(15) Submit semiannually to the agency, or more frequently if requested by the agency, information regarding facility staff-to-resident ratios, staff turnover, and staff stability, including information regarding certified nursing assistants, licensed nurses, the director of nursing, and the facility administrator. For purposes of this reporting:

(a) Staff-to-resident ratios must be reported in the categories specified in s. 400.23(3)(a) and applicable rules. The ratio must be reported as an average for the most recent calendar quarter.

(b) Staff turnover must be reported for the most recent 12-month period ending on the last workday of the most recent calendar quarter prior to the date the information is submitted. The turnover rate must be computed quarterly, with the annual rate being the cumulative sum of the quarterly rates. The turnover rate is the total number of terminations or separations experienced during the quarter, excluding any employee terminated during a probationary period of 3 months or less, divided by the total number of staff employed at the end of the period for which the rate is computed, and expressed as a percentage.

(c) The formula for determining staff stability is the total number of employees that have been employed for more than 12 months, divided by the total number of employees employed at the end of the most recent calendar quarter, and expressed as a percentage.

(d) A nursing facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for a period of 6 consecutive days. For the purposes of this paragraph, any person who was a resident of the facility and was absent from the facility for the purpose of receiving medical care at a separate location or was on a leave of absence is not considered a new admission. Failure to impose such an admissions moratorium constitutes a class II deficiency.

(e) A nursing facility which does not have a conditional license may be cited for failure to comply with the standards in s. 400.23(3)(a) only if it has failed to meet those standards on 2 consecutive days or if it has failed to meet at least 97 percent of those standards on any one day.

(f) A facility which has a conditional license must be in compliance with the standards in s. 400.23 (3)(a) at all times.

Nothing in this section shall limit the agency's ability to impose a deficiency or take other actions if a facility does not have enough staff to meet the residents' needs.

(16) Report monthly the number of vacant beds in the facility which are available for resident occupancy on the day the information is reported.

(17) Notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

(18) If the facility implements a dining and hospitality attendant program, ensure that the program is developed and implemented under the supervision of the facility director of nursing. A licensed nurse, licensed speech or occupational therapist, or a registered dietitian must conduct training of dining and hospitality attendants. A person employed by a facility as a dining and hospitality attendant must perform tasks under the direct supervision of a licensed nurse.

(19) Report to the agency any filing for bankruptcy protection by the facility or its parent corporation, divestiture or spin-off of its assets, or corporate reorganization within 30 days after the completion of such activity.

[1](20) Maintain general and professional liability insurance coverage that is in force at all times. In lieu of general and professional liability insurance coverage, a state-designated teaching nursing home and its affiliated assisted living facilities created under s. 430.80 may demonstrate proof of financial responsibility as provided in s. 430.80(3)(h); the exception provided in this paragraph shall expire July 1, 2005.

(21) Maintain in the medical record for each resident a daily chart of certified nursing assistant services provided to the resident. The certified nursing assistant who is caring for the resident must complete this record by the end of his or her shift. This record must indicate assistance with activities of daily living, assistance with eating, and assistance with drinking, and must record each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration.

(22) Before November 30 of each year, subject to the availability of an adequate supply of the necessary vaccine, provide for immunizations against influenza viruses to all its consenting residents in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Subject to these exemptions, any consenting person who becomes a resident of the facility after November 30 but before March 31 of the following year must be immunized within 5 working days after becoming a resident. Immunization shall not be provided to any resident who provides documentation that he or she has been immunized as required by this subsection. This subsection does not prohibit a resident from receiving the immunization from his or her personal physician if he or she so chooses. A resident who chooses to receive the immunization from his or her personal physician shall provide proof of immunization to the facility. The agency may adopt and enforce any rules necessary to comply with or implement this subsection.

(23) Assess all residents for eligibility for pneumococcal polysaccharide vaccination (PPV) and vaccinate residents when indicated within 60 days after the effective date of this act in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Residents admitted after the effective date of this act shall be assessed within 5 working days of admission and, when indicated, vaccinated within 60 days in accordance with the recommendations of the United States Centers for Disease Control and Prevention, subject to exemptions for medical contraindications and religious or personal beliefs. Immunization shall not be provided to any resident who provides documentation that he or she has been immunized as required by this subsection. This subsection does not prohibit a resident from receiving the immunization from his or her personal physician if he or she so chooses. A resident who chooses to receive the immunization from his or her personal physician shall provide proof of immunization to the facility. The agency may adopt and enforce any rules necessary to comply with or implement this subsection.

(24) Annually encourage and promote to its employees the benefits associated with immunizations against influenza viruses in accordance with the recommendations of the United States Centers for Disease Control and Prevention. The agency may adopt and enforce any rules necessary to comply with or implement this subsection.

Facilities that have been awarded a Gold Seal under the program established in s. 400.235 may develop a plan to provide certified nursing assistant training as prescribed by federal regulations and state rules and may apply to the agency for approval of their program.

**History.**--s. 13, ch. 69-309; ss. 19, 35, ch. 69-106; s. 12, ch. 70-361; s. 3, ch. 76-168; s. 241, ch. 77-147; s. 3, ch. 77-401; s. 1, ch. 77-457; ss. 9, 18, ch. 80-186; ss. 2, 3, ch. 81-318; ss. 18, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 17, 49, ch. 93-217; s. 21, ch. 95-418; s. 12, ch. 99-394; s. 18, ch. 2000-263; s. 4, ch. 2000-350; s. 1, ch. 2001-42; ss. 22, 57, ch. 2001-45; s. 35, ch. 2001-62; s. 144,

ch. 2001-277; s. 60, ch. 2002-1; s. 29, ch. 2002-223; s. 6, ch. 2002-400; s. 23, ch. 2003-57; s. 2, ch. 2003-120.

[1]**Note.**--Section 9, ch. 2002-400, provides that "[i]n order to expedite the availability of general and professional liability insurance for nursing homes, the Agency for Health Care Administration, subject to appropriations included in the General Appropriation Act, shall advance $6 million for the purpose of capitalizing the risk retention group. The terms of repayment may not extend beyond 3 years from the date of funding. For purposes of this project, notwithstanding the provisions of s. 631.271, Florida Statutes, the agency's claim shall be considered a class 3 claim."

**400.1413 Volunteers in nursing homes.**--

(1) It is the intent of the Legislature to encourage the involvement of volunteers in nursing homes in this state. The Legislature also acknowledges that the licensee is responsible for all the activities that take place in the nursing home and recognizes the licensee's need to be aware of and coordinate volunteer activities in the nursing home. Therefore, a nursing home may require that volunteers:

(a) Sign in and out with staff of the nursing home upon entering or leaving the facility.

(b) Wear an identification badge while in the building.

(c) Participate in a facility orientation and training program.

(2) This section does not affect the activities of state or local long-term care ombudsman councils authorized under part I.

**History.**--s. 23, ch. 2001-45.

**400.1415 Patient records; penalties for alteration.**--

(1) Any person who fraudulently alters, defaces, or falsifies any medical record or releases medical records for the purposes of solicitation or marketing the sale of goods or services absent a specific written release or authorization permitting utilization of patient information, or other nursing home record, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges.

**History.**--s. 5, ch. 93-217; s. 7, ch. 99-394; s. 11, ch. 2001-222; s. 142, ch. 2001-277.

**Note.**--Former s. 400.0231.

**400.142 Emergency medication kits; orders not to resuscitate.** --

(1) Other provisions of this chapter or of chapter 465, chapter 499, or chapter 893 to the contrary notwithstanding, each nursing home operating pursuant to a license issued by the agency may maintain an emergency medication kit for the purpose of storing medicinal drugs to be administered under emergency conditions to residents residing in such facility.

(2) The agency shall adopt such rules as it may deem appropriate to the effective implementation of this act, including, but not limited to, rules which:

(a) Define the term "emergency medication kit."

(b) Describe the medicinal drugs eligible to be placed in emergency medication kits.

(c) Establish requirements for the storing of medicinal drugs in emergency medication kits and the maintenance of records with respect thereto.

(d) Establish requirements for the administration of medicinal drugs to residents under emergency conditions from emergency medication kits.

(3) Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

**History.**--ss. 40, 83, ch. 83-181; s. 30, ch. 93-177; ss. 32, 49, ch. 93-217; s. 3, ch. 99-331; s. 2, ch. 2000-295.

**Note.**--Former s. 400.3221.

**400.145 Records of care and treatment of resident; copies to be furnished.**--

(1) Unless expressly prohibited by a legally competent resident, any nursing home licensed pursuant to this part shall furnish to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, of a current resident, within 7 working days after receipt of a written request, or of a former resident, within 10 working days after receipt of a written request, a copy of that resident's records which are in the possession of the facility. Such records shall include medical and psychiatric records and any records concerning the care and treatment of the resident performed by the facility, except progress notes and consultation report sections of a psychiatric nature. Copies of such records shall not be considered part of a deceased resident's estate and may be made available prior to the administration of an estate, upon request, to the spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765. A facility may charge a reasonable fee for the copying of resident records. Such fee shall not exceed $1 per page for the first 25 pages and 25 cents per page for each page in excess of 25 pages. The facility shall further allow any such spouse, guardian, surrogate, proxy, or attorney in fact, as provided in chapters 744 and 765, to examine the original records in its possession, or microfilms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed, to help assure that the records are not damaged, destroyed, or altered.

(2) No person shall be allowed to obtain copies of residents' records pursuant to this section more often than once per month, except that physician's reports in the residents' records may be obtained as often as necessary to effectively monitor the residents' condition.

**History.**--s. 1, ch. 87-302; s. 23, ch. 91-71; s. 30, ch. 93-177; s. 18, ch. 93-217; s. 228, ch. 96-406.

**400.147 Internal risk management and quality assurance program.**--

(1) Every facility shall, as part of its administrative functions, establish an internal risk management and quality assurance program, the purpose of which is to assess resident care practices; review facility quality indicators, facility incident reports, deficiencies cited by the agency, and resident grievances; and develop plans of action to correct and respond quickly to identified quality deficiencies. The program must include:

(a) A designated person to serve as risk manager, who is responsible for implementation and oversight of the facility's risk management and quality assurance program as required by this section.

(b) A risk management and quality assurance committee consisting of the facility risk manager, the administrator, the director of nursing, the medical director, and at least three other members of the facility staff. The risk management and quality assurance committee shall meet at least monthly.

(c) Policies and procedures to implement the internal risk management and quality assurance program, which must include the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to residents.

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.

(e) The development of appropriate measures to minimize the risk of adverse incidents to residents, including, but not limited to, education and training in risk management and risk prevention for all nonphysician personnel, as follows:

1. Such education and training of all nonphysician personnel must be part of their initial orientation; and

2. At least 1 hour of such education and training must be provided annually for all nonphysician personnel of the licensed facility working in clinical areas and providing resident care.

(f) The analysis of resident grievances that relate to resident care and the quality of clinical services.

(2) The internal risk management and quality assurance program is the responsibility of the facility administrator.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of adverse incidents to residents and violations of residents' rights shall be encouraged and their implementation and operation facilitated.

(4) Each internal risk management and quality assurance program shall include the use of incident reports to be filed with the risk manager and the facility administrator. The risk manager shall have free access to all resident records of the licensed facility. The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management and quality assurance program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

(5) For purposes of reporting to the agency under this section, the term "adverse incident" means:

(a) An event over which facility personnel could exercise control and which is associated in whole or in part with the facility's intervention, rather than the condition for which such intervention occurred, and which results in one of the following:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. A limitation of neurological, physical, or sensory function;

6. Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives; or

7. Any condition that required the transfer of the resident, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident;

(b) Abuse, neglect, or exploitation as defined in s. 415.102;

(c) Abuse, neglect and harm as defined in s. 39.01;

(d) Resident elopement; or

(e) An event that is reported to law enforcement.

(6) The internal risk manager of each licensed facility shall:

(a) Investigate every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact when the allegation is that the sexual misconduct occurred at the facility or at the grounds of the facility;

(b) Report every allegation of sexual misconduct to the administrator of the licensed facility; and

(c) Notify the resident representative or guardian of the victim that an allegation of sexual misconduct has been made and that an investigation is being conducted.

(7) The facility shall initiate an investigation and shall notify the agency within 1 business day after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d). The notification must be made in writing and be provided electronically, by facsimile device or overnight mail delivery. The notification must include information regarding the identity of the affected resident, the type of adverse incident, the initiation of an investigation by the facility, and whether the events causing or resulting in the adverse incident represent a potential risk to any other resident. The notification is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(8)(a) Each facility shall complete the investigation and submit an adverse incident report to the agency for each adverse incident within 15 calendar days after its occurrence. If, after a complete investigation, the risk manager determines that the incident was not an adverse incident as defined in subsection (5), the facility shall include this information in the report. The agency shall develop a form for reporting this information.

(b) The information reported to the agency pursuant to paragraph (a) which relates to persons

licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(c) The report submitted to the agency must also contain the name of the risk manager of the facility.

(d) The adverse incident report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board.

(9) By the 10th of each month, each facility subject to this section shall report any notice received pursuant to s. 400.0233(2) and each initial complaint that was filed with the clerk of the court and served on the facility during the previous month by a resident or a resident's family member, guardian, conservator, or personal legal representative. The report must include the name of the resident, the resident's date of birth and social security number, the Medicaid identification number for Medicaid-eligible persons, the date or dates of the incident leading to the claim or dates of residency, if applicable, and the type of injury or violation of rights alleged to have occurred. Each facility shall also submit a copy of the notices received pursuant to s. 400.0233(2) and complaints filed with the clerk of the court. This report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.

(10) The agency shall review, as part of its licensure inspection process, the internal risk management and quality assurance program at each facility regulated by this section to determine whether the program meets standards established in statutory laws and rules, is being conducted in a manner designed to reduce adverse incidents, and is appropriately reporting incidents as required by this section.

(11) There is no monetary liability on the part of, and a cause of action for damages may not arise against, any risk manager for the implementation and oversight of the internal risk management and quality assurance program in a facility licensed under this part as required by this section, or for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management and quality assurance program if the risk manager acts without intentional fraud.

(12) If the agency, through its receipt of the adverse incident reports prescribed in subsection (7), or through any investigation, has a reasonable belief that conduct by a staff member or employee of a facility is grounds for disciplinary action by the appropriate regulatory board, the agency shall report this fact to the regulatory board.

(13) The agency may adopt rules to administer this section.

(14) The agency shall annually submit to the Legislature a report on nursing home adverse incidents. The report must include the following information arranged by county:

(a) The total number of adverse incidents.

(b) A listing, by category, of the types of adverse incidents, the number of incidents occurring within each category, and the type of staff involved.

(c) A listing, by category, of the types of injury caused and the number of injuries occurring within each category.

(d) Types of liability claims filed based on an adverse incident or reportable injury.

(e) Disciplinary action taken against staff, categorized by type of staff involved.

(15) Information gathered by a credentialing organization under a quality assurance program is not discoverable from the credentialing organization. This subsection does not limit discovery of, access to, or use of facility records, including those records from which the credentialing organization gathered its information.

**History.**--s. 24, ch. 2001-45; s. 8, ch. 2002-400.

**400.148 Medicaid "Up-or-Out" Quality of Care Contract Management Program.**--

(1) The Legislature finds that the federal Medicare program has implemented successful models of managing the medical and supportive-care needs of long-term nursing home residents. These programs have maintained the highest practicable level of good health and have the potential to reduce the incidence of preventable illnesses among long-stay residents of nursing homes, thereby increasing the quality of care for residents and reducing the number of lawsuits against nursing homes. Such models are operated at no cost to the state. It is the intent of the Legislature that the Agency for Health Care Administration replicate such oversight for Medicaid recipients in poor-performing nursing homes and in assisted living facilities and nursing homes that are experiencing disproportionate numbers of lawsuits, with the goal of improving the quality of care in such homes or facilitating the revocation of licensure.

(2) The Agency for Health Care Administration shall develop a pilot project in selected counties to demonstrate the effect of assigning skilled and trained medical personnel to ensure the quality of care, safety, and continuity of care for long-stay Medicaid recipients in the highest-scoring nursing homes in the Florida Nursing Home Guide on the date the project is implemented. The agency is authorized to begin the pilot project, subject to appropriation, in the highest-scoring homes in counties where such services are immediately available. On January 1 of each year of the pilot project, the agency shall submit to the appropriations and substantive committees of the Legislature and the Governor an assessment of the program and a proposal for expansion of the program to additional facilities. The staff of the pilot project shall assist regulatory staff in imposing regulatory sanctions, including revocation of licensure, pursuant to s. 400.121 against nursing homes that have quality-of-care violations.

(3) The pilot project must ensure:

(a) Oversight and coordination of all aspects of a resident's medical care and stay in a nursing home;

(b) Facilitation of close communication between the resident, the resident's guardian or legal representative, the resident's attending physician, the resident's family, and staff of the nursing facility;

(c) Frequent onsite visits to the resident;

(d) Early detection of medical or quality problems that have the potential to lead to adverse outcomes and unnecessary hospitalization;

(e) Close communication with regulatory staff;

(f) Immediate investigation of resident quality-of-care complaints and communication and cooperation with the appropriate entity to address those complaints, including the ombudsman, state agencies, agencies responsible for Medicaid program integrity, and local law enforcement agencies;

(g) Assistance to the resident or the resident's representative to relocate the resident if quality-of-care issues are not otherwise addressed; and

(h) Use of Medicare and other third-party funds to support activities of the program, to the extent possible.

(4) The agency shall model the pilot project activities after such Medicare-approved demonstration projects.

(5) The agency may contract to provide similar oversight services to Medicaid recipients.

(6) The agency shall, jointly with the Statewide Public Guardianship Office, develop a system in the pilot project areas to identify Medicaid recipients who are residents of a participating nursing home or assisted living facility who have diminished ability to make their own decisions and who do not have relatives or family available to act as guardians in nursing homes listed on the Nursing Home Guide Watch List. The agency and the Statewide Public Guardianship Office shall give such residents priority for publicly funded guardianship services.

**History.**--s. 25, ch. 2001-45.

**400.151 Contracts.**--

(1) The presence of each resident in a facility shall be covered by a contract, executed by the licensee and the resident or his or her designee or legal representative at the time of admission or prior thereto and at the expiration of the term of a previous contract, and modified by the licensee and the resident or his or her designee or legal representative at the time the source of payment for the resident's care changes. Each party to the contract is entitled to a duplicate original thereof, printed in boldfaced type, and the licensee shall keep on file all contracts which it has with residents. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration or such longer period as may be provided in the rules of the agency. Microfilmed records or records reproduced by a similar process of duplication may be kept in lieu of the original records.

(2) Each contract to which this section applies shall contain express provisions specifically setting forth the services and accommodations to be provided by the licensee, the rates or charges therefor, bed reservation and refund policies, and any other matters which the parties deem appropriate. The licensee shall attach to the contract a list of services and supplies available but not covered by the per diem rate of the facility or by Titles XVIII and XIX of the Social Security Act and the standard charge to the resident for each item. The licensee shall provide written notification to each party to the contract of any changes in any attachment thereto, no fewer than 14 days in advance of the effective date of those changes. The agency shall specify by rule an alternative method for notification of changes in the cost of supplies. If the resident is a party to the contract, the licensee shall provide him or her with a written and oral notification of the changes.

**History.**--s. 14, ch. 69-309; ss. 19, 35, ch. 69-106; s. 13, ch. 70-361; s. 3, ch. 76-168; s. 1, ch. 77-457; ss. 10, 18, ch. 80-186; ss. 2, 3, ch. 81-318; ss. 19, 79, 83, ch. 83-181; s. 46, ch. 85-81; s. 30, ch. 93-177; ss. 19, 49, ch. 93-217; s. 767, ch. 95-148.

**400.162 Property and personal affairs of residents.** --

(1) The admission of a resident to a facility and his or her presence in the facility shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of the aforementioned persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safety and orderly management of the

facility.

(2) No licensee, owner, administrator, employee, or representative thereof shall act as guardian, trustee, or conservator for any resident of the facility or any of such resident's property unless the person is the resident's spouse or a blood relative within the third degree of consanguinity.

(3) A licensee shall provide for the safekeeping of personal effects, funds, and other property of the resident in the facility. Whenever necessary for the protection of valuables, or in order to avoid unreasonable responsibility therefor, the licensee may require that such valuables be excluded or removed from the facility and kept at some place not subject to the control of the licensee. At the request of a resident, the facility shall mark the resident's personal property with the resident's name or another type of identification, without defacing the property. Any theft or loss of a resident's personal property shall be documented by the facility. The facility shall develop policies and procedures to minimize the risk of theft or loss of the personal property of residents. A copy of the policy shall be provided to every employee and to each resident at admission. Facility policies must include provisions related to reporting theft or loss of a resident's property to law enforcement and any facility waiver of liability for loss or theft. The facility shall post notice of these policies and procedures, and any revision thereof, in places accessible to residents.

(4) A licensee shall keep complete and accurate records of all funds and other effects and property of its residents received by it for safekeeping.

(5)(a) Any funds or other property belonging to a resident which are received by a licensee shall be held in trust. Funds held in trust shall be kept separate from the funds and property of the facility; shall be deposited in a bank, savings association, trust company, or credit union located in this state and, if possible, located in the same district in which the facility is located; shall not be represented as part of the assets of the facility on a financial statement; and shall be used or otherwise expended only for the account of the resident.

(b)1. Any licensee which holds resident funds in trust, as provided in paragraph (a), during the period for which a license is requested or issued shall file a surety bond with the agency in an amount equal to twice the average monthly balance in the resident trust fund during the prior year or $5,000, whichever is greater. The bond shall be executed by the licensee as principal and by a surety company authorized and licensed to do business in the state as surety. The bond shall be conditioned upon the faithful compliance of the licensee with the provisions of this section and shall run to the agency for the benefit of any resident injured by the violation by the licensee of the provisions of this section.

2. A new bond or a proper continuation certificate shall be required on the annual renewal date of each licensee's bond. Such bond or certificate shall be filed with the agency as provided in subparagraph 1.

3. Any surety company which cancels or does not renew the bond of any licensee shall notify the agency, in writing, not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal.

(c) As an alternative to posting a surety bond, the licensee may enter into a self-insurance agreement as specified in rules adopted by the agency. Funds contained in the pool shall run to any resident suffering financial loss as a result of the violation by the licensee of the provisions of this section. Such funds shall be awarded to any resident in an amount equal to the amount that the resident can establish, by affidavit or other adequate evidence, was deposited in trust with the licensee and which could not be paid to the resident within 30 days of the resident's request. The agency shall promulgate rules with regard to the establishment, organization, and operation of such self-insurance pools. Such rules shall include, but shall not be limited to, requirements for monetary reserves to be maintained by such self-insurers to assure their financial solvency.

(d) If, at any time during the period for which a license is issued, a licensee that has not purchased a surety bond or entered into a self-insurance agreement, as provided in paragraphs (b) and (c), is requested to provide safekeeping for the personal funds of a resident, the licensee shall notify the agency of the request and make application for a surety bond or for participation in a self-insurance agreement within 7 days of the request, exclusive of weekends and holidays. Copies of the application, along with written documentation of related correspondence with an insurance agency or group, shall be maintained by the licensee for review by the agency and the State Nursing Home and Long-Term Care Facility Ombudsman Council.

(e) Moneys or securities received as advance payment for care may at no time exceed the cost of care for a 6-month period.

(f) At least every 3 months, the licensee shall furnish the resident and the guardian, trustee, or conservator, if any, for the resident a complete and verified statement of all funds and other property to which this subsection applies, detailing the amounts and items received, together with their sources and disposition. In any event, the licensee shall furnish such a statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property on account of a resident also shall be entitled to receive such statement annually and upon discharge or transfer and such other report as it may require pursuant to law.

(6) In the event of the death of a resident, a licensee shall return all refunds and funds held in trust to the resident's personal representative, if one has been appointed at the time the nursing home disburses such funds, and if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the nursing home to the resident. In the event the resident has no spouse or adult next of kin or such person cannot be located, funds due to the resident shall be placed in an interest-bearing account in a bank, savings association, trust company, or credit union located in this state and, if possible, located within the same district in which the facility is located, which funds shall not be represented as part of the assets of the facility on a financial statement, and the licensee shall maintain such account until such time as the trust funds are disbursed pursuant to the provisions of the Florida Probate Code. All other property of a deceased resident being held in trust by the licensee shall be returned to the resident's personal representative, if one has been appointed at the time the nursing home disburses such property, and if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the nursing home to the resident. In the event the resident has no spouse or adult next of kin or such person cannot be located, property being held in trust shall be safeguarded until such time as the property is disbursed pursuant to the provisions of the Florida Probate Code. The trust funds and property of deceased residents shall be kept separate from the funds and the property of the licensee and from the funds and property of the residents of the facility. The nursing home needs to maintain only one account in which the trust funds amounting to less than $100 of deceased residents are placed. However, it shall be the obligation of the nursing home to maintain adequate records to permit compilation of interest due each individual resident's account. Separate accounts shall be maintained with respect to trust funds of deceased residents equal to or in excess of $100. In the event the trust funds of the deceased resident are not disbursed pursuant to the provisions of the Florida Probate Code within 2 years of the death of the resident, the trust funds shall be deposited in the Resident Protection Trust Fund and expended as provided for in s. 400.063, notwithstanding the provisions of any other law of this state. Any other property of a deceased resident held in trust by a licensee which is not disbursed in accordance with the provisions of the Florida Probate Code shall escheat to the state as provided by law.

**History.**--s. 15, ch. 69-309; s. 14, ch. 70-361; s. 3, ch. 76-168; s. 1, ch. 77-457; ss. 7, 9, ch. 79-268; ss. 2, 3, ch. 81-318; ss. 3, 19, ch. 82-148; ss. 20, 79, 83, ch. 83-181; s. 1, ch. 85-286; s. 37, ch. 87-225; s. 30, ch. 93-177; ss. 20, 49, ch. 93-217; s. 768, ch. 95-148; s. 13, ch. 99-394.

**400.165 Itemized resident billing, form and content prescribed by the agency.**--

(1) Within 7 days following discharge or release from a nursing home, or within 7 days after the earliest date at which the cost of all goods or services provided on behalf of the resident are billed to the facility, the nursing home shall submit to the resident, or to his or her survivor or legal guardian, an itemized statement detailing in language comprehensible to an ordinary layperson the specific nature of charges or expenses incurred by the resident. The initial billing shall contain a statement of specific services received and expenses incurred for such items of service, enumerating in detail the constituent components of the services received within each department of the nursing home and including unit price data on rates charged by the nursing home as may be prescribed by the agency.

(2) Each statement shall:

(a) Not include charges of nursing home-based physicians if billed separately.

(b) Not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

(c) List drugs by brand or generic name and may not refer to drug code numbers when referring to drugs of any sort.

(d) Specifically identify therapy treatment as to the date, type, and length of treatment when therapy treatment is a part of the statement. The person receiving a statement pursuant to this section shall be fully and accurately informed as to each charge and service provided by the institution preparing the statement.

(3) On each itemized statement there shall appear the words "A FOR-PROFIT (or NOT-FOR-PROFIT or PUBLIC) NURSING HOME LICENSED BY THE STATE OF FLORIDA" or substantially similar words sufficient to identify clearly and plainly the ownership status of the nursing home.

(4) In any billing for services subsequent to the initial billing for such services, the resident, or the resident's survivor or legal guardian, may elect, at his or her option, to receive a copy of the detailed statement of specific services received and expenses incurred for each such item of service as provided in subsection (1).

(5) No physician, dentist, or nursing home may add to the price charged by any third party except for a service or handling charge representing a cost actually incurred as an item of expense; however, the physician, dentist, or nursing home is entitled to fair compensation for all professional services rendered. The amount of the service or handling charge, if any, shall be set forth clearly in the bill to the resident.

**History.**--ss. 22, 27, ch. 82-182; ss. 21, 79, 81, 83, ch. 83-181; s. 30, ch. 93-177; ss. 21, 49, ch. 93-217; s. 769, ch. 95-148.

**Note.**--Former s. 400.425.

**400.17 Bribes, kickbacks, certain solicitations prohibited.**--

(1) As used in this section, the term:

(a) "Bribe" means any consideration corruptly given, received, promised, solicited, or offered to any individual with intent or purpose to influence the performance of any act or omission.

(b) "Kickback" means that part of the payment for items or services which is returned to the payor by the provider of such items or services with the intent or purpose to induce the payor to purchase the items or services from the provider.

(2) Whoever furnishes items or services directly or indirectly to a nursing home resident and solicits, offers, or receives any:

(a) Kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment; or

(b) Return of part of an amount given in payment for referring any such individual to another person for the furnishing of such items or services;

is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or by fine not exceeding $5,000, or both.

(3) No person shall, in connection with the solicitation of contributions to nursing homes, willfully misrepresent or mislead anyone, by any manner, means, practice, or device whatsoever, to believe that the receipts of such solicitation will be used for charitable purposes, if such is not the fact.

(4) Solicitation of contributions of any kind in a threatening, coercive, or unduly forceful manner by or on behalf of a nursing home by any agent, employee, owner, or representative of a nursing home shall be grounds for denial, suspension, or revocation of the license for any nursing home on behalf of which such contributions were solicited.

(5) The admission, maintenance, or treatment of a nursing home resident whose care is supported in whole or in part by state funds may not be made conditional upon the receipt of any manner of contribution or donation from any person. However, this may not be construed to prohibit the offer or receipt of contributions or donations to a nursing home which are not related to the care of a specific resident. Contributions solicited or received in violation of this subsection shall be grounds for denial, suspension, or revocation of a license for any nursing home on behalf of which such contributions were solicited.

**History.**--s. 16, ch. 69-309; s. 16, ch. 70-361; s. 3, ch. 76-168; s. 3, ch. 76-201; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 22, 79, 83, ch. 83-181; s. 30, ch. 93-177; s. 49, ch. 93-217.

**400.175 Patients with Alzheimer's disease or other related disorders; certain disclosures.**--A facility licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The facility must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the facility and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the facility's records as part of the license renewal procedure.

**History.**--s. 1, ch. 93-105.

**400.1755 Care for persons with Alzheimer's disease or related disorders.**--

(1) As a condition of licensure, facilities licensed under this part must provide to each of their employees, upon beginning employment, basic written information about interacting with persons with Alzheimer's disease or a related disorder.

(2) All employees who are expected to, or whose responsibilities require them to, have direct contact with residents with Alzheimer's disease or a related disorder must, in addition to being provided the information required in subsection (1), also have an initial training of at least 1 hour completed in the first 3 months after beginning employment. This training must include, but is not limited to, an overview of dementias and must provide basic skills in communicating with persons with dementia.

(3) An individual who provides direct care shall be considered a direct caregiver and must complete the required initial training and an additional 3 hours of training within 9 months after beginning employment. This training shall include, but is not limited to, managing problem behaviors, promoting the resident's independence in activities of daily living, and skills in working with families and caregivers.

(a) The required 4 hours of training for certified nursing assistants are part of the total hours of training required annually.

(b) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward this total of 4 hours.

(4) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.

(5) The Department of Elderly Affairs or its designee must approve the initial and continuing training provided in the facilities. The department must approve training offered in a variety of formats, including, but not limited to, Internet-based training, videos, teleconferencing, and classroom instruction. The department shall keep a list of current providers who are approved to provide initial and continuing training. The department shall adopt rules to establish standards for the trainers and the training required in this section.

(6) Upon completing any training listed in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility or to an assisted living facility, home health agency, adult day care center, or adult family-care home. The direct caregiver must comply with other applicable continuing education requirements.

An employee hired on or after July 1, 2001, need not comply with the guidelines created in this section before July 1, 2002.

**History.**--s. 26, ch. 2001-45.

**400.176 Rebates prohibited; penalties.**--

(1) It is unlawful for any person to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any physician, surgeon, organization, agency, or person, either directly or indirectly, for residents referred to a nursing home licensed under this part.

(2) The agency shall adopt rules which assess administrative penalties for acts prohibited by subsection (1). In the case of an entity licensed by the agency, such penalties may include any disciplinary action available to the agency under the appropriate licensing laws. In the case of an entity not licensed by the agency, such penalties may include:

(a) A fine not to exceed $5,000; and

(b) If applicable, a recommendation by the agency to the appropriate licensing board that disciplinary action be taken.

**History.**--s. 2, ch. 79-106; s. 2, ch. 81-318; ss. 23, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 22, 49, ch. 93-217.

**400.179 Sale or transfer of ownership of a nursing facility; liability for Medicaid underpayments and overpayments.**--

(1) It is the intent of the Legislature to protect the rights of nursing home residents and the security of public funds when a nursing facility is sold or the ownership is transferred.

(2) Whenever a nursing facility is sold or the ownership is transferred, including leasing, the transferee shall make application to the agency for a new license at least 90 days prior to the date of transfer of ownership.

(3) The transferor shall notify the agency in writing at least 90 days prior to the date of transfer of ownership. The transferor shall be responsible and liable for the lawful operation of the nursing facility and the welfare of the residents domiciled in the facility until the date the transferee is licensed by the agency. The transferor shall be liable for any and all penalties imposed against the facility for violations occurring prior to the date of transfer of ownership.

(4) The transferor shall, prior to transfer of ownership, repay or make arrangements to repay to the agency or the Department of Children and Family Services any amounts owed to the agency or the department. Should the transferor fail to repay or make arrangements to repay the amounts owed to the agency or the department prior to the transfer of ownership, the issuance of a license to the transferee shall be delayed until repayment or until arrangements for repayment are made.

(5) Because any transfer of a nursing facility may expose the fact that Medicaid may have underpaid or overpaid the transferor, and because in most instances, any such underpayment or overpayment can only be determined following a formal field audit, the liabilities for any such underpayments or overpayments shall be as follows:

(a) The Medicaid program shall be liable to the transferor for any underpayments owed during the transferor's period of operation of the facility.

(b) Without regard to whether the transferor had leased or owned the nursing facility, the transferor shall remain liable to the Medicaid program for all Medicaid overpayments received during the transferor's period of operation of the facility, regardless of when determined.

(c) Where the facility transfer takes any form of a sale of assets, in addition to the transferor's continuing liability for any such overpayments, if the transferor fails to meet these obligations, the transferee shall be liable for all liabilities that can be readily identifiable 90 days in advance of the transfer. Such liability shall continue in succession until the debt is ultimately paid or otherwise resolved. It shall be the burden of the transferee to determine the amount of all such readily identifiable overpayments from the Agency for Health Care Administration, and the agency shall cooperate in every way with the identification of such amounts. Readily identifiable overpayments shall include overpayments that will result from, but not be limited to:

1. Medicaid rate changes or adjustments;

2. Any depreciation recapture;

3. Any recapture of fair rental value system indexing; or

4. Audits completed by the agency.

The transferor shall remain liable for any such Medicaid overpayments that were not readily identifiable 90 days in advance of the nursing facility transfer.

(d) Where the transfer involves a facility that has been leased by the transferor:

1. The transferee shall, as a condition to being issued a license by the agency, acquire, maintain, and provide proof to the agency of a bond with a term of 30 months, renewable annually, in an amount not less than the total of 3 months Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility.

2. A leasehold licensee may meet the requirements of subparagraph 1. by payment of a nonrefundable fee, paid at initial licensure, paid at the time of any subsequent change of ownership, and paid at the time of any subsequent annual license renewal, in the amount of 2 percent of the total of 3 months' Medicaid payments to the facility computed on the basis of the preceding 12-month average Medicaid payments to the facility. If a preceding 12-month average is not available, projected Medicaid payments may be used. The fee shall be deposited into the Health Care Trust Fund and shall be accounted for separately as a Medicaid nursing home overpayment account. These fees shall be used at the sole discretion of the agency to repay nursing home Medicaid overpayments. Payment of this fee shall not release the licensee from any liability for any Medicaid overpayments, nor shall payment bar the agency from seeking to recoup overpayments from the licensee and any other liable party. As a condition of exercising this lease bond alternative, licensees paying this fee must maintain an existing lease bond through the end of the 30-month term period of that bond. The agency is herein granted specific authority to promulgate all rules pertaining to the administration and management of this account, including withdrawals from the account, subject to federal review and approval. This provision shall take effect upon becoming law and shall apply to any leasehold license application.

a. The financial viability of the Medicaid nursing home overpayment account shall be determined by the agency through annual review of the account balance and the amount of total outstanding, unpaid Medicaid overpayments owing from leasehold licensees to the agency as determined by final agency audits.

b. The agency, in consultation with the Florida Health Care Association and the Florida Association of Homes for the Aging, shall study and make recommendations on the minimum amount to be held in reserve to protect against Medicaid overpayments to leasehold licensees and on the issue of successor liability for Medicaid overpayments upon sale or transfer of ownership of a nursing facility. The agency shall submit the findings and recommendations of the study to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2003.

3. The leasehold licensee may meet the bond requirement through other arrangements acceptable to the agency. The agency is herein granted specific authority to promulgate rules pertaining to lease bond arrangements.

4. All existing nursing facility licensees, operating the facility as a leasehold, shall acquire, maintain, and provide proof to the agency of the 30-month bond required in subparagraph 1., above, on and after July 1, 1993, for each license renewal.

5. It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30-month bond and to provide proof of such renewal to the agency annually at the time of application for license renewal.

6. Any failure of the nursing facility operator to acquire, maintain, renew annually, or provide proof to the agency shall be grounds for the agency to deny, cancel, revoke, or suspend the facility license to operate such facility and to take any further action, including, but not limited to, enjoining the facility, asserting a moratorium, or applying for a receiver, deemed necessary to ensure compliance with this section and to safeguard and protect the health, safety, and welfare of the facility's residents. A lease agreement required as a condition of bond financing or refinancing under s. 154.213 by a health facilities authority or required under s. 159.30 by a county or municipality is not a leasehold for purposes of this paragraph and is not subject to the bond requirement of this paragraph.

**History.**--ss. 12, 18, ch. 80-186; s. 2, ch. 81-318; ss. 24, 79, 83, ch. 83-181; s. 51, ch. 83-218; s.

30, ch. 93-177; ss. 23, 49, ch. 93-217; s. 119, ch. 99-8; s. 15, ch. 2001-377; s. 28, ch. 2002-223; s. 10, ch. 2002-400; s. 1, ch. 2003-405.

**400.18 Closing of nursing facility.**--

(1) Whenever a licensee voluntarily discontinues operation, and during the period when it is preparing for such discontinuance, it shall inform the agency not less than 90 days prior to the discontinuance of operation. The licensee also shall inform the resident or the next of kin, legal representative, or agency acting on behalf of the resident of the fact, and the proposed time, of such discontinuance and give at least 90 days' notice so that suitable arrangements may be made for the transfer and care of the resident. In the event any resident has no such person to represent him or her, the licensee shall be responsible for securing a suitable transfer of the resident before the discontinuance of operation. The agency shall be responsible for arranging for the transfer of those residents requiring transfer who are receiving assistance under the Medicaid program.

(2) A representative of the agency shall be placed in a facility 30 days before the voluntary discontinuance of operation, or immediately upon the determination by the agency that the licensee is discontinuing operation or that existing conditions or practices represent an immediate danger to the health, safety, or security of the residents in the facility, to:

(a) Monitor the transfer of residents to other facilities.

(b) Ensure that the rights of residents are protected.

(c) Observe the operation of the facility.

(d) Assist the management of the facility by advising the management on compliance with state and federal laws and rules.

(e) Recommend further action by the agency.

(3) The agency shall discontinue the monitoring of a facility pursuant to subsection (2) when:

(a) All residents in the facility have been relocated; or

(b) The agency determines that the conditions which gave rise to the placement of a representative of the agency in the facility no longer exist and the agency is reasonably assured that those conditions will not recur.

(4) Immediately upon discontinuance of operation of a facility, the licensee shall surrender the license therefor to the agency, and the license shall be canceled.

**History.**--s. 17, ch. 69-309; ss. 19, 35, ch. 69-106; s. 15, ch. 70-361; s. 3, ch. 76-168; s. 4, ch. 76-201; s. 1, ch. 77-457; ss. 11, 18, ch. 80-186; ss. 2, 3, ch. 81-318; ss. 5, 22, ch. 82-182; ss. 25, 79, 83, ch. 83-181; s. 58, ch. 91-282; s. 30, ch. 93-177; ss. 24, 49, ch. 93-217; s. 770, ch. 95-148.

**400.19 Right of entry and inspection.**--

(1) The agency and any duly designated officer or employee thereof or a member of the State Long-Term Care Ombudsman Council or the local long-term care ombudsman council shall have the right to enter upon and into the premises of any facility licensed pursuant to this part, or any distinct nursing home unit of a hospital licensed under chapter 395 or any freestanding facility licensed under chapter 395 that provides extended care or other long-term care services, at any reasonable time in order to determine the state of compliance with the provisions of this part and rules in force pursuant thereto. The right of entry and inspection shall also extend to any premises

which the agency has reason to believe is being operated or maintained as a facility without a license, but no such entry or inspection of any premises shall be made without the permission of the owner or person in charge thereof, unless a warrant is first obtained from the circuit court authorizing same. Any application for a facility license or renewal thereof, made pursuant to this part, shall constitute permission for and complete acquiescence in any entry or inspection of the premises for which the license is sought, in order to facilitate verification of the information submitted on or in connection with the application; to discover, investigate, and determine the existence of abuse or neglect; or to elicit, receive, respond to, and resolve complaints. The agency shall, within 60 days after receipt of a complaint made by a resident or resident's representative, complete its investigation and provide to the complainant its findings and resolution.

(2) The agency shall coordinate nursing home facility licensing activities and responsibilities of any duly designated officer or employee involved in nursing home facility inspection to assure necessary, equitable, and consistent supervision of inspection personnel without unnecessary duplication of inspections, consultation services, or complaint investigations. To facilitate such coordination, all rules promulgated by the agency pursuant to this part shall be distributed to nursing homes licensed under s. 400.062 30 days prior to implementation. This requirement does not apply to emergency rules.

(3) The agency shall every 15 months conduct at least one unannounced inspection to determine compliance by the licensee with statutes, and with rules promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. The survey shall be conducted every 6 months for the next 2-year period if the facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be $6,000, one-half to be paid at the completion of each survey. The agency may adjust this fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during the annual inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to the provisions of chapter 110.

(4) The agency shall conduct unannounced onsite facility reviews following written verification of licensee noncompliance in instances in which a long-term care ombudsman council, pursuant to ss. 400.0071 and 400.0075, has received a complaint and has documented deficiencies in resident care or in the physical plant of the facility that threaten the health, safety, or security of residents, or when the agency documents through inspection that conditions in a facility present a direct or indirect threat to the health, safety, or security of residents. However, the agency shall conduct unannounced onsite reviews every 3 months of each facility while the facility has a conditional license. Deficiencies related to physical plant do not require followup reviews after the agency has determined that correction of the deficiency has been accomplished and that the correction is of the nature that continued compliance can be reasonably expected.

**History.**--s. 18, ch. 69-309; ss. 19, 35, ch. 69-106; s. 17, ch. 70-361; s. 3, ch. 76-168; s. 5, ch. 76-201; s. 1, ch. 77-457; ss. 35, 36, ch. 79-190; ss. 13, 18, ch. 80-186; ss. 2, 3, ch. 81-318; ss. 12, 19, ch. 82-148; ss. 26, 79, 83, ch. 83-181; ss. 21, 30, ch. 93-177; ss. 25, 49, ch. 93-217; s. 14, ch. 99-394; s. 139, ch. 2000-349; s. 59, ch. 2000-367; s. 27, ch. 2001-45.

**400.191 Availability, distribution, and posting of reports and records.**--

(1) The agency shall provide information to the public about all of the licensed nursing home facilities operating in the state. The agency shall, within 60 days after an annual inspection visit or within 30 days after any interim visit to a facility, send copies of the inspection reports to the local long-term care ombudsman council, the agency's local office, and a public library or the county seat for the county in which the facility is located.

(2) The agency shall provide additional information in consumer-friendly printed and electronic formats to assist consumers and their families in comparing and evaluating nursing home facilities.

(a) The agency shall provide an Internet site which shall include at least the following information either directly or indirectly through a link to another established site or sites of the agency's choosing:

1. A list by name and address of all nursing home facilities in this state.

2. Whether such nursing home facilities are proprietary or nonproprietary.

3. The current owner of the facility's license and the year that that entity became the owner of the license.

4. The name of the owner or owners of each facility and whether the facility is affiliated with a company or other organization owning or managing more than one nursing facility in this state.

5. The total number of beds in each facility.

6. The number of private and semiprivate rooms in each facility.

7. The religious affiliation, if any, of each facility.

8. The languages spoken by the administrator and staff of each facility.

9. Whether or not each facility accepts Medicare or Medicaid recipients or insurance, health maintenance organization, Veterans Administration, CHAMPUS program, or workers' compensation coverage.

10. Recreational and other programs available at each facility.

11. Special care units or programs offered at each facility.

12. Whether the facility is a part of a retirement community that offers other services pursuant to part III, part IV, or part V.

13. Survey and deficiency information contained on the Online Survey Certification and Reporting (OSCAR) system of the federal Health Care Financing Administration, including annual survey, revisit, and complaint survey information, for each facility for the past 45 months. For noncertified nursing homes, state survey and deficiency information, including annual survey, revisit, and complaint survey information for the past 45 months shall be provided.

14. A summary of the Online Survey Certification and Reporting (OSCAR) data for each facility over the past 45 months. Such summary may include a score, rating, or comparison ranking with respect to other facilities based on the number of citations received by the facility of annual, revisit, and complaint surveys; the severity and scope of the citations; and the number of annual recertification surveys the facility has had during the past 45 months. The score, rating, or comparison ranking may be presented in either numeric or symbolic form for the intended consumer audience.

(b) The agency shall provide the following information in printed form:

1. A list by name and address of all nursing home facilities in this state.

2. Whether such nursing home facilities are proprietary or nonproprietary.

3. The current owner or owners of the facility's license and the year that entity became the owner of the license.

4. The total number of beds, and of private and semiprivate rooms, in each facility.

5. The religious affiliation, if any, of each facility.

6. The name of the owner of each facility and whether the facility is affiliated with a company or other organization owning or managing more than one nursing facility in this state.

7. The languages spoken by the administrator and staff of each facility.

8. Whether or not each facility accepts Medicare or Medicaid recipients or insurance, health maintenance organization, Veterans Administration, CHAMPUS program, or workers' compensation coverage.

9. Recreational programs, special care units, and other programs available at each facility.

10. The Internet address for the site where more detailed information can be seen.

11. A statement advising consumers that each facility will have its own policies and procedures related to protecting resident property.

12. A summary of the Online Survey Certification and Reporting (OSCAR) data for each facility over the past 45 months. Such summary may include a score, rating, or comparison ranking with respect to other facilities based on the number of citations received by the facility on annual, revisit, and complaint surveys; the severity and scope of the citations; the number of citations; and the number of annual recertification surveys the facility has had during the past 45 months. The score, rating, or comparison ranking may be presented in either numeric or symbolic form for the intended consumer audience.

(c) For purposes of this subsection, references to the Online Survey Certification and Reporting (OSCAR) system shall refer to any future system that the Health Care Financing Administration develops to replace the current OSCAR system.

(d) The agency may provide the following additional information on an Internet site or in printed form as the information becomes available:

1. The licensure status history of each facility.

2. The rating history of each facility.

3. The regulatory history of each facility, which may include federal sanctions, state sanctions, federal fines, state fines, and other actions.

4. Whether the facility currently possesses the Gold Seal designation awarded pursuant to s. 400.235.

5. Internet links to the Internet sites of the facilities or their affiliates.

(3) Each nursing home facility licensee shall maintain as public information, available upon request, records of all cost and inspection reports pertaining to that facility that have been filed with, or issued by, any governmental agency. Copies of such reports shall be retained in such records for not less than 5 years from the date the reports are filed or issued.

(a) The agency shall quarterly publish a "Nursing Home Guide Watch List" to assist consumers in evaluating the quality of nursing home care in Florida. The watch list must identify each facility that met the criteria for a conditional licensure status on any day within the quarter covered by the list and each facility that was operating under bankruptcy protection on any day within the quarter. The watch list must include, but is not limited to, the facility's name, address, and ownership; the county in which the facility operates; the license expiration date; the number of licensed beds; a description of the deficiency causing the facility to be placed on the list; any corrective action taken; and the cumulative number of times the facility has been on a watch list. The watch list must include a brief description regarding how to choose a nursing home, the categories of licensure, the agency's inspection process, an explanation of terms used in the watch list, and the addresses and phone numbers of the agency's managed care and health quality area offices.

(b) Upon publication of each quarterly watch list, the agency must transmit a copy of the watch list to each nursing home facility by mail and must make the watch list available on the agency's Internet website.

(4) Any records of a nursing home facility determined by the agency to be necessary and essential to establish lawful compliance with any rules or standards shall be made available to the agency on the premises of the facility.

(5) Every nursing home facility licensee shall:

(a) Post, in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public:

1. A concise summary of the last inspection report pertaining to the nursing home and issued by the agency, with references to the page numbers of the full reports, noting any deficiencies found by the agency and the actions taken by the licensee to rectify such deficiencies and indicating in such summaries where the full reports may be inspected in the nursing home.

2. A copy of the most recent version of the Florida Nursing Home Guide Watch List.

(b) Upon request, provide to any person who has completed a written application with an intent to be admitted to, or to any resident of, such nursing home, or to any relative, spouse, or guardian of such person, a copy of the last inspection report pertaining to the nursing home and issued by the agency, provided the person requesting the report agrees to pay a reasonable charge to cover copying costs.

(6) The agency may adopt rules as necessary to administer this section.

**History.**--s. 6, ch. 76-201; ss. 2, 12, ch. 80-198; s. 250, ch. 81-259; s. 2, ch. 81-318; ss. 6, 22, ch. 82-182; ss. 27, 79, 83, ch. 83-181; s. 16, ch. 90-347; s. 30, ch. 93-177; ss. 26, 49, ch. 93-217; s. 26, ch. 97-100; s. 15, ch. 99-394; s. 140, ch. 2000-349; s. 5, ch. 2000-350; s. 60, ch. 2000-367; ss. 28, 55, ch. 2001-45; s. 16, ch. 2001-377; s. 38, ch. 2003-1.

**400.195 Agency reporting requirements.**--

(1) For the period beginning June 30, 2001, and ending June 30, 2005, the Agency for Health Care Administration shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives with respect to nursing homes. The first report shall be submitted no later than December 30, 2002, and subsequent reports shall be submitted every 6 months thereafter. The report shall identify facilities based on their ownership characteristics, size, business structure, for-profit or not-for-profit status, and any other characteristics the agency determines useful in analyzing the varied segments of the nursing home industry and shall report:

(a) The number of notices of intent to litigate received by each facility each month.

(b) The number of complaints on behalf of a resident or resident legal representative that were filed with the clerk of the court each month.

(c) The month in which the injury which is the basis for the suit occurred or was discovered or, if unavailable, the dates of residency of the resident involved, beginning with the date of initial admission and latest discharge date.

(d) Information regarding deficiencies cited, including information used to develop the Nursing Home Guide WATCH LIST pursuant to s. 400.191, and applicable rules, a summary of data generated on nursing homes by Centers for Medicare and Medicaid Services Nursing Home Quality Information Project, and information collected pursuant to s. 400.147(9), relating to litigation.

(2) Facilities subject to this part must submit the information necessary to compile this report each month on existing forms, as modified, provided by the agency.

(3) The agency shall delineate the available information on a monthly basis.

**History.**--s. 7, ch. 2002-400.

**400.20 Licensed nursing home administrator required.**--No nursing home shall operate except under the supervision of a licensed nursing home administrator, and no person shall be a nursing home administrator unless he or she is the holder of a current license as provided in chapter 468.

**History.**--s. 19, ch. 69-309; s. 18, ch. 70-361; s. 3, ch. 76-168; s. 242, ch. 77-147; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 28, 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 27, 49, ch. 93-217; s. 771, ch. 95-148.

**400.211 Persons employed as nursing assistants; certification requirement.**--

(1) To serve as a nursing assistant in any nursing home, a person must be certified as a nursing assistant under part II of chapter 464, unless the person is a registered nurse or practical nurse licensed in accordance with part I of chapter 464 or an applicant for such licensure who is permitted to practice nursing in accordance with rules adopted by the Board of Nursing pursuant to part I of chapter 464.

(2) The following categories of persons who are not certified as nursing assistants under part II of chapter 464 may be employed by a nursing facility for a period of 4 months:

(a) Persons who are enrolled in, or have completed, a state-approved nursing assistant program;

(b) Persons who have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state; or

(c) Persons who have preliminarily passed the state's certification exam.

The certification requirement must be met within 4 months after initial employment as a nursing assistant in a licensed nursing facility.

(3) Nursing homes shall require persons seeking employment as a certified nursing assistant to submit an employment history to the facility. The facility shall verify the employment history unless, through diligent efforts, such verification is not possible. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, a former employer who reasonably and in good faith communicates his or her honest opinion about a former employee's job performance.

(4) When employed by a nursing home facility for a 12-month period or longer, a nursing assistant, to maintain certification, shall submit to a performance review every 12 months and must receive regular inservice education based on the outcome of such reviews. The inservice training must:

(a) Be sufficient to ensure the continuing competence of nursing assistants and must meet the standard specified in s. 464.203(7);

(b) Include, at a minimum:

1. Techniques for assisting with eating and proper feeding;

2. Principles of adequate nutrition and hydration;

3. Techniques for assisting and responding to the cognitively impaired resident or the resident with difficult behaviors;

4. Techniques for caring for the resident at the end-of-life; and

5. Recognizing changes that place a resident at risk for pressure ulcers and falls; and

(c) Address areas of weakness as determined in nursing assistant performance reviews and may address the special needs of residents as determined by the nursing home facility staff.

Costs associated with this training may not be reimbursed from additional Medicaid funding through interim rate adjustments.

**History.**--ss. 2, 3, ch. 82-163; ss. 29, 79, 82, 83, ch. 83-181; s. 1, ch. 86-253; s. 8, ch. 89-294; s. 61, ch. 92-136; s. 30, ch. 93-177; ss. 28, 49, ch. 93-217; s. 49, ch. 94-218; s. 1054, ch. 95-148; s. 38, ch. 95-228; s. 127, ch. 95-418; s. 10, ch. 96-268; s. 24, ch. 98-166; s. 3, ch. 98-248; s. 120, ch. 99-8; s. 206, ch. 99-397; s. 95, ch. 2000-318; s. 29, ch. 2001-45; s. 5, ch. 2004-298.

**400.215 Personnel screening requirement.**--

(1) The agency shall require background screening as provided in chapter 435 for all employees or prospective employees of facilities licensed under this part who are expected to, or whose responsibilities may require them to:

(a) Provide personal care or services to residents;

(b) Have access to resident living areas; or

(c) Have access to resident funds or other personal property.

(2) Employers and employees shall comply with the requirements of s. 435.05.

(a) Notwithstanding the provisions of s. 435.05(1), facilities must have in their possession evidence that level 1 screening has been completed before allowing an employee to begin working with patients as provided in subsection (1). All information necessary for conducting background screening using level 1 standards as specified in s. 435.03 shall be submitted by the nursing facility to the agency. Results of the background screening shall be provided by the agency to the requesting nursing facility.

(b) Employees qualified under the provisions of paragraph (a) who have not maintained continuous residency within the state for the 5 years immediately preceding the date of request for background screening must complete level 2 screening, as provided in chapter 435. Such employees may work in a conditional status up to 180 days pending the receipt of written findings evidencing the completion of level 2 screening. Level 2 screening shall not be required of employees or prospective employees who attest in writing under penalty of perjury that they meet the residency requirement. Completion of level 2 screening shall require the employee or prospective employee to furnish to the nursing facility a full set of fingerprints to enable a criminal background investigation to be conducted. The nursing facility shall submit the completed fingerprint card to the agency. The agency shall establish a record of the request in the database provided for in paragraph (c) and forward the request to the Department of Law Enforcement, which is authorized to submit the fingerprints to the Federal Bureau of Investigation for a national criminal history records check. The results of the national criminal history records check shall be returned to the agency, which shall maintain the results in the database provided for in paragraph (c). The agency shall notify the administrator of the requesting nursing facility or the administrator of any other facility licensed under chapter 393, chapter 394, chapter 395, chapter 397, or this chapter, as requested by such facility, as to whether or not the employee has qualified under level 1 or level 2 screening. An employee or prospective employee who has qualified under level 2 screening and has maintained such continuous residency within the state shall not be required to complete a subsequent level 2 screening as a condition of employment at another facility.

(c) The agency shall establish and maintain a database of background screening information which shall include the results of both level 1 and level 2 screening. The Department of Law Enforcement shall timely provide to the agency, electronically, the results of each statewide screening for incorporation into the database. The agency shall, upon request from any facility, agency, or program required by or authorized by law to screen its employees or applicants, notify the administrator of the facility, agency, or program of the qualifying or disqualifying status of the employee or applicant named in the request.

(d) Applicants and employees shall be excluded from employment pursuant to s. 435.06.

(3) The applicant is responsible for paying the fees associated with obtaining the required screening. Payment for the screening shall be submitted to the agency. The agency shall establish a schedule of fees to cover the costs of level 1 and level 2 screening. Facilities may reimburse employees for these costs. The Department of Law Enforcement shall charge the agency for a level 1 or level 2 screening a rate sufficient to cover the costs of such screening pursuant to s. 943.053 (3). The agency shall, as allowable, reimburse nursing facilities for the cost of conducting background screening as required by this section. This reimbursement will not be subject to any rate ceilings or payment targets in the Medicaid Reimbursement plan.

(4)(a) As provided in s. 435.07, the agency may grant an exemption from disqualification to an employee or prospective employee who is subject to this section and who has not received a professional license or certification from the Department of Health.

(b) As provided in s. 435.07, the appropriate regulatory board within the Department of Health, or that department itself when there is no board, may grant an exemption from disqualification to an employee or prospective employee who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department.

(5) Any provision of law to the contrary notwithstanding, persons who have been screened and qualified as required by this section and who have not been unemployed for more than 180 days thereafter, and who under penalty of perjury attest to not having been convicted of a disqualifying offense since the completion of such screening, shall not be required to be rescreened. An employer may obtain, pursuant to s. 435.10, written verification of qualifying screening results from the previous employer or other entity which caused such screening to be performed.

(6) The agency and the Department of Health shall have authority to adopt rules pursuant to the Administrative Procedure Act to implement this section.

(7) All employees shall comply with the requirements of this section by October 1, 1998. No current employee of a nursing facility as of the effective date of this act shall be required to submit to rescreening if the nursing facility has in its possession written evidence that the person has been screened and qualified according to level 1 standards as specified in s. 435.03(1). Any current employee who meets the level 1 requirement but does not meet the 5-year residency requirement as specified in this section must provide to the employing nursing facility written attestation under penalty of perjury that the employee has not been convicted of a disqualifying offense in another state or jurisdiction. All applicants hired on or after October 1, 1998, shall comply with the requirements of this section.

(8) There is no monetary or unemployment liability on the part of, and no cause of action for damages arising against an employer that, upon notice of a disqualifying offense listed under chapter 435 or an act of domestic violence, terminates the employee against whom the report was issued, whether or not the employee has filed for an exemption with the Department of Health or the Agency for Health Care Administration.

**History.**--s. 2, ch. 98-248; s. 16, ch. 99-394; s. 96, ch. 2000-318; s. 72, ch. 2000-349; s. 10, ch. 2004-267.

**400.23 Rules; evaluation and deficiencies; licensure status.**--

(1) It is the intent of the Legislature that rules published and enforced pursuant to this part shall include criteria by which a reasonable and consistent quality of resident care may be ensured and the results of such resident care can be demonstrated and by which safe and sanitary nursing homes can be provided. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a nursing home. In addition, efforts shall be made to minimize the paperwork associated with the reporting and documentation requirements of these rules.

(2) Pursuant to the intention of the Legislature, the agency, in consultation with the Department of Health and the Department of Elderly Affairs, shall adopt and enforce rules to implement this part, which shall include reasonable and fair criteria in relation to:

[1](a) The location of the facility and housing conditions that will ensure the health, safety, and comfort of residents, including an adequate call system. In making such rules, the agency shall be guided by criteria recommended by nationally recognized reputable professional groups and associations with knowledge of such subject matters. The agency shall update or revise such criteria as the need arises. The agency may require alterations to a building if it determines that an existing condition constitutes a distinct hazard to life, health, or safety. In performing any inspections of facilities authorized by this part, the agency may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code which apply to nursing homes. The agency is directed to provide assistance to the Florida Building Commission in updating the construction standards of the code relative to nursing homes.

(b) The number and qualifications of all personnel, including management, medical, nursing, and other professional personnel, and nursing assistants, orderlies, and support personnel, having

responsibility for any part of the care given residents.

(c) All sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene which will ensure the health and comfort of residents.

(d) The equipment essential to the health and welfare of the residents.

(e) A uniform accounting system.

(f) The care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof, based on rules developed under this chapter and the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (December 22, 1987), Title IV (Medicare, Medicaid, and Other Health-Related Programs), Subtitle C (Nursing Home Reform), as amended.

(g) The preparation and annual update of a comprehensive emergency management plan. The agency shall adopt rules establishing minimum criteria for the plan after consultation with the Department of Community Affairs. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Department of Community Affairs. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(h) The availability, distribution, and posting of reports and records pursuant to s. 400.191 and the Gold Seal Program pursuant to s. 400.235.

(3)[2](a) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning January 1, 2003, and increasing to 2.9 hours of direct care per resident per day beginning July 1, 2005. Beginning January 1, 2002, no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if they provide nursing assistance services to residents on a full-time basis. Each nursing home must document compliance with staffing standards as required under this paragraph and post daily the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted toward the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and shall not also be counted toward the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

(b) The agency shall adopt rules to allow properly trained staff of a nursing facility, in addition to certified nursing assistants and licensed nurses, to assist residents with eating. The rules shall specify the minimum training requirements and shall specify the physiological conditions or disorders of residents which would necessitate that the eating assistance be provided by nursing personnel of the facility. Nonnursing staff providing eating assistance to residents under the provisions of this subsection shall not count toward compliance with minimum staffing standards.

(c) Licensed practical nurses licensed under chapter 464 who are providing nursing services in nursing home facilities under this part may supervise the activities of other licensed practical nurses, certified nursing assistants, and other unlicensed personnel providing services in such facilities in accordance with rules adopted by the Board of Nursing.

(4) Rules developed pursuant to this section shall not restrict the use of shared staffing and shared programming in facilities which are part of retirement communities that provide multiple levels of care and otherwise meet the requirement of law or rule.

(5) The agency, in collaboration with the Division of Children's Medical Services of the Department of Health, must, no later than December 31, 1993, adopt rules for minimum standards of care for persons under 21 years of age who reside in nursing home facilities. The rules must include a methodology for reviewing a nursing home facility under ss. 408.031-408.045 which serves only persons under 21 years of age. A facility may be exempt from these standards for specific persons between 18 and 21 years of age, if the person's physician agrees that minimum standards of care based on age are not necessary.

(6) Prior to conducting a survey of the facility, the survey team shall obtain a copy of the local long-term care ombudsman council report on the facility. Problems noted in the report shall be incorporated into and followed up through the agency's inspection process. This procedure does not preclude the local long-term care ombudsman council from requesting the agency to conduct a followup visit to the facility.

(7) The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. The agency shall assign a licensure status of standard or conditional to each nursing home.

(a) A standard licensure status means that a facility has no class I or class II deficiencies and has corrected all class III deficiencies within the time established by the agency.

(b) A conditional licensure status means that a facility, due to the presence of one or more class I or class II deficiencies, or class III deficiencies not corrected within the time established by the agency, is not in substantial compliance at the time of the survey with criteria established under this part or with rules adopted by the agency. If the facility has no class I, class II, or class III deficiencies at the time of the followup survey, a standard licensure status may be assigned.

(c) In evaluating the overall quality of care and services and determining whether the facility will receive a conditional or standard license, the agency shall consider the needs and limitations of residents in the facility and the results of interviews and surveys of a representative sampling of residents, families of residents, ombudsman council members in the planning and service area in which the facility is located, guardians of residents, and staff of the nursing home facility.

(d) The current licensure status of each facility must be indicated in bold print on the face of the license. A list of the deficiencies of the facility shall be posted in a prominent place that is in clear and unobstructed public view at or near the place where residents are being admitted to that facility. Licensees receiving a conditional licensure status for a facility shall prepare, within 10

working days after receiving notice of deficiencies, a plan for correction of all deficiencies and shall submit the plan to the agency for approval.

(e) Each licensee shall post its license in a prominent place that is in clear and unobstructed public view at or near the place where residents are being admitted to the facility.

(f) The agency shall adopt rules that:

1. Establish uniform procedures for the evaluation of facilities.

2. Provide criteria in the areas referenced in paragraph (c).

3. Address other areas necessary for carrying out the intent of this section.

(8) The agency shall adopt rules to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature and the scope of the deficiency. The scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency where more than a very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents. The agency shall indicate the classification on the face of the notice of deficiencies as follows:

(a) A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A fine must be levied notwithstanding the correction of the deficiency.

(b) A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class II deficiency is subject to a civil penalty of $2,500 for an isolated deficiency, $5,000 for a patterned deficiency, and $7,500 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A fine shall be levied notwithstanding the correction of the deficiency.

(c) A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to the resident or has the potential to compromise the resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A class III deficiency is subject to a civil penalty of $1,000 for an isolated deficiency, $2,000 for a patterned deficiency, and $3,000 for a widespread deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more

class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A citation for a class III deficiency must specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, no civil penalty shall be imposed.

(d) A class IV deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident. If the class IV deficiency is isolated, no plan of correction is required.

(9) Civil penalties paid by any licensee under subsection (8) shall be deposited in the Health Care Trust Fund and expended as provided in s. 400.063.

(10) Agency records, reports, ranking systems, Internet information, and publications must be promptly updated to reflect the most current agency actions.

**History.**--s. 22, ch. 69-309; ss. 19, 35, ch. 69-106; s. 19, ch. 70-361; s. 3, ch. 76-168; s. 7, ch. 76-201; s. 2, ch. 76-252; s. 2, ch. 77-188; s. 13, ch. 77-401; s. 1, ch. 77-457; s. 1, ch. 78-393; ss. 8, 9, ch. 79-268; ss. 3, 12, ch. 80-198; ss. 1, 2, ch. 80-211; s. 251, ch. 81-259; ss. 2, 3, ch. 81-318; ss. 30, 79, 83, ch. 83-181; s. 2, ch. 86-253; s. 1, ch. 90-125; ss. 9, 77, ch. 91-282; s. 30, ch. 93-177; s. 25, ch. 93-211; ss. 29, 49, ch. 93-217; s. 42, ch. 98-89; s. 121, ch. 99-8; s. 14, ch. 99-332; s. 17, ch. 99-394; s. 29, ch. 2000-141; s. 97, ch. 2000-318; s. 141, ch. 2000-349; s. 6, ch. 2000-350; s. 61, ch. 2000-367; ss. 30, 54, ch. 2001-45; s. 34, ch. 2001-186; s. 3, ch. 2001-372; s. 39, ch. 2003-1; s. 2, ch. 2003-405; s. 1, ch. 2004-270; s. 4, ch. 2004-298.

**[1]Note.**--As amended by s. 23, ch. 2000-141, and s. 30, ch. 2001-45. The amendment by s. 30, ch. 2001-45, failed to incorporate the changes by s. 29, ch. 2000-141. The section as published gives full effect to both amendments. As amended by s. 30, ch. 2001-45, only, paragraph (2)(a) reads:

(a) The location and construction of the facility; including fire and life safety, plumbing, heating, cooling, lighting, ventilation, and other housing conditions which will ensure the health, safety, and comfort of residents, including an adequate call system. The agency shall establish standards for facilities and equipment to increase the extent to which new facilities and a new wing or floor added to an existing facility after July 1, 1999, are structurally capable of serving as shelters only for residents, staff, and families of residents and staff, and equipped to be self-supporting during and immediately following disasters. In making such rules, the agency shall be guided by criteria recommended by nationally recognized reputable professional groups and associations with knowledge of such subject matters. The agency shall update or revise such criteria as the need arises. All nursing homes must comply with those lifesafety code requirements and building code standards applicable at the time of approval of their construction plans. The agency may require alterations to a building if it determines that an existing condition constitutes a distinct hazard to life, health, or safety. The agency shall adopt fair and reasonable rules setting forth conditions under which existing facilities undergoing additions, alterations, conversions, renovations, or repairs shall be required to comply with the most recent updated or revised standards.

**[2]Note.**--Section 1, ch. 2004-270, amended paragraph (3)(a) "[e]ffective [May 28, 2004] and applying retroactively to May 1, 2004."

**400.232 Review and approval of plans; fees and costs.**--The design, construction, erection, alteration, modification, repair, and demolition of all public and private health care facilities are governed by the Florida Building Code and the Florida Fire Prevention Code under ss. 553.73 and 633.022. In addition to the requirements of ss. 553.79 and 553.80, the agency shall review the facility plans and survey the construction of facilities licensed under this chapter.

(1) The agency shall approve or disapprove the plans and specifications within 60 days after receipt of the final plans and specifications. The agency may be granted one 15-day extension for the review period, if the director of the agency so approves. If the agency fails to act within the

specified time, it shall be deemed to have approved the plans and specifications. When the agency disapproves plans and specifications, it shall set forth in writing the reasons for disapproval. Conferences and consultations may be provided as necessary.

(2) The agency is authorized to charge an initial fee of $2,000 for review of plans and construction on all projects, no part of which is refundable. The agency may also collect a fee, not to exceed 1 percent of the estimated construction cost or the actual cost of review, whichever is less, for the portion of the review which encompasses initial review through the initial revised construction document review. The agency is further authorized to collect its actual costs on all subsequent portions of the review and construction inspections. Initial fee payment shall accompany the initial submission of plans and specifications. Any subsequent payment that is due is payable upon receipt of the invoice from the agency. Notwithstanding any other provisions of law to the contrary, all money received by the agency pursuant to the provisions of this section shall be deemed to be trust funds, to be held and applied solely for the operations required under this section.

**History.**--s. 22, ch. 69-309; ss. 19, 35, ch. 69-106; s. 19, ch. 70-361; s. 3, ch. 76-168; s. 7, ch. 76-201; s. 2, ch. 77-188; s. 1, ch. 77-457; ss. 8, 9, ch. 79-268; ss. 2, 3, ch. 81-318; ss. 30, 79, 83, ch. 83-181; s. 1, ch. 90-125; ss. 9, 77, ch. 91-282; s. 30, ch. 93-177; ss. 29, 49, ch. 93-217; s. 17, ch. 99-394; s. 30, ch. 2000-141; s. 34, ch. 2001-186; s. 3, ch. 2001-372.

**Note.**--Former s. 400.23(11), (12).

**400.235 Nursing home quality and licensure status; Gold Seal Program.**--

(1) To protect the health and welfare of persons receiving care in nursing facilities, it is the intent of the Legislature to develop a regulatory framework that promotes the stability of the industry and facilitates the physical, social, and emotional well-being of nursing facility residents.

(2) The Legislature intends to develop an award and recognition program for nursing facilities that demonstrate excellence in long-term care over a sustained period. This program shall be known as the Gold Seal Program.

(3)(a) The Gold Seal Program shall be developed and implemented by the Governor's Panel on Excellence in Long-Term Care which shall operate under the authority of the Executive Office of the Governor. The panel shall be composed of three persons appointed by the Governor, to include a consumer advocate for senior citizens and two persons with expertise in the fields of quality management, service delivery excellence, or public sector accountability; three persons appointed by the Secretary of Elderly Affairs, to include an active member of a nursing facility family and resident care council and a member of the University Consortium on Aging; the State Long-Term Care Ombudsman; one person appointed by the Florida Life Care Residents Association; one person appointed by the Secretary of Health; two persons appointed by the Secretary of Health Care Administration; one person appointed by the Florida Association of Homes for the Aging; and one person appointed by the Florida Health Care Association. Vacancies on the panel shall be filled in the same manner as the original appointments.

(b) Members of the Governor's Panel on Excellence in Long-Term Care shall be prohibited from having any ownership interest in a nursing facility. Any member of the panel who is employed by a nursing facility in any capacity shall be prohibited from participating in reviewing or voting on recommendations involving the facility by which the member is employed or any facility under common ownership with that facility.

(c) Recommendations to the panel for designation of a nursing facility as a Gold Seal facility may be received by the panel after January 1, 2000. The activities of the panel shall be supported by staff of the Department of Elderly Affairs and the Agency for Health Care Administration.

(4) The panel shall consider the quality of care provided to residents when evaluating a facility for

the Gold Seal Program. The panel shall determine the procedure or procedures for measuring the quality of care.

(5) Facilities must meet the following additional criteria for recognition as a Gold Seal Program facility:

(a) Had no class I or class II deficiencies within the 30 months preceding application for the program.

(b) Evidence financial soundness and stability according to standards adopted by the agency in administrative rule. Such standards must include, but not be limited to, criteria for the use of financial statements that are prepared in accordance with generally accepted accounting principles and that are reviewed or audited by certified public accountants. A nursing home that is part of the same corporate entity as a continuing care facility licensed under chapter 651 which meets the minimum liquid reserve requirements specified in s. 651.035 and is accredited by a recognized accrediting organization under s. 651.028 and rules of the Office of Insurance Regulation satisfies this requirement as long as the accreditation is not provisional. Facilities operated by a federal or state agency are deemed to be financially stable for purposes of applying for the Gold Seal.

(c) Participate in a consumer satisfaction process, and demonstrate that information is elicited from residents, family members, and guardians about satisfaction with the nursing facility, its environment, the services and care provided, the staff's skills and interactions with residents, attention to residents' needs, and the facility's efforts to act on information gathered from the consumer satisfaction measures.

(d) Evidence the involvement of families and members of the community in the facility on a regular basis.

(e) Have a stable workforce, as described in s. 400.141, as evidenced by a relatively low rate of turnover among certified nursing assistants and licensed nurses within the 30 months preceding application for the Gold Seal Program, and demonstrate a continuing effort to maintain a stable workforce and to reduce turnover of licensed nurses and certified nursing assistants.

(f) Evidence an outstanding record regarding the number and types of substantiated complaints reported to the State Long-Term Care Ombudsman Council within the 30 months preceding application for the program.

(g) Provide targeted inservice training provided to meet training needs identified by internal or external quality assurance efforts.

A facility assigned a conditional licensure status may not qualify for consideration for the Gold Seal Program until after it has operated for 30 months with no class I or class II deficiencies and has completed a regularly scheduled relicensure survey.

(6) The agency, nursing facility industry organizations, consumers, State Long-Term Care Ombudsman Council, and members of the community may recommend to the Governor facilities that meet the established criteria for consideration for and award of the Gold Seal. The panel shall review nominees and make a recommendation to the Governor for final approval and award. The decision of the Governor is final and is not subject to appeal.

(7) A facility must be licensed and operating for 30 months before it is eligible to apply for the Gold Seal Program. The agency shall establish by rule the frequency of review for designation as a Gold Seal Program facility and under what circumstances a facility may be denied the privilege of using this designation. The designation of a facility as a Gold Seal Program facility is not transferable to another license, except when an existing facility is being relicensed in the name of an entity related to the current licenseholder by common ownership or control, and there will be

no change in the management, operation, or programs at the facility as a result of the relicensure.

(8)(a) Facilities awarded the Gold Seal may use the designation in their advertising and marketing.

(b) Upon approval by the United States Department of Health and Human Services, the agency shall adopt a revised schedule of survey and relicensure visits for Gold Seal Program facilities. Gold Seal Program facilities may be surveyed for certification and relicensure every 2 years, so long as they maintain the standards associated with retaining the Gold Seal.

(9) The agency may adopt rules as necessary to administer this section.

**History.**--s. 18, ch. 99-394; s. 12, ch. 2000-305; s. 7, ch. 2000-350; ss. 31, 58, ch. 2001-45; s. 17, ch. 2001-377; s. 24, ch. 2003-57; s. 1, ch. 2003-120; s. 6, ch. 2004-298.

**400.241 Prohibited acts; penalties for violations.**--

(1) It is unlawful for any person or public body to establish, conduct, manage, or operate a home as defined in this part without obtaining a valid current license.

(2) It is unlawful for any person or public body to offer or advertise to the public, in any way by any medium whatever, nursing home care or service or custodial services without obtaining a valid current license. It is unlawful for any holder of a license issued pursuant to the provisions of this part to advertise or hold out to the public that it holds a license for a facility other than that for which it actually holds a license.

(3) It is unlawful for any person, long-term care facility, or other entity to willfully interfere with the unannounced inspections mandated by s. 400.19(3). Alerting or advising a facility of the actual or approximate date of such inspection shall be a per se violation of this subsection.

(4) A violation of any provision of this part or of any minimum standard, rule, or regulation adopted pursuant thereto constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of a continuing violation shall be considered a separate offense.

**History.**--s. 11, ch. 70-361; s. 347, ch. 71-136; s. 3, ch. 76-168; s. 1, ch. 77-457; ss. 2, 3, ch. 81-318; ss. 31, 79, 83, ch. 83-181; s. 30, ch. 93-177; s. 49, ch. 93-217; s. 19, ch. 99-394.

**400.25 Educational program authorized.**--The agency may conduct a clinic or seminar at such times and places as shall be convenient for the greatest number at which information may be offered in the general field of health education, management, and other subjects that will increase the knowledge and efficiency of applicants or licensees under this part. The board must approve the educational content of such clinic or seminar if it is intended to satisfy the educational requirements of the board.

**History.**--s. 24, ch. 69-309; ss. 19, 35, ch. 69-106; s. 21, ch. 70-361; s. 3, ch. 76-168; s. 243, ch. 77-147; s. 1, ch. 77-457; s. 252, ch. 81-259; ss. 2, 3, ch. 81-318; ss. 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 30, 49, ch. 93-217.

**400.275 Agency duties.**--

(1) The agency shall ensure that each newly hired nursing home surveyor, as a part of basic training, is assigned full-time to a licensed nursing home for at least 2 days within a 7-day period to observe facility operations outside of the survey process before the surveyor begins survey responsibilities. Such observations may not be the sole basis of a deficiency citation against the facility. The agency may not assign an individual to be a member of a survey team for purposes of a

survey, evaluation, or consultation visit at a nursing home facility in which the surveyor was an employee within the preceding 5 years.

(2) The agency shall semiannually provide for joint training of nursing home surveyors and staff of facilities licensed under this part on at least one of the 10 federal citations that were most frequently issued against nursing facilities in this state during the previous calendar year.

(3) Each member of a nursing home survey team who is a health professional licensed under part I of chapter 464, part X of chapter 468, or chapter 491 shall earn not less than 50 percent of required continuing education credits in geriatric care. Each member of a nursing home survey team who is a health professional licensed under chapter 465 shall earn not less than 30 percent of required continuing education credits in geriatric care.

(4) The agency must ensure that when a deficiency is related to substandard quality of care, a physician with geriatric experience licensed under chapter 458 or chapter 459 or a registered nurse with geriatric experience licensed under chapter 464 participates in the agency's informal dispute resolution process.

**History.**--s. 32, ch. 2001-45.

**400.33 Legislative intent; community-based care for the elderly.**--It is the intent of the Legislature to encourage the development of programs for community-based care for the elderly as an alternative to institutionalization. The Legislature finds and declares that routine health care provided on an outpatient basis is one such program, the availability of which would fill an unmet need, improve the quality and quantity of health care available to elderly persons while minimizing the cost of such care, and reduce the incidence of unnecessary or premature institutionalization of elderly persons. The purpose of this section and s. 400.332 is to encourage the development of geriatric outpatient nurse clinics to make such services available. The Legislature intends that existing and available nursing facility treatment rooms be used for geriatric outpatient nurse clinics in order that the cost of such programs be kept low.

**History.**--s. 1, ch. 77-401; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 30, ch. 93-177; ss. 33, 49, ch. 93-217.

**400.332 Funds received not revenues for purpose of Medicaid program.**--Any funds received by a nursing home in connection with its participation in the geriatric outpatient nurse clinic program shall not be considered as revenues for purposes of cost reports under the Medicaid program.

**History.**--s. 4, ch. 77-401; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 59, ch. 91-282; s. 30, ch. 93-177; s. 49, ch. 93-217.

**400.334 Activity relating to unions by nursing home employees.**--

(1) Participation by an employee of a nursing home in any activity that assists, promotes, deters, or discourages union organizing shall not be allowed during any time the employee is counted in staffing calculations for minimum staffing standards.

(2) Salaries paid by any health care provider to an employee for any activity that assists, promotes, deters, or discourages union organizing shall not be an allowable cost for Medicaid cost reporting purposes.

(3) Any expense, including, but not limited to, legal and consulting fees and salaries of supervisors and employees, incurred for activities directly relating to influencing employees with respect to unionization shall not be an allowable cost for Medicaid cost reporting purposes.

(4) This section does not apply to any activity performed, or any expense incurred, in connection with:

(a) Addressing a grievance or negotiating or administering a collective bargaining agreement;

(b) Performing an activity required by federal or state law or by a collective bargaining agreement; or

(c) Keeping employees informed of issues and keeping lines of communication open between employees and employers as a part of normal personnel management,

provided such activities or expenses are not directly related to influencing employees with respect to unionization.

**History.**--s. 1, ch. 2002-231.

## PART III

## ASSISTED LIVING FACILITIES

**400.401 Short title; purpose.**--

(1) This act may be cited as the "Assisted Living Facilities Act."

(2) The purpose of this act is to promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment, to encourage the development of facilities that promote the dignity, individuality, privacy, and decisionmaking ability of such persons, to provide for the health, safety, and welfare of residents of assisted living facilities in the state, to promote continued improvement of such facilities, to encourage the development of innovative and affordable facilities particularly for persons with low to moderate incomes, to ensure that all agencies of the state cooperate in the protection of such residents, and to ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Family Services, the Department of Health, assisted living facilities, and other community agencies. To the maximum extent possible, appropriate community-based programs must be available to state-supported residents to augment the services provided in assisted living facilities. The Legislature recognizes that assisted living facilities are an important part of the continuum of long-term care in the state. In support of the goal of aging in place, the Legislature further recognizes that assisted living facilities should be operated and regulated as residential environments with supportive services and not as medical or nursing facilities. The services available in these facilities, either directly or through contract or agreement, are intended to help residents remain as independent as possible. Regulations governing these facilities must be sufficiently flexible to allow facilities to adopt policies that enable residents to age in place when resources are available to meet their needs and accommodate their preferences.

(3) The principle that a license issued under this part is a public trust and a privilege and is not an entitlement should guide the finder of fact or trier of law at any administrative proceeding or in a court action initiated by the Agency for Health Care Administration to enforce this part.

**History.**--ss. 1, 2, ch. 75-233; ss. 12, 13, ch. 80-198; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 2, ch. 87-371; s. 2, ch. 91-263; s. 28, ch. 92-33; ss. 1, 38, 39, ch. 93-216; s. 6, ch. 95-210; s. 46, ch. 95-418; s. 122, ch. 99-8.

**400.402 Definitions.**--When used in this part, the term:

(1) "Activities of daily living" means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, and toileting, and other similar tasks.

(2) "Administrator" means an individual at least 21 years of age who is responsible for the operation and maintenance of an assisted living facility.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Aging in place" or "age in place" means the process of providing increased or adjusted services to a person to compensate for the physical or mental decline that may occur with the aging process, in order to maximize the person's dignity and independence and permit them to remain in a familiar, noninstitutional, residential environment for as long as possible. Such services may be provided by facility staff, volunteers, family, or friends, or through contractual arrangements with a third party.

(5) "Applicant" means an individual owner, corporation, partnership, firm, association, or governmental entity that applies for a license.

(6) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

(7) "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms.

(8) "Community living support plan" means a written document prepared by a mental health resident and the resident's mental health case manager in consultation with the administrator of an assisted living facility with a limited mental health license or the administrator's designee. A copy must be provided to the administrator. The plan must include information about the supports, services, and special needs of the resident which enable the resident to live in the assisted living facility and a method by which facility staff can recognize and respond to the signs and symptoms particular to that resident which indicate the need for professional services.

(9) "Cooperative agreement" means a written statement of understanding between a mental health care provider and the administrator of the assisted living facility with a limited mental health license in which a mental health resident is living. The agreement must specify directions for accessing emergency and after-hours care for the mental health resident. A single cooperative agreement may service all mental health residents who are clients of the same mental health care provider.

(10) "Department" means the Department of Elderly Affairs.

(11) "Emergency" means a situation, physical condition, or method of operation which presents imminent danger of death or serious physical or mental harm to facility residents.

(12) "Extended congregate care" means acts beyond those authorized in subsection (17) that may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services which may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(13) "Guardian" means a person to whom the law has entrusted the custody and control of the person or property, or both, of a person who has been legally adjudged incapacitated.

(14) "Limited nursing services" means acts that may be performed pursuant to part I of chapter 464

by persons licensed thereunder while carrying out their professional duties but limited to those acts which the department specifies by rule. Acts which may be specified by rule as allowable limited nursing services shall be for persons who meet the admission criteria established by the department for assisted living facilities and shall not be complex enough to require 24-hour nursing supervision and may include such services as the application and care of routine dressings, and care of casts, braces, and splints.

(15) "Managed risk" means the process by which the facility staff discuss the service plan and the needs of the resident with the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, in such a way that the consequences of a decision, including any inherent risk, are explained to all parties and reviewed periodically in conjunction with the service plan, taking into account changes in the resident's status and the ability of the facility to respond accordingly.

(16) "Mental health resident" means an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation.

(17) "Personal services" means direct physical assistance with or supervision of the activities of daily living and the self-administration of medication and other similar services which the department may define by rule. "Personal services" shall not be construed to mean the provision of medical, nursing, dental, or mental health services.

(18) "Physical restraint" means a device which physically limits, restricts, or deprives an individual of movement or mobility, including, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include any device which was not specifically manufactured as a restraint but which has been altered, arranged, or otherwise used for this purpose. The term shall not include bandage material used for the purpose of binding a wound or injury.

(19) "Relative" means an individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half brother, or half sister of an owner or administrator.

(20) "Resident" means a person 18 years of age or older, residing in and receiving care from a facility.

(21) "Resident's representative or designee" means a person other than the owner, or an agent or employee of the facility, designated in writing by the resident, if legally competent, to receive notice of changes in the contract executed pursuant to s. 400.424; to receive notice of and to participate in meetings between the resident and the facility owner, administrator, or staff concerning the rights of the resident; to assist the resident in contacting the ombudsman council if the resident has a complaint against the facility; or to bring legal action on behalf of the resident pursuant to s. 400.429.

(22) "Service plan" means a written plan, developed and agreed upon by the resident and, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact, if any, and the administrator or designee representing the facility, which addresses the unique physical and psychosocial needs, abilities, and personal preferences of each resident receiving extended congregate care services. The plan shall include a brief written description, in easily understood language, of what services shall be provided, who shall provide the services, when the services shall be rendered, and the purposes and benefits of the services.

(23) "Shared responsibility" means exploring the options available to a resident within a facility and the risks involved with each option when making decisions pertaining to the resident's abilities, preferences, and service needs, thereby enabling the resident and, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney in fact, and the facility to develop a service plan which best meets the resident's needs and seeks to improve the resident's quality of life.

(24) "Supervision" means reminding residents to engage in activities of daily living and the self-administration of medication, and, when necessary, observing or providing verbal cuing to residents while they perform these activities.

(25) "Supplemental security income," Title XVI of the Social Security Act, means a program through which the Federal Government guarantees a minimum monthly income to every person who is age 65 or older, or disabled, or blind and meets the income and asset requirements.

(26) "Supportive services" means services designed to encourage and assist aged persons or adults with disabilities to remain in the least restrictive living environment and to maintain their independence as long as possible.

(27) "Twenty-four-hour nursing supervision" means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services shall be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or the disease state or stage.

**History.**--s. 3, ch. 75-233; ss. 12, 14, ch. 80-198; s. 2, ch. 81-318; ss. 6, 19, ch. 82-148; ss. 41, 79, 83, ch. 83-181; s. 4, ch. 85-145; s. 3, ch. 87-371; s. 10, ch. 89-294; s. 3, ch. 91-263; s. 1, ch. 93-209; ss. 2, 38, 39, ch. 93-216; s. 7, ch. 95-210; ss. 1, 22, 47, ch. 95-418; s. 2, ch. 97-82; s. 1, ch. 98-80; s. 98, ch. 2000-318.

**400.404 Facilities to be licensed; exemptions.**--

(1) For the administration of this part, facilities to be licensed by the agency shall include all assisted living facilities as defined in this part.

(2) The following are exempt from licensure under this part:

(a) Any facility, institution, or other place operated by the Federal Government or any agency of the Federal Government.

(b) Any facility or part of a facility licensed under chapter 393 or chapter 394.

(c) Any facility licensed as an adult family-care home under part VII.

(d) Any person who provides housing, meals, and one or more personal services on a 24-hour basis in the person's own home to not more than two adults who do not receive optional state supplementation. The person who provides the housing, meals, and personal services must own or rent the home and reside therein.

(e) Any home or facility approved by the United States Department of Veterans Affairs as a residential care home wherein care is provided exclusively to three or fewer veterans.

(f) Any facility that has been incorporated in this state for 50 years or more on or before July 1,

1983, and the board of directors of which is nominated or elected by the residents, until the facility is sold or its ownership is transferred; or any facility, with improvements or additions thereto, which has existed and operated continuously in this state for 60 years or more on or before July 1, 1989, is directly or indirectly owned and operated by a nationally recognized fraternal organization, is not open to the public, and accepts only its own members and their spouses as residents.

(g) Any facility certified under chapter 651, or a retirement community, may provide services authorized under this part or part IV of this chapter to its residents who live in single-family homes, duplexes, quadruplexes, or apartments located on the campus without obtaining a license to operate an assisted living facility if residential units within such buildings are used by residents who do not require staff supervision for that portion of the day when personal services are not being delivered and the owner obtains a home health license to provide such services. However, any building or distinct part of a building on the campus that is designated for persons who receive personal services and require supervision beyond that which is available while such services are being rendered must be licensed in accordance with this part. If a facility provides personal services to residents who do not otherwise require supervision and the owner is not licensed as a home health agency, the buildings or distinct parts of buildings where such services are rendered must be licensed under this part. A resident of a facility that obtains a home health license may contract with a home health agency of his or her choice, provided that the home health agency provides liability insurance and workers' compensation coverage for its employees. Facilities covered by this exemption may establish policies that give residents the option of contracting for services and care beyond that which is provided by the facility to enable them to age in place. For purposes of this section, a retirement community consists of a facility licensed under this part or under part II, and apartments designed for independent living located on the same campus.

(h) Any residential unit for independent living which is located within a facility certified under chapter 651, or any residential unit which is colocated with a nursing home licensed under part II or colocated with a facility licensed under this part in which services are provided through an outpatient clinic or a nursing home on an outpatient basis.

**History.**--ss. 4, 5, ch. 75-233; ss. 12, 15, ch. 80-198; s. 2, ch. 81-318; ss. 42, 79, 83, ch. 83-181; s. 4, ch. 87-371; s. 4, ch. 91-263; ss. 3, 38, 39, ch. 93-216; s. 19, ch. 93-268; s. 2, ch. 94-206; s. 1055, ch. 95-148; s. 8, ch. 95-210; s. 2, ch. 98-80; s. 1, ch. 98-148.

**400.407 License required; fee, display.**--

(1) A license issued by the agency is required for an assisted living facility operating in this state.

(2) Separate licenses shall be required for facilities maintained in separate premises, even though operated under the same management. A separate license shall not be required for separate buildings on the same grounds.

(3) Any license granted by the agency must state the maximum resident capacity of the facility, the type of care for which the license is granted, the date the license is issued, the expiration date of the license, and any other information deemed necessary by the agency. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(a) A standard license shall be issued to facilities providing one or more of the personal services identified in s. 400.402. Such facilities may also employ or contract with a person licensed under part I of chapter 464 to administer medications and perform other tasks as specified in s. 400.4255.

(b) An extended congregate care license shall be issued to facilities providing, directly or through contract, services beyond those authorized in paragraph (a), including acts performed pursuant to part I of chapter 464 by persons licensed thereunder, and supportive services defined by rule to

persons who otherwise would be disqualified from continued residence in a facility licensed under this part.

1. In order for extended congregate care services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of a facility. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part. Notification of approval or denial of such request shall be made within 90 days after receipt of such request and all necessary documentation. Existing facilities qualifying to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards as specified in rule from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards resulting in a requirement to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium on admissions or initiation of injunctive proceedings.

2. Facilities that are licensed to provide extended congregate care services shall maintain a written progress report on each person who receives such services, which report describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit such facilities at least quarterly to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part and with rules that relate to extended congregate care. One of these visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects such facility. The agency may waive one of the required yearly monitoring visits for a facility that has been licensed for at least 24 months to provide extended congregate care services, if, during the inspection, the registered nurse determines that extended congregate care services are being provided appropriately, and if the facility has no class I or class II violations and no uncorrected class III violations. Before such decision is made, the agency shall consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated.

3. Facilities that are licensed to provide extended congregate care services shall:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of

the building, to assist with the evacuation of residents in an emergency, as necessary.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place to the extent possible, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, either directly or through contract, the services of a person licensed pursuant to part I of chapter 464.

h. In addition to the training mandated in s. 400.452, provide specialized training as defined by rule for facility staff.

4. Facilities licensed to provide extended congregate care services are exempt from the criteria for continued residency as set forth in rules adopted under s. 400.441. Facilities so licensed shall adopt their own requirements within guidelines for continued residency set forth by the department in rule. However, such facilities may not serve residents who require 24-hour nursing supervision. Facilities licensed to provide extended congregate care services shall provide each resident with a written copy of facility policies governing admission and retention.

5. The primary purpose of extended congregate care services is to allow residents, as they become more impaired, the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency. A facility licensed to provide extended congregate care services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the extended congregate care facility.

6. Before admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 400.426(4) and the facility must develop a preliminary service plan for the individual.

7. When a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility shall make arrangements for relocating the person in accordance with s. 400.428(1)(k).

8. Failure to provide extended congregate care services may result in denial of extended congregate care license renewal.

9. No later than January 1 of each year, the department, in consultation with the agency, shall prepare and submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the chairs of appropriate legislative committees, a report on the status of, and recommendations related to, extended congregate care services. The status report must include, but need not be limited to, the following information:

a. A description of the facilities licensed to provide such services, including total number of beds licensed under this part.

b. The number and characteristics of residents receiving such services.

c. The types of services rendered that could not be provided through a standard license.

d. An analysis of deficiencies cited during licensure inspections.

e. The number of residents who required extended congregate care services at admission and the source of admission.

f. Recommendations for statutory or regulatory changes.

g. The availability of extended congregate care to state clients residing in facilities licensed under this part and in need of additional services, and recommendations for appropriations to subsidize extended congregate care services for such persons.

h. Such other information as the department considers appropriate.

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. Such designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part. Notification of approval or denial of such request shall be made within 90 days after receipt of such request and all necessary documentation. Existing facilities qualifying to provide limited nursing services shall have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. Facilities that are licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services, which report describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit such facilities at least twice a year to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part and with related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 400.428(1)(k), unless the facility is licensed to provide extended congregate care services.

(4)(a) The biennial license fee required of a facility is $300 per license, with an additional fee of $50 per resident based on the total licensed resident capacity of the facility, except that no additional fee will be assessed for beds designated for recipients of optional state supplementation payments provided for in s. 409.212. The total fee may not exceed $10,000, no part of which shall be returned to the facility. The agency shall adjust the per bed license fee and the total licensure fee annually by not more than the change in the consumer price index based on the 12 months immediately preceding the increase.

(b) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide extended congregate care services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $400 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility. No part of this fee shall be returned to the facility. The agency may adjust the per bed license fee and the annual license fee once each year by not more than the average rate of inflation for the 12

months immediately preceding the increase.

(c) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide limited nursing services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $250 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility. No part of this fee shall be returned to the facility. The agency may adjust the per bed license fee and the biennial license fee once each year by not more than the average rate of inflation for the 12 months immediately preceding the increase.

(5) Counties or municipalities applying for licenses under this part are exempt from the payment of license fees.

(6) The license shall be displayed in a conspicuous place inside the facility.

(7) A license shall be valid only in the possession of the individual, firm, partnership, association, or corporation to which it is issued and shall not be subject to sale, assignment, or other transfer, voluntary or involuntary; nor shall a license be valid for any premises other than that for which originally issued.

(8) A fee may be charged to a facility requesting a duplicate license. The fee shall not exceed the actual cost of duplication and postage.

**History.**--s. 6, ch. 75-233; s. 8, ch. 79-12; ss. 12, 16, ch. 80-198; s. 2, ch. 81-318; ss. 43, 79, 83, ch. 83-181; s. 2, ch. 86-104; s. 5, ch. 87-371; s. 11, ch. 89-294; s. 5, ch. 91-263; s. 10, ch. 91-282; s. 22, ch. 93-177; ss. 4, 38, 39, ch. 93-216; s. 20, ch. 95-146; s. 9, ch. 95-210; ss. 2, 18, 23, ch. 95-418; s. 3, ch. 97-82; s. 18, ch. 97-96; s. 3, ch. 98-80; s. 99, ch. 2000-318; s. 33, ch. 2001-45.

**400.4075 Limited mental health license.** --An assisted living facility that serves three or more mental health residents must obtain a limited mental health license.

(1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected deficiencies or violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This training will be provided by or approved by the Department of Children and Family Services.

(2) Facilities licensed to provide services to mental health residents shall provide appropriate supervision and staffing to provide for the health, safety, and welfare of such residents.

(3) A facility that has a limited mental health license must:

(a) Have a copy of each mental health resident's community living support plan and the cooperative agreement with the mental health care services provider. The support plan and the agreement may be combined.

(b) Have documentation that is provided by the Department of Children and Family Services that each mental health resident has been assessed and determined to be able to live in the community in an assisted living facility with a limited mental health license.

(c) Make the community living support plan available for inspection by the resident, the resident's legal guardian, the resident's health care surrogate, and other individuals who have a lawful basis for reviewing this document.

(d) Assist the mental health resident in carrying out the activities identified in the individual's community living support plan.

(4) A facility with a limited mental health license may enter into a cooperative agreement with a private mental health provider. For purposes of the limited mental health license, the private mental health provider may act as the case manager.

**History.**--s. 3, ch. 95-418; s. 37, ch. 96-169; s. 4, ch. 97-82; s. 66, ch. 97-100; s. 4, ch. 98-80.

**400.408 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties; verification of licensure status.**--

(1)(a) It is unlawful to own, operate, or maintain an assisted living facility without obtaining a license under this part.

(b) Except as provided under paragraph (d), any person who owns, operates, or maintains an unlicensed assisted living facility commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(c) Any person found guilty of violating paragraph (a) a second or subsequent time commits a felony of the second degree, punishable as provided under s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(d) Any person who owns, operates, or maintains an unlicensed assisted living facility due to a change in this part or a modification in department rule within 6 months after the effective date of such change and who, within 10 working days after receiving notification from the agency, fails to cease operation or apply for a license under this part commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(e) Any facility that fails to cease operation after agency notification may be fined for each day of noncompliance pursuant to s. 400.419.

(f) When a licensee has an interest in more than one assisted living facility, and fails to license any one of these facilities, the agency may revoke the license, impose a moratorium, or impose a fine pursuant to s. 400.419, on any or all of the licensed facilities until such time as the unlicensed facility is licensed or ceases operation.

(g) If the agency determines that an owner is operating or maintaining an assisted living facility without obtaining a license and determines that a condition exists in the facility that poses a threat to the health, safety, or welfare of a resident of the facility, the owner is subject to the same actions and fines imposed against a licensed facility as specified in ss. 400.414 and 400.419.

(h) Any person aware of the operation of an unlicensed assisted living facility must report that facility to the agency. The agency shall provide to the department's elder information and referral providers a list, by county, of licensed assisted living facilities, to assist persons who are considering an assisted living facility placement in locating a licensed facility.

(i) Each field office of the Agency for Health Care Administration shall establish a local coordinating workgroup which includes representatives of local law enforcement agencies, state attorneys, the Medicaid Fraud Control Unit of the Department of Legal Affairs, local fire authorities, the Department of Children and Family Services, the district long-term care ombudsman council, and the district human rights advocacy committee to assist in identifying the operation of unlicensed facilities and to develop and implement a plan to ensure effective enforcement of state laws relating to such facilities. The workgroup shall report its findings, actions, and recommendations semiannually to the Director of Health Facility Regulation of the

agency.

(2) It is unlawful to knowingly refer a person for residency to an unlicensed assisted living facility; to an assisted living facility the license of which is under denial or has been suspended or revoked; or to an assisted living facility that has a moratorium on admissions. Any person who violates this subsection commits a noncriminal violation, punishable by a fine not exceeding $500 as provided in s. 775.083.

(a) Any health care practitioner, as defined in s. 456.001, who is aware of the operation of an unlicensed facility shall report that facility to the agency. Failure to report a facility that the practitioner knows or has reasonable cause to suspect is unlicensed shall be reported to the practitioner's licensing board.

(b) Any hospital or community mental health center licensed under chapter 395 or chapter 394 which knowingly discharges a patient or client to an unlicensed facility is subject to sanction by the agency.

(c) Any employee of the agency or department, or the Department of Children and Family Services, who knowingly refers a person for residency to an unlicensed facility; to a facility the license of which is under denial or has been suspended or revoked; or to a facility that has a moratorium on admissions is subject to disciplinary action by the agency or department, or the Department of Children and Family Services.

(d) The employer of any person who is under contract with the agency or department, or the Department of Children and Family Services, and who knowingly refers a person for residency to an unlicensed facility; to a facility the license of which is under denial or has been suspended or revoked; or to a facility that has a moratorium on admissions shall be fined and required to prepare a corrective action plan designed to prevent such referrals.

(e) The agency shall provide the department and the Department of Children and Family Services with a list of licensed facilities within each county and shall update the list at least quarterly.

(f) At least annually, the agency shall notify, in appropriate trade publications, physicians licensed under chapter 458 or chapter 459, hospitals licensed under chapter 395, nursing home facilities licensed under part II of this chapter, and employees of the agency or the department, or the Department of Children and Family Services, who are responsible for referring persons for residency, that it is unlawful to knowingly refer a person for residency to an unlicensed assisted living facility and shall notify them of the penalty for violating such prohibition. The department and the Department of Children and Family Services shall, in turn, notify service providers under contract to the respective departments who have responsibility for resident referrals to facilities. Further, the notice must direct each noticed facility and individual to contact the appropriate agency office in order to verify the licensure status of any facility prior to referring any person for residency. Each notice must include the name, telephone number, and mailing address of the appropriate office to contact.

**History.**--s. 17, ch. 88-350; s. 6, ch. 91-263; s. 29, ch. 92-33; ss. 5, 39, ch. 93-216; s. 10, ch. 95-210; ss. 4, 48, ch. 95-418; s. 5, ch. 98-80; s. 1, ch. 99-179; s. 1, ch. 2000-318; s. 36, ch. 2001-62; s. 2, ch. 2004-344.

**400.411 Initial application for license; provisional license.**--

(1) Application for a license shall be made to the agency on forms furnished by it and shall be accompanied by the appropriate license fee.

(2) The applicant may be an individual owner, a corporation, a partnership, a firm, an association, or a governmental entity.

[1](3) The application must be signed by the applicant under oath and must contain the following:

(a) The name, address, date of birth, and social security number of the applicant and the name by which the facility is to be known. If the applicant is a firm, partnership, or association, the application shall contain the name, address, date of birth, and social security number of every member thereof. If the applicant is a corporation, the application shall contain the corporation's name and address; the name, address, date of birth, and social security number of each of its directors and officers; and the name and address of each person having at least a 5-percent ownership interest in the corporation.

(b) The name and address of any professional service, firm, association, partnership, or corporation that is to provide goods, leases, or services to the facility if a 5-percent or greater ownership interest in the service, firm, association, partnership, or corporation is owned by a person whose name must be listed on the application under paragraph (a).

(c) The name and address of any long-term care facility with which the applicant, administrator, or financial officer has been affiliated through ownership or employment within 5 years of the date of this license application; and a signed affidavit disclosing any financial or ownership interest that the applicant, or any person listed in paragraph (a), holds or has held within the last 5 years in any facility licensed under this part, or in any other entity licensed by this state or another state to provide health or residential care, which facility or entity closed or ceased to operate as a result of financial problems, or has had a receiver appointed or a license denied, suspended or revoked, or was subject to a moratorium on admissions, or has had an injunctive proceeding initiated against it.

(d) A description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(e) The names and addresses of persons of whom the agency may inquire as to the character, reputation, and financial responsibility of the owner and, if different from the applicant, the administrator and financial officer.

(f) Identification of all other homes or facilities, including the addresses and the license or licenses under which they operate, if applicable, which are currently operated by the applicant or administrator and which provide housing, meals, and personal services to residents.

(g) The location of the facility for which a license is sought and documentation, signed by the appropriate local government official, which states that the applicant has met local zoning requirements.

(h) The name, address, date of birth, social security number, education, and experience of the administrator, if different from the applicant.

(4) The applicant shall furnish satisfactory proof of financial ability to operate and conduct the facility in accordance with the requirements of this part. A certificate of authority, pursuant to chapter 651, may be provided as proof of financial ability.

(5) If the applicant is a continuing care facility certified under chapter 651, a copy of the facility's certificate of authority must be provided.

(6) The applicant shall provide proof of liability insurance as defined in s. 624.605.

(7) If the applicant is a community residential home, the applicant must provide proof that it has met the requirements specified in chapter 419.

(8) The applicant must provide the agency with proof of legal right to occupy the property.

(9) The applicant must furnish proof that the facility has received a satisfactory firesafety inspection. The local authority having jurisdiction or the State Fire Marshal must conduct the inspection within 30 days after written request by the applicant.

(10) The applicant must furnish documentation of a satisfactory sanitation inspection of the facility by the county health department.

(11) The applicant must furnish proof of compliance with level 2 background screening as required under s. 400.4174.

(12) A provisional license may be issued to an applicant making initial application for licensure or making application for a change of ownership. A provisional license shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency.

(13) A county or municipality may not issue an occupational license that is being obtained for the purpose of operating a facility regulated under this part without first ascertaining that the applicant has been licensed to operate such facility at the specified location or locations by the agency. The agency shall furnish to local agencies responsible for issuing occupational licenses sufficient instruction for making such determinations.

**History.**--s. 7, ch. 75-233; s. 3, ch. 77-323; ss. 12, 17, ch. 80-198; s. 2, ch. 81-318; ss. 7, 19, ch. 82-148; ss. 44, 47, 79, 83, ch. 83-181; s. 5, ch. 85-145; s. 1, ch. 85-251; s. 6, ch. 87-371; s. 12, ch. 89-294; s. 7, ch. 91-263; ss. 6, 38, 39, ch. 93-216; s. 5, ch. 95-418; s. 6, ch. 98-80; s. 42, ch. 98-171.

**[1]Note.**--As amended by s. 42, ch. 98-171. This material was also amended by s. 6, ch. 98-80. A portion of former paragraph (2)(c) was stricken by s. 42, ch. 98-171, and the remaining text of that paragraph was redesignated as paragraph (3)(c); the portion of former paragraph (2)(c) stricken by s. 42, ch. 98-171, was redesignated as paragraph (3)(c) and amended by s. 6, ch. 98-80. As amended by s. 6, ch. 98-80, this material would have read:

(c) Information sufficient to establish the suitable character, financial stability, and competency of the applicant and of each person specified in the application under paragraph (a) and, if different from the applicant, the administrator, and financial officer.

**400.412 Sale or transfer of ownership of a facility.**--It is the intent of the Legislature to protect the rights of the residents of an assisted living facility when the facility is sold or the ownership thereof is transferred. Therefore, whenever a facility is sold or the ownership thereof is transferred, including leasing:

(1) The transferee shall make application to the agency for a new license at least 60 days before the date of transfer of ownership. The application must comply with the provisions of s. 400.411.

(2)(a) The transferor shall notify the agency in writing at least 60 days before the date of transfer of ownership.

(b) The new owner shall notify the residents, in writing, of the transfer of ownership within 7 days of his or her receipt of the license.

(3) The transferor shall be responsible and liable for:

(a) The lawful operation of the facility and the welfare of the residents domiciled in the facility until the date the transferee is licensed by the agency.

(b) Any and all penalties imposed against the facility for violations occurring before the date of transfer of ownership unless the penalty imposed is a moratorium on admissions or denial of licensure. The moratorium on admissions or denial of licensure remains in effect after the transfer of ownership, unless the agency has approved the transferee's corrective action plan or the conditions which created the moratorium or denial have been corrected, and may be grounds for denial of license to the transferee in accordance with chapter 120.

(c) Any outstanding liability to the state, unless the transferee has agreed, as a condition of sale or transfer, to accept the outstanding liabilities and to guarantee payment therefor; except that, if the transferee fails to meet these obligations, the transferor shall remain liable for the outstanding liability.

(4) The transferor of a facility the license of which is denied pending an administrative hearing shall, as a part of the written transfer-of-ownership contract, advise the transferee that a plan of correction must be submitted by the transferee and approved by the agency at least 7 days before the transfer of ownership and that failure to correct the condition which resulted in the moratorium on admissions or denial of licensure is grounds for denial of the transferee's license.

(5) The transferee must provide the agency with proof of legal right to occupy the property before a license may be issued. Proof may include, but is not limited to, copies of warranty deeds, or copies of lease or rental agreements, contracts for deeds, quitclaim deeds, or other such documentation.

**History.**--ss. 45, 83, ch. 83-181; s. 7, ch. 87-371; s. 8, ch. 91-263; ss. 7, 38, 39, ch. 93-216; s. 772, ch. 95-148; s. 11, ch. 95-210; s. 6, ch. 95-418.

**400.414 Denial, revocation, or suspension of license; imposition of administrative fine; grounds.**--

(1) The agency may deny, revoke, or suspend any license issued under this part, or impose an administrative fine in the manner provided in chapter 120, for any of the following actions by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 400.4174, or for the actions of any facility employee:

(a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(b) The determination by the agency that the owner lacks the financial ability to provide continuing adequate care to residents.

(c) Misappropriation or conversion of the property of a resident of the facility.

(d) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a facility resident.

(e) A citation of any of the following deficiencies as defined in s. 400.419:

1. One or more cited class I deficiencies.

2. Three or more cited class II deficiencies.

3. Five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified.

(f) A determination that a person subject to level 2 background screening under s. 400.4174(1)

does not meet the screening standards of s. 435.04 or that the facility is retaining an employee subject to level 1 background screening standards under s. 400.4174(2) who does not meet the screening standards of s. 435.03 and for whom exemptions from disqualification have not been provided by the agency.

(g) A determination that an employee, volunteer, administrator, or owner, or person who otherwise has access to the residents of a facility does not meet the criteria specified in s. 435.03 (2), and the owner or administrator has not taken action to remove the person. Exemptions from disqualification may be granted as set forth in s. 435.07. No administrative action may be taken against the facility if the person is granted an exemption.

(h) Violation of a moratorium.

(i) Failure of the license applicant, the licensee during relicensure, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal.

(j) A fraudulent statement or omission of any material fact on an application for a license or any other document required by the agency, including the submission of a license application that conceals the fact that any board member, officer, or person owning 5 percent or more of the facility may not meet the background screening requirements of s. 400.4174, or that the applicant has been excluded, permanently suspended, or terminated from the Medicaid or Medicare programs.

(k) An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted living facilities or other firesafety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the agency by the local authority having jurisdiction or the State Fire Marshal.

(l) Exclusion, permanent suspension, or termination from the Medicare or Medicaid programs.

(m) Knowingly operating any unlicensed facility or providing without a license any service that must be licensed under this chapter.

(n) Any act constituting a ground upon which application for a license may be denied.

Administrative proceedings challenging agency action under this subsection shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

(2) Upon notification by the local authority having jurisdiction or by the State Fire Marshal, the agency may deny or revoke the license of an assisted living facility that fails to correct cited fire code violations that affect or threaten the health, safety, or welfare of a resident of a facility.

(3) The agency may deny a license to any applicant or to any officer or board member of an applicant who is a firm, corporation, partnership, or association or who owns 5 percent or more of the facility, if the applicant, officer, or board member has or had a 25-percent or greater financial or ownership interest in any other facility licensed under this part, or in any entity licensed by this state or another state to provide health or residential care, which facility or entity during the 5 years prior to the application for a license closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium on admissions; had an injunctive proceeding initiated against it; or has an outstanding fine assessed under this chapter.

(4) The agency shall deny or revoke the license of an assisted living facility that has two or more class I violations that are similar or identical to violations identified by the agency during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.

(5) An action taken by the agency to suspend, deny, or revoke a facility's license under this part, in which the agency claims that the facility owner or an employee of the facility has threatened the health, safety, or welfare of a resident of the [1]facility be heard by the Division of Administrative Hearings of the Department of Management Services within 120 days after receipt of the facility's request for a hearing, unless that time limitation is waived by both parties. The administrative law judge must render a decision within 30 days after receipt of a proposed recommended order.

(6) The agency shall provide to the Division of Hotels and Restaurants of the Department of Business and Professional Regulation, on a monthly basis, a list of those assisted living facilities that have had their licenses denied, suspended, or revoked or that are involved in an appellate proceeding pursuant to s. 120.60 related to the denial, suspension, or revocation of a license.

(7) Agency notification of a license suspension or revocation, or denial of a license renewal, shall be posted and visible to the public at the facility.

(8) The agency may issue a temporary license pending final disposition of a proceeding involving the suspension or revocation of an assisted living facility license.

**History.**--s. 8, ch. 75-233; ss. 12, 18, ch. 80-198; s. 2, ch. 81-318; ss. 46, 79, 83, ch. 83-181; s. 8, ch. 87-371; s. 13, ch. 89-294; s. 30, ch. 91-71; s. 46, ch. 92-58; ss. 8, 38, 39, ch. 93-216; s. 50, ch. 94-218; s. 39, ch. 95-228; s. 7, ch. 95-418; s. 38, ch. 96-169; s. 126, ch. 96-410; s. 7, ch. 98-80; s. 43, ch. 98-171; s. 73, ch. 2000-349; s. 34, ch. 2001-45; s. 19, ch. 2003-57; s. 13, ch. 2004-267.

**[1]Note.**--The words "facility be heard" are as enacted by s. 43, ch. 98-171.

**400.415 Moratorium on admissions; notice.**--The agency may impose an immediate moratorium on admissions to any assisted living facility if the agency determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility.

(1) A facility the license of which is denied, revoked, or suspended pursuant to s. 400.414 may be subject to immediate imposition of a moratorium on admissions to run concurrently with licensure denial, revocation, or suspension.

(2) When a moratorium is placed on a facility, notice of the moratorium shall be posted and visible to the public at the facility until the moratorium is lifted.

(3) The department may by rule establish conditions that constitute grounds for imposing a moratorium on a facility and procedures for imposing and lifting a moratorium, as necessary to administer this section.

**History.**--ss. 46, 83, ch. 83-181; ss. 9, 38, 39, ch. 93-216; s. 8, ch. 95-418; s. 8, ch. 98-80.

**400.417 Expiration of license; renewal; conditional license.** --

(1) Biennial licenses, unless sooner suspended or revoked, shall expire 2 years from the date of issuance. Limited nursing, extended congregate care, and limited mental health licenses shall expire at the same time as the facility's standard license, regardless of when issued. The agency shall notify the facility at least 120 days prior to expiration that a renewal license is necessary to continue operation. The notification must be provided electronically or by mail delivery. Ninety days prior to the expiration date, an application for renewal shall be submitted to the agency. Fees must be prorated. The failure to file a timely renewal application shall result in a late fee charged to the facility in an amount equal to 50 percent of the current fee.

(2) A license shall be renewed within 90 days upon the timely filing of an application on forms

furnished by the agency and the provision of satisfactory proof of ability to operate and conduct the facility in accordance with the requirements of this part and adopted rules, including proof that the facility has received a satisfactory firesafety inspection, conducted by the local authority having jurisdiction or the State Fire Marshal, within the preceding 12 months and an affidavit of compliance with the background screening requirements of s. 400.4174.

(3) An applicant for renewal of a license who has complied with the provisions of s. 400.411 with respect to proof of financial ability to operate shall not be required to provide further proof unless the facility or any other facility owned or operated in whole or in part by the same person has demonstrated financial instability as provided under s. 400.447(2) or unless the agency suspects that the facility is not financially stable as a result of the annual survey or complaints from the public or a report from the State Long-Term Care Ombudsman Council. Each facility must report to the agency any adverse court action concerning the facility's financial viability, within 7 days after its occurrence. The agency shall have access to books, records, and any other financial documents maintained by the facility to the extent necessary to determine the facility's financial stability. A license for the operation of a facility shall not be renewed if the licensee has any outstanding fines assessed pursuant to this part which are in final order status.

(4) A licensee against whom a revocation or suspension proceeding is pending at the time of license renewal may be issued a conditional license effective until final disposition by the agency. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional license for the duration of the judicial proceeding.

(5) A conditional license may be issued to an applicant for license renewal if the applicant fails to meet all standards and requirements for licensure. A conditional license issued under this subsection shall be limited in duration to a specific period of time not to exceed 6 months, as determined by the agency, and shall be accompanied by an agency-approved plan of correction.

(6) When an extended care or limited nursing license is requested during a facility's biennial license period, the fee shall be prorated in order to permit the additional license to expire at the end of the biennial license period. The fee shall be calculated as of the date the additional license application is received by the agency.

(7) The department may by rule establish renewal procedures, identify forms, and specify documentation necessary to administer this section.

**History.**--s. 9, ch. 75-233; ss. 12, 19, ch. 80-198; s. 2, ch. 81-318; ss. 9, 19, ch. 82-148; ss. 47, 79, 83, ch. 83-181; s. 2, ch. 88-350; s. 14, ch. 89-294; s. 9, ch. 91-263; s. 23, ch. 93-177; ss. 10, 38, 39, ch. 93-216; s. 9, ch. 95-418; s. 9, ch. 98-80; s. 44, ch. 98-171; s. 212, ch. 99-13; s. 20, ch. 2003-57.

**400.4174 Background screening; exemptions.**--

(1)(a) Level 2 background screening must be conducted on each of the following persons, who shall be considered employees for the purposes of conducting screening under chapter 435:

1. The facility owner if an individual, the administrator, and the financial officer.

2. An officer or board member if the facility owner is a firm, corporation, partnership, or association, or any person owning 5 percent or more of the facility if the agency has probable cause to believe that such person has been convicted of any offense prohibited by s. 435.04. For each officer, board member, or person owning 5 percent or more who has been convicted of any such offense, the facility shall submit to the agency a description and explanation of the conviction at the time of license application. This subparagraph does not apply to a board member of a not-for-profit corporation or organization if the board member serves solely in a voluntary capacity, does not regularly take part in the day-to-day operational decisions of the corporation or

organization, receives no remuneration for his or her services, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the board member and facility submit a statement affirming that the board member's relationship to the facility satisfies the requirements of this subparagraph.

(b) Proof of compliance with level 2 screening standards which has been submitted within the previous 5 years to meet any facility or professional licensure requirements of the agency or the Department of Health satisfies the requirements of this subsection, provided that such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of chapter 435. Proof of compliance with the background screening requirements of the Financial Services Commission and the Office of Insurance Regulation for applicants for a certificate of authority to operate a continuing care retirement community under chapter 651, submitted within the last 5 years, satisfies the Department of Law Enforcement and Federal Bureau of Investigation portions of a level 2 background check.

(c) The agency may grant a provisional license to a facility applying for an initial license when each individual required by this subsection to undergo screening has completed the Department of Law Enforcement background checks, but has not yet received results from the Federal Bureau of Investigation, or when a request for an exemption from disqualification has been submitted to the agency pursuant to s. 435.07, but a response has not been issued.

(2) The owner or administrator of an assisted living facility must conduct level 1 background screening, as set forth in chapter 435, on all employees hired on or after October 1, 1998, who perform personal services as defined in s. 400.402(17). The agency may exempt an individual from employment disqualification as set forth in chapter 435. Such persons shall be considered as having met this requirement if:

(a) Proof of compliance with level 1 screening requirements obtained to meet any professional license requirements in this state is provided and accompanied, under penalty of perjury, by a copy of the person's current professional license and an affidavit of current compliance with the background screening requirements.

(b) The person required to be screened has been continuously employed in the same type of occupation for which the person is seeking employment without a breach in service which exceeds 180 days, and proof of compliance with the level 1 screening requirement which is no more than 2 years old is provided. Proof of compliance shall be provided directly from one employer or contractor to another, and not from the person screened. Upon request, a copy of screening results shall be provided by the employer retaining documentation of the screening to the person screened.

(c) The person required to be screened is employed by a corporation or business entity or related corporation or business entity that owns, operates, or manages more than one facility or agency licensed under this chapter, and for whom a level 1 screening was conducted by the corporation or business entity as a condition of initial or continued employment.

**History.**--ss. 15, 25, ch. 89-294; ss. 11, 38, 39, ch. 93-216; s. 10, ch. 98-80; ss. 45, 71, ch. 98-171; s. 142, ch. 98-403; s. 213, ch. 99-13; s. 74, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 418, ch. 2003-261; s. 14, ch. 2004-267.

**400.4176 Notice of change of administrator.**--If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 400.452. Background screening shall be completed on any new administrator as specified in [1]s. 400.4174.

**History.**--ss. 44, 83, ch. 83-181; s. 10, ch. 91-263; ss. 12, 38, 39, ch. 93-216; ss. 10, 24, ch. 95-418;

s. 11, ch. 98-80; s. 46, ch. 98-171.

[1]**Note.**--As amended by s. 46, ch. 98-171. Section 400.4176 was also amended by s. 11, ch. 98-80, and that version cites to s. 400.411 instead of s. 400.4174.

**400.4177 Patients with Alzheimer's disease or other related disorders; certain disclosures.**--A facility licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The facility must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the facility and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the facility's records as part of the license renewal procedure.

**History.**--s. 2, ch. 93-105.

**400.4178 Special care for persons with Alzheimer's disease or other related disorders.**--

(1) A facility which advertises that it provides special care for persons with Alzheimer's disease or other related disorders must meet the following standards of operation:

(a)1. If the facility has 17 or more residents, have an awake staff member on duty at all hours of the day and night; or

2. If the facility has fewer than 17 residents, have an awake staff member on duty at all hours of the day and night or have mechanisms in place to monitor and ensure the safety of the facility's residents.

(b) Offer activities specifically designed for persons who are cognitively impaired.

(c) Have a physical environment that provides for the safety and welfare of the facility's residents.

(d) Employ staff who have completed the training and continuing education required in subsection (2).

(2)(a) An individual who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, and who has regular contact with such residents, must complete up to 4 hours of initial dementia-specific training developed or approved by the department. The training shall be completed within 3 months after beginning employment and shall satisfy the core training requirements of s. 400.452(2)(g).

(b) A direct caregiver who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, and who provides direct care to such residents, must complete the required initial training and 4 additional hours of training developed or approved by the department. The training shall be completed within 9 months after beginning employment and shall satisfy the core training requirements of s. 400.452(2)(g).

(c) An individual who is employed by a facility that provides special care for residents with Alzheimer's disease or other related disorders, but who only has incidental contact with such residents, must be given, at a minimum, general information on interacting with individuals with Alzheimer's disease or other related disorders, within 3 months after beginning employment.

(3) In addition to the training required under subsection (2), a direct caregiver must participate in a minimum of 4 contact hours of continuing education each calendar year. The continuing

education must include one or more topics included in the dementia-specific training developed or approved by the department, in which the caregiver has not received previous training.

(4) Upon completing any training listed in subsection (2), the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different facility. The employee or direct caregiver must comply with other applicable continuing education requirements.

(5) The department, or its designee, shall approve the initial and continuing education courses and providers.

(6) The department shall keep a current list of providers who are approved to provide initial and continuing education for staff of facilities that provide special care for persons with Alzheimer's disease or other related disorders.

(7) Any facility more than 90 percent of whose residents receive monthly optional supplementation payments is not required to pay for the training and education programs required under this section. A facility that has one or more such residents shall pay a reduced fee that is proportional to the percentage of such residents in the facility. A facility that does not have any residents who receive monthly optional supplementation payments must pay a reasonable fee, as established by the department, for such training and education programs.

(8) The department shall adopt rules to establish standards for trainers and training and to implement this section.

**History.**--s. 15, ch. 97-82.

**400.418 Disposition of fees and administrative fines.**--

(1) Income from license fees, inspection fees, late fees, and administrative fines generated pursuant to ss. 400.407, 400.408, 400.417, 400.419, and 400.431 shall be deposited in the Health Care Trust Fund administered by the agency. Such funds shall be directed to and used by the agency for the following purposes:

(a) Up to 50 percent of the trust funds accrued each fiscal year under this part may be used to offset the expenses of receivership, pursuant to s. 400.422, if the court determines that the income and assets of the facility are insufficient to provide for adequate management and operation.

(b) An amount of $5,000 of the trust funds accrued each year under this part shall be allocated to pay for inspection-related physical and mental health examinations requested by the agency pursuant to s. 400.426 for residents who are either recipients of supplemental security income or have monthly incomes not in excess of the maximum combined federal and state cash subsidies available to supplemental security income recipients, as provided for in s. 409.212. Such funds shall only be used where the resident is ineligible for Medicaid.

(c) Any trust funds accrued each year under this part and not used for the purposes specified in paragraphs (a) and (b) shall be used to offset the costs of the licensure program, including the costs of conducting background investigations, verifying information submitted, defraying the costs of processing the names of applicants, and conducting inspections and monitoring visits pursuant to this part.

(2) Income from fees generated pursuant to s. 400.441(5) shall be deposited in the Health Care Trust Fund and used to offset the costs of printing and postage.

**History.**--ss. 12, 20, ch. 80-198; s. 2, ch. 81-318; ss. 8, 19, ch. 82-148; ss. 48, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 16, ch. 89-294; s. 11, ch. 91-263; s. 11, ch. 91-282; ss. 13, 38, 39, ch. 93-216; s. 19, ch. 95-418; s. 12, ch. 98-80.

**400.419 Violations; imposition of administrative fines; grounds.** --

(1) The agency shall impose an administrative fine in the manner provided in chapter 120 for any of the actions or violations as set forth within this section by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 400.4174, for the actions of any facility employee, or for an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(2) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:

(a) Class "I" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine for a cited class I violation in an amount not less than $5,000 and not exceeding $10,000 for each violation. A fine may be levied notwithstanding the correction of the violation.

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the facility residents, other than class I violations. The agency shall impose an administrative fine for a cited class II violation in an amount not less than $1,000 and not exceeding $5,000 for each violation. A fine shall be levied notwithstanding the correction of the violation.

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of facility residents, other than class I or class II violations. The agency shall impose an administrative fine for a cited class III violation in an amount not less than $500 and not exceeding $1,000 for each violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, no fine may be imposed, unless it is a repeated offense.

(d) Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a building or to required reports, forms, or documents that do not have the potential of negatively affecting residents. These violations are of a type that the agency determines do not threaten the health, safety, or security of residents of the facility. The agency shall impose an administrative fine for a cited class IV violation in an amount not less than $100 and not exceeding $200 for each violation. A citation for a class IV violation must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, no fine shall be imposed. Any class IV violation that is corrected during the time an agency survey is being conducted will be identified as an agency finding and not as a violation.

(3) In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential

harm, and the extent to which the provisions of the applicable laws or rules were violated.

(b) Actions taken by the owner or administrator to correct violations.

(c) Any previous violations.

(d) The financial benefit to the facility of committing or continuing the violation.

(e) The licensed capacity of the facility.

(4) Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(5) Any action taken to correct a violation shall be documented in writing by the owner or administrator of the facility and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated facility, revoke or deny a facility's license when a facility administrator fraudulently misrepresents action taken to correct a violation.

(6) For fines that are upheld following administrative or judicial review, the violator shall pay the fine, plus interest at the rate as specified in s. 55.03, for each day beyond the date set by the agency for payment of the fine.

(7) Any unlicensed facility that continues to operate after agency notification is subject to a $1,000 fine per day.

(8) Any licensed facility whose owner or administrator concurrently operates an unlicensed facility shall be subject to an administrative fine of $5,000 per day.

(9) Any facility whose owner fails to apply for a change-of-ownership license in accordance with s. 400.412 and operates the facility under the new ownership is subject to a fine of $5,000.

(10) In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted under s. 400.428(3)(c) to verify the correction of the violations.

(11) The agency, as an alternative to or in conjunction with an administrative action against a facility for violations of this part and adopted rules, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner or administrator of the facility, prior to written notification. The agency, instead of fixing a period within which the facility shall enter into compliance with standards, may request a plan of corrective action from the facility which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(12) Administrative fines paid by any facility under this section shall be deposited into the Health Care Trust Fund and expended as provided in s. 400.418.

(13) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined $5,000 or more for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Family Services, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring

persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list.

**History.**--ss. 12, 21, ch. 80-198; s. 254, ch. 81-259; s. 2, ch. 81-318; ss. 49, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 17, ch. 89-294; s. 12, ch. 91-263; ss. 14, 38, 39, ch. 93-216; s. 13, ch. 98-80; s. 2, ch. 99-179; s. 19, ch. 2000-263; s. 142, ch. 2000-349; s. 62, ch. 2000-367; s. 35, ch. 2001-45; s. 21, ch. 2003-57.

**400.4195 Rebates prohibited; penalties.**--

(1) It is unlawful for any assisted living facility licensed under this part to contract or promise to pay or receive any commission, bonus, kickback, or rebate or engage in any split-fee arrangement in any form whatsoever with any physician, surgeon, organization, agency, or person, either directly or indirectly, for residents referred to an assisted living facility licensed under this part. A facility may employ or contract with persons to market the facility, provided the employee or contract provider clearly indicates that he or she represents the facility. A person or agency independent of the facility may provide placement or referral services for a fee to individuals seeking assistance in finding a suitable facility; however, any fee paid for placement or referral services must be paid by the individual looking for a facility, not by the facility.

(2) A violation of this section shall be considered patient brokering and is punishable as provided in s. 817.505.

**History.**--ss. 18, 25, ch. 89-294; s. 13, ch. 91-263; ss. 15, 38, 39, ch. 93-216; s. 773, ch. 95-148; s. 12, ch. 95-210; s. 14, ch. 98-80.

**400.42 Certain solicitation prohibited; third-party supplementation.**--

(1) A person may not, in connection with the solicitation of contributions by or on behalf of an assisted living facility or facilities, misrepresent or mislead any person, by any manner, means, practice, or device whatsoever, to believe that the receipts of such solicitation will be used for charitable purposes, if that is not the fact.

(2) Solicitation of contributions of any kind in a threatening, coercive, or unduly forceful manner by or on behalf of an assisted living facility or facilities by any agent, employee, owner, or representative of any assisted living facility or facilities is grounds for denial, suspension, or revocation of the license of the assisted living facility or facilities by or on behalf of which such contributions were solicited.

(3) The admission or maintenance of assisted living facility residents whose care is supported, in whole or in part, by state funds may not be conditioned upon the receipt of any manner of contribution or donation from any person. The solicitation or receipt of contributions in violation of this subsection is grounds for denial, suspension, or revocation of license, as provided in s. 400.414, for any assisted living facility by or on behalf of which such contributions were solicited.

(4) An assisted living facility may accept additional supplementation from third parties on behalf of residents receiving optional state supplementation in accordance with s. 409.212.

**History.**--ss. 50, 83, ch. 83-181; ss. 16, 38, 39, ch. 93-216; s. 13, ch. 95-210.

**400.421 Injunctive proceedings.**--

(1) The agency may institute injunctive proceedings in a court of competent jurisdiction to:

(a) Enforce the provisions of this part or any minimum standard, rule, or order issued or entered

into pursuant thereto when the attempt by the agency to correct a violation through administrative fines has failed or when the violation materially affects the health, safety, or welfare of residents; or

(b) Terminate the operation of a facility when violations of any provisions of this part or of any standard or rule promulgated pursuant thereto exist which materially affect the health, safety, or welfare of residents.

(2) Such injunctive relief may be temporary or permanent.

(3) The Legislature recognizes that in some instances, action is necessary to protect residents of assisted living facilities from immediate, life-threatening situations. In such cases, the court may allow a temporary injunction without bond on proper proof being made. If it appears by competent evidence or a sworn, substantiated affidavit that a temporary injunction should issue, the court, pending the determination on final hearing, shall enjoin operation of the facility.

**History.**--s. 10, ch. 75-233; ss. 12, 22, ch. 80-198; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 9, ch. 87-371; ss. 17, 38, 39, ch. 93-216; s. 14, ch. 95-210.

**400.422 Receivership proceedings.**--

(1) As an alternative to or in conjunction with an injunctive proceeding, the agency may petition a court of competent jurisdiction for the appointment of a receiver, if suitable alternate placements are not available, when any of the following conditions exist:

(a) The facility is operating without a license and refuses to make application for a license as required by ss. 400.407 and 400.408.

(b) The facility is closing or has informed the agency that it intends to close and adequate arrangements have not been made for relocation of the residents within 7 days, exclusive of weekends and holidays, of the closing of the facility.

(c) The agency determines there exist in the facility conditions which present an imminent danger to the health, safety, or welfare of the residents of the facility or a substantial probability that death or serious physical harm would result therefrom.

(d) The facility cannot meet its financial obligation for providing food, shelter, care, and utilities.

(2) Petitions for receivership shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, shall have priority. A hearing shall be conducted within 5 days of the filing of the petition, at which time all interested parties shall have the opportunity to present evidence pertaining to the petition. The agency shall notify, by certified mail, the owner or administrator of the facility named in the petition and the facility resident or, if applicable, the resident's representative or designee, or the resident's surrogate, guardian, or attorney in fact, of its filing, the substance of the violation, and the date and place set for the hearing. The court shall grant the petition only upon finding that the health, safety, or welfare of facility residents would be threatened if a condition existing at the time the petition was filed is permitted to continue. A receiver shall not be appointed ex parte unless the court determines that one or more of the conditions in subsection (1) exist; that the facility owner or administrator cannot be found; that all reasonable means of locating the owner or administrator and notifying him or her of the petition and hearing have been exhausted; or that the owner or administrator after notification of the hearing chooses not to attend. After such findings, the court may appoint any qualified person as a receiver, except it may not appoint any owner or affiliate of the facility which is in receivership. The receiver may be selected from a list of persons qualified to act as receivers developed by the agency and presented to the court with each petition for receivership. Under no circumstances may the agency or designated agency employee be

appointed as a receiver for more than 60 days; however, the receiver may petition the court, one time only, for a 30-day extension. The court shall grant the extension upon a showing of good cause.

(3) The receiver must make provisions for the continued health, safety, and welfare of all residents of the facility and:

(a) Shall exercise those powers and perform those duties set out by the court.

(b) Shall operate the facility in such a manner as to assure safety and adequate health care for the residents.

(c) Shall take such action as is reasonably necessary to protect or conserve the assets or property of the facility for which the receiver is appointed, or the proceeds from any transfer thereof, and may use them only in the performance of the powers and duties set forth in this section and by order of the court.

(d) May use the building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the facility at the time the petition for receivership was filed. The receiver shall collect payments for all goods and services provided to residents or others during the period of the receivership at the same rate of payment charged by the owners at the time the petition for receivership was filed, or at a fair and reasonable rate otherwise approved by the court.

(e) May correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety or health of residents while they remain in the facility, if the total cost of correction does not exceed $10,000. The court may order expenditures for this purpose in excess of $10,000 on application from the receiver after notice to the owner and a hearing.

(f) May let contracts and hire agents and employees to carry out the powers and duties of the receiver.

(g) Shall honor all leases, mortgages, and secured transactions governing the building in which the facility is located and all goods and fixtures in the building of which the receiver has taken possession, but only to the extent of payments which, in the case of a rental agreement, are for the use of the property during the period of the receivership, or which, in the case of a purchase agreement, become due during the period of the receivership.

(h) Shall have full power to direct and manage and to discharge employees of the facility, subject to any contract rights they may have. The receiver shall pay employees at the rate of compensation, including benefits, approved by the court. A receivership does not relieve the owner of any obligation to employees made prior to the appointment of a receiver and not carried out by the receiver.

(i) Shall be entitled to and take possession of all property or assets of residents which are in the possession of a facility or its owner. The receiver shall preserve all property, assets, and records of residents of which the receiver takes possession and shall provide for the prompt transfer of the property, assets, and records to the new placement of any transferred resident. An inventory list certified by the owner and receiver shall be made immediately at the time the receiver takes possession of the facility.

(4)(a) A person who is served with notice of an order of the court appointing a receiver and of the receiver's name and address shall be liable to pay the receiver for any goods or services provided by the receiver after the date of the order if the person would have been liable for the goods or services as supplied by the owner. The receiver shall give a receipt for each payment and shall keep a copy of each receipt on file. The receiver shall deposit accounts received in a separate

account and shall use this account for all disbursements.

(b) The receiver may bring an action to enforce the liability created by paragraph (a).

(c) A payment to the receiver of any sum owing to the facility or its owner shall discharge any obligation to the facility to the extent of the payment.

(5)(a) A receiver may petition the court that he or she not be required to honor any lease, mortgage, secured transaction, or other wholly or partially executory contract entered into by the owner of the facility if the rent, price, or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rent, price, or rate of interest at the time the contract was entered into, or if any material provision of the agreement was unreasonable, when compared to contracts negotiated under similar conditions. Any relief in this form provided by the court shall be limited to the life of the receivership, unless otherwise determined by the court.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage, or security interest which the receiver has obtained a court order to avoid under paragraph (a), and if the real estate or goods are necessary for the continued operation of the facility under this section, the receiver may apply to the court to set a reasonable rental, price, or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing on the application within 15 days. The receiver shall send notice of the application to any known persons who own the property involved at least 10 days prior to the hearing. Payment by the receiver of the amount determined by the court to be reasonable is a defense to any action against the receiver for payment or for possession of the goods or real estate subject to the lease, security interest, or mortgage involved by any person who received such notice, but the payment does not relieve the owner of the facility of any liability for the difference between the amount paid by the receiver and the amount due under the original lease, security interest, or mortgage involved.

(6) The court shall set the compensation of the receiver, which will be considered a necessary expense of a receivership.

(7) A receiver may be held liable in a personal capacity only for the receiver's own gross negligence, intentional acts, or breach of fiduciary duty.

(8) The court may require a receiver to post a bond.

(9) The court may direct the agency to allocate funds from the Health Care Trust Fund to the receiver, subject to the provisions of s. 400.418(1).

(10) The court may terminate a receivership when:

(a) The court determines that the receivership is no longer necessary because the conditions which gave rise to the receivership no longer exist or the agency grants the facility a new license; or

(b) All of the residents in the facility have been transferred or discharged.

(11) Within 30 days after termination, the receiver shall give the court a complete accounting of all property of which the receiver has taken possession, of all funds collected, and of the expenses of the receivership.

(12) Nothing in this section shall be deemed to relieve any owner, administrator, or employee of a facility placed in receivership of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner, administrator, or employee prior to the appointment of a receiver; nor shall anything contained in this section be construed to suspend during the receivership any obligation of the owner, administrator, or employee for payment of taxes or other

operating and maintenance expenses of the facility or of the owner, administrator, employee, or any other person for the payment of mortgages or liens. The owner shall retain the right to sell or mortgage any facility under receivership, subject to approval of the court which ordered the receivership.

**History.**--ss. 12, 22, ch. 80-198; s. 255, ch. 81-259; s. 2, ch. 81-318; ss. 51, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 14, ch. 91-263; ss. 18, 38, 39, ch. 93-216; s. 774, ch. 95-148; s. 15, ch. 98-80.

**400.423 Internal risk management and quality assurance program; adverse incidents and reporting requirements.**--

(1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.

(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means:

(a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident.

(b) Abuse, neglect, or exploitation as defined in s. 415.102;

(c) Events reported to law enforcement; or

(d) Elopement.

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

(5) Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if

applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.

(6) The agency shall annually submit to the Legislature a report on assisted living facility adverse incident reports. The report must include the following information arranged by county:

(a) A total number of adverse incidents;

(b) A listing, by category, of the type of adverse incidents occurring within each category and the type of staff involved;

(c) A listing, by category, of the types of injuries, if any, and the number of injuries occurring within each category;

(d) Types of liability claims filed based on an adverse incident report or reportable injury; and

(e) Disciplinary action taken against staff, categorized by the type of staff involved.

(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.

(8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.

(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.

(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.

**History.**--s. 36, ch. 2001-45.

**400.424 Contracts.**--

(1) The presence of each resident in a facility shall be covered by a contract, executed at the time of admission or prior thereto, between the licensee and the resident or his or her designee or legal representative. Each party to the contract shall be provided with a duplicate original thereof, and the licensee shall keep on file in the facility all such contracts. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration.

(2) Each contract must contain express provisions specifically setting forth the services and accommodations to be provided by the facility; the rates or charges; provision for at least 30 days' written notice of a rate increase; the rights, duties, and obligations of the residents, other than those specified in s. 400.428; and other matters that the parties deem appropriate. Whenever money is deposited or advanced by a resident in a contract as security for performance of the

contract agreement or as advance rent for other than the next immediate rental period:

(a) Such funds shall be deposited in a banking institution in this state that is located, if possible, in the same community in which the facility is located; shall be kept separate from the funds and property of the facility; may not be represented as part of the assets of the facility on financial statements; and shall be used, or otherwise expended, only for the account of the resident.

(b) The licensee shall, within 30 days of receipt of advance rent or a security deposit, notify the resident or residents in writing of the manner in which the licensee is holding the advance rent or security deposit and state the name and address of the depository where the moneys are being held. The licensee shall notify residents of the facility's policy on advance deposits.

(3)(a) The contract shall include a refund policy to be implemented at the time of a resident's transfer, discharge, or death. The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them. The contract shall also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of death or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract. However, a resident may not be required to provide the licensee with more than 30 days' notice of termination. If after a contract is terminated, the facility intends to make a claim against a refund due the resident, the facility shall notify the resident or responsible party in writing of the claim and shall provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or death of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 400.418.

(b) If a licensee agrees to reserve a bed for a resident who is admitted to a medical facility, including, but not limited to, a nursing home, health care facility, or psychiatric facility, the resident or his or her responsible party shall notify the licensee of any change in status that would prevent the resident from returning to the facility. Until such notice is received, the agreed-upon daily rate may be charged by the licensee.

(c) The purpose of any advance payment and a refund policy for such payment, including any advance payment for housing, meals, or personal services, shall be covered in the contract.

(4) The contract shall state whether or not the facility is affiliated with any religious organization and, if so, which organization and its general responsibility to the facility.

(5) Neither the contract nor any provision thereof relieves any licensee of any requirement or obligation imposed upon it by this part or rules adopted under this part.

(6) In lieu of the provisions of this section, facilities certified under chapter 651 shall comply with the requirements of s. 651.055.

(7) Notwithstanding the provisions of this section, facilities which consist of 60 or more

apartments may require refund policies and termination notices in accordance with the provisions of part II of chapter 83, provided that the lease is terminated automatically without financial penalty in the event of a resident's death or relocation due to psychiatric hospitalization or to medical reasons which necessitate services or care beyond which the facility is licensed to provide. The date of termination in such instances shall be the date the unit is fully vacated. A lease may be substituted for the contract if it meets the disclosure requirements of this section. For the purpose of this section, the term "apartment" means a room or set of rooms with a kitchen or kitchenette and lavatory located within one or more buildings containing other similar or like residential units.

(8) The department may by rule clarify terms, establish procedures, clarify refund policies and contract provisions, and specify documentation as necessary to administer this section.

**History.**--s. 11, ch. 75-233; ss. 12, 23, ch. 80-198; s. 2, ch. 81-318; ss. 52, 79, 83, ch. 83-181; s. 10, ch. 87-371; s. 1, ch. 88-364; s. 15, ch. 91-263; ss. 19, 38, 39, ch. 93-216; s. 775, ch. 95-148; s. 2, ch. 98-148.

**400.4255 Use of personnel; emergency care.**--

(1)(a) Persons under contract to the facility, facility staff, or volunteers, who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), and others as defined by rule, may administer medications to residents, take residents' vital signs, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by a physician, observe residents, document observations on the appropriate resident's record, report observations to the resident's physician, and contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 400.426. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician.

(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's physician. However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility.

(c) In an emergency situation, licensed personnel may carry out their professional duties pursuant to part I of chapter 464 until emergency medical personnel assume responsibility for care.

(2) In facilities licensed to provide extended congregate care, persons under contract to the facility, facility staff, or volunteers, who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), or those persons certified as nursing assistants pursuant to part II of chapter 464, may also perform all duties within the scope of their license or certification, as approved by the facility administrator and pursuant to this part.

(3) Facility staff may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and rules adopted by the department. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

**History.**--ss. 16, 38, ch. 91-263; ss. 20, 38, 39, ch. 93-216; s. 4, ch. 99-331; s. 3, ch. 2000-295; s. 100, ch. 2000-318.

**400.4256 Assistance with self-administration of medication.**--

(1) For the purposes of this section, the term:

(a) "Informed consent" means advising the resident, or the resident's surrogate, guardian, or attorney in fact, that an assisted living facility is not required to have a licensed nurse on staff, that the resident may be receiving assistance with self-administration of medication from an unlicensed person, and that such assistance, if provided by an unlicensed person, will or will not be overseen by a licensed nurse.

(b) "Unlicensed person" means an individual not currently licensed to practice nursing or medicine who is employed by or under contract to an assisted living facility and who has received training with respect to assisting with the self-administration of medication in an assisted living facility as provided under s. 400.452 prior to providing such assistance as described in this section.

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident.

(b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth.

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

(f) Keeping a record of when a resident receives assistance with self-administration under this section.

(4) Assistance with self-administration does not include:

(a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

(b) The preparation of syringes for injection or the administration of medications by any injectable route.

(c) Administration of medications through intermittent positive pressure breathing machines or a nebulizer.

(d) Administration of medications by way of a tube inserted in a cavity of the body.

(e) Administration of parenteral preparations.

(f) Irrigations or debriding agents used in the treatment of a skin condition.

(g) Rectal, urethral, or vaginal preparations.

(h) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.

(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.

(6) The department may by rule establish facility procedures and interpret terms as necessary to implement this section.

**History.**--s. 16, ch. 98-80; s. 214, ch. 99-13.

**400.426 Appropriateness of placements; examinations of residents.**--

(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Family Services, the administrator must notify the appropriate contact person in the applicable department.

(2) A physician or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility.

(3) Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

(4) If possible, each resident shall have been examined by a licensed physician or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall

become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 400.407(3)(b)6.

(5) Except as provided in s. 400.407, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.

(6) Any resident accepted in a facility and placed by the department or the Department of Children and Family Services shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Family Services must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of optional state supplementation require such assistance.

(7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

(8) The Department of Children and Family Services may require an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Family Services; or long-term care ombudsman council member who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings shall be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

(9) If, at any time after admission to a facility, a resident appears to need care beyond that which the facility is licensed to provide, the agency shall require the resident to be physically examined by a licensed physician or licensed nurse practitioner. This examination shall, to the extent possible, be performed by the resident's preferred physician or nurse practitioner and shall be paid for by the resident with personal funds, except as provided in s. 400.418(1)(b). Following this examination, the examining physician or licensed nurse practitioner shall complete and sign a medical form provided by the agency. The completed medical form shall be submitted to the

agency within 30 days after the date the facility owner or administrator is notified by the agency that the physical examination is required. After consultation with the physician or licensed nurse practitioner who performed the examination, a medical review team designated by the agency shall then determine whether the resident is appropriately residing in the facility. The medical review team shall base its decision on a comprehensive review of the resident's physical and functional status, including the resident's preferences, and not on an isolated health-related problem. In the case of a mental health resident, if the resident appears to have needs in addition to those identified in the community living support plan, the agency may require an evaluation by a mental health professional, as determined by the Department of Children and Family Services. A facility may not be required to retain a resident who requires more services or care than the facility is able to provide in accordance with its policies and criteria for admission and continued residency. Members of the medical review team making the final determination may not include the agency personnel who initially questioned the appropriateness of a resident's placement. Such determination is final and binding upon the facility and the resident. Any resident who is determined by the medical review team to be inappropriately residing in a facility shall be given 30 days' written notice to relocate by the owner or administrator, unless the resident's continued residence in the facility presents an imminent danger to the health, safety, or welfare of the resident or a substantial probability exists that death or serious physical harm would result to the resident if allowed to remain in the facility.

(10) A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.

(11) Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

(12) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part VI of this chapter, shall be retained in a facility licensed under this part.

**History.**--ss. 12, 30, ch. 80-198; s. 2, ch. 81-318; ss. 53, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 6, ch. 85-145; s. 11, ch. 87-371; s. 19, ch. 89-294; s. 17, ch. 91-263; ss. 21, 38, 39, ch. 93-216; s. 776, ch. 95-148; s. 15, ch. 95-210; ss. 25, 49, ch. 95-418; s. 39, ch. 96-169; s. 5, ch. 97-82; s. 215, ch. 99-13; s. 101, ch. 2000-318; s. 75, ch. 2000-349; s. 37, ch. 2001-45; s. 61, ch. 2002-1.

**400.427 Property and personal affairs of residents.** --

(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated incompetent or incapacitated under state law, managing his or her own affairs.

(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

(2) A facility, or an owner, administrator, employee, or representative thereof, may not act as the guardian, trustee, or conservator for any resident of the assisted living facility or any of such resident's property. An owner, administrator, or staff member, or representative thereof, may not act as a competent resident's payee for social security, veteran's, or railroad benefits without the

consent of the resident. Any facility whose owner, administrator, or staff, or representative thereof, serves as representative payee for any resident of the facility shall file a surety bond with the agency in an amount equal to twice the average monthly aggregate income or personal funds due to residents, or expendable for their account, which are received by a facility. Any facility whose owner, administrator, or staff, or a representative thereof, is granted power of attorney for any resident of the facility shall file a surety bond with the agency for each resident for whom such power of attorney is granted. The surety bond shall be in an amount equal to twice the average monthly income of the resident, plus the value of any resident's property under the control of the attorney in fact. The bond shall be executed by the facility as principal and a licensed surety company. The bond shall be conditioned upon the faithful compliance of the facility with this section and shall run to the agency for the benefit of any resident who suffers a financial loss as a result of the misuse or misappropriation by a facility of funds held pursuant to this subsection. Any surety company that cancels or does not renew the bond of any licensee shall notify the agency in writing not less than 30 days in advance of such action, giving the reason for the cancellation or nonrenewal. Any facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility shall, on a monthly basis, be required to provide the resident a written statement of any transaction made on behalf of the resident pursuant to this subsection, and a copy of such statement given to the resident shall be retained in each resident's file and available for agency inspection.

(3) A facility, upon mutual consent with the resident, shall provide for the safekeeping in the facility of personal effects not in excess of $500 and funds of the resident not in excess of $200 cash, and shall keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500.

(4) Any funds or other property belonging to or due to a resident, or expendable for his or her account, which is received by a facility shall be trust funds which shall be kept separate from the funds and property of the facility and other residents or shall be specifically credited to such resident. Such trust funds shall be used or otherwise expended only for the account of the resident. At least once every 3 months, unless upon order of a court of competent jurisdiction, the facility shall furnish the resident and his or her guardian, trustee, or conservator, if any, a complete and verified statement of all funds and other property to which this subsection applies, detailing the amount and items received, together with their sources and disposition. In any event, the facility shall furnish such statement annually and upon the discharge or transfer of a resident. Any governmental agency or private charitable agency contributing funds or other property to the account of a resident shall also be entitled to receive such statement annually and upon the discharge or transfer of the resident.

(5) Any personal funds available to facility residents may be used by residents as they choose to obtain clothing, personal items, leisure activities, and other supplies and services for their personal use. A facility may not demand, require, or contract for payment of all or any part of the personal funds in satisfaction of the facility rate for supplies and services beyond that amount agreed to in writing and may not levy an additional charge to the individual or the account for any supplies or services that the facility has agreed by contract to provide as part of the standard monthly rate. Any service or supplies provided by the facility which are charged separately to the individual or the account may be provided only with the specific written consent of the individual, who shall be furnished in advance of the provision of the services or supplies with an itemized written statement to be attached to the contract setting forth the charges for the services or supplies.

(6)(a) In addition to any damages or civil penalties to which a person is subject, any person who:

1. Intentionally withholds a resident's personal funds, personal property, or personal needs allowance, or who demands, beneficially receives, or contracts for payment of all or any part of a resident's personal property or personal needs allowance in satisfaction of the facility rate for supplies and services; or

2. Borrows from or pledges any personal funds of a resident, other than the amount agreed to by written contract under s. 400.424,

commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Any facility owner, administrator, or staff, or representative thereof, who is granted power of attorney for any resident of the facility and who misuses or misappropriates funds obtained through this power commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(7) In the event of the death of a resident, a licensee shall return all refunds, funds, and property held in trust to the resident's personal representative, if one has been appointed at the time the facility disburses such funds, and, if not, to the resident's spouse or adult next of kin named in a beneficiary designation form provided by the facility to the resident. If the resident has no spouse or adult next of kin or such person cannot be located, funds due the resident shall be placed in an interest-bearing account, and all property held in trust by the facility shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code. Such funds shall be kept separate from the funds and property of the facility and other residents of the facility. If the funds of the deceased resident are not disbursed pursuant to the Florida Probate Code within 2 years after the resident's death, the funds shall be deposited in the Health Care Trust Fund administered by the agency.

(8) The department may by rule clarify terms and specify procedures and documentation necessary to administer the provisions of this section relating to the proper management of residents' funds and personal property and the execution of surety bonds.

**History.**--s. 12, ch. 75-233; ss. 12, 24, ch. 80-198; s. 2, ch. 81-152; s. 2, ch. 81-318; ss. 4, 19, ch. 82-148; ss. 54, 79, 83, ch. 83-181; s. 3, ch. 86-104; s. 12, ch. 87-371; s. 72, ch. 91-224; s. 18, ch. 91-263; ss. 22, 38, 39, ch. 93-216; s. 777, ch. 95-148; s. 3, ch. 98-148; s. 216, ch. 99-13.

**400.4275 Business practice; personnel records; liability insurance.**--The assisted living facility shall be administered on a sound financial basis that is consistent with good business practices.

(1) The administrator or owner of a facility shall maintain accurate business records that identify, summarize, and classify funds received and expenses disbursed and shall use written accounting procedures and a recognized accounting system.

(2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule.

(3) The administrator or owner of a facility shall maintain liability insurance coverage that is in force at all times.

(4) The department may by rule clarify terms, establish requirements for financial records, accounting procedures, personnel procedures, insurance coverage, and reporting procedures, and specify documentation as necessary to implement the requirements of this section.

**History.**--s. 4, ch. 98-148.

**400.428 Resident bill of rights.**--

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States

as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.

(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.

(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.

(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 400.427.

(g) Share a room with his or her spouse if both are residents of the facility.

(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.

(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or

explained to residents who cannot read. This notice shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline and, when applicable, the Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council, where complaints may be lodged. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, Advocacy Center for Persons with Disabilities, Inc., and the Florida local advocacy council.

(3)(a) The agency shall conduct a survey to determine general compliance with facility standards and compliance with residents' rights as a prerequisite to initial licensure or licensure renewal.

(b) In order to determine whether the facility is adequately protecting residents' rights, the biennial survey shall include private informal conversations with a sample of residents and consultation with the ombudsman council in the planning and service area in which the facility is located to discuss residents' experiences within the facility.

(c) During any calendar year in which no survey is conducted, the agency shall conduct at least one monitoring visit of each facility cited in the previous year for a class I or class II violation, or more than three uncorrected class III violations.

(d) The agency may conduct periodic followup inspections as necessary to monitor the compliance of facilities with a history of any class I, class II, or class III violations that threaten the health, safety, or security of residents.

(e) The agency may conduct complaint investigations as warranted to investigate any allegations of noncompliance with requirements required under this part or rules adopted under this part.

(4) The facility shall not hamper or prevent residents from exercising their rights as specified in this section.

(5) No facility or employee of a facility may serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, inside or outside the facility.

(c) Files a civil action alleging a violation of the provisions of this part or notifies a state attorney or the Attorney General of a possible violation of such provisions.

(6) Any facility which terminates the residency of an individual who participated in activities specified in subsection (5) shall show good cause in a court of competent jurisdiction.

(7) Any person who submits or reports a complaint concerning a suspected violation of the provisions of this part or concerning services and conditions in facilities, or who testifies in any administrative or judicial proceeding arising from such a complaint, shall have immunity from any civil or criminal liability therefor, unless such person has acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

**History.**--ss. 12, 31, ch. 80-198; s. 2, ch. 81-318; ss. 55, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 65, ch. 91-221; s. 19, ch. 91-263; ss. 23, 38, 39, ch. 93-216; s. 778, ch. 95-148; s. 11, ch. 95-418; s. 17, ch. 98-80; s. 20, ch. 2000-263; ss. 76, 143, ch. 2000-349; s. 63, ch. 2000-367; s. 38, ch. 2001-45.

**400.429 Civil actions to enforce rights.**--

(1) Any person or resident whose rights as specified in this part are violated shall have a cause of action. The action may be brought by the resident or his or her guardian, or by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death. If the action alleges a claim for the resident's rights or for negligence that caused the death of the resident, the claimant shall be required to elect either survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for the resident's rights or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual damages, and punitive damages for violation of the rights of a resident or negligence. Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 400.429-400.4303 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in s. 400.428. This section does not preclude theories of recovery not arising out of negligence or s. 400.428 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 400.429-400.4303.

(2) In any claim brought pursuant to this part alleging a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

Nothing in this part shall be interpreted to create strict liability. A violation of the rights set forth in s. 400.428 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(3) In any claim brought pursuant to this section, a licensee, person, or entity shall have a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(4) In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse shall have the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(5) Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(6) In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the

conduct that caused the actual harm to the resident.

(7) The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the Agency for Health Care Administration at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The requirement of providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

**History.**--ss. 12, 32, ch. 80-198; s. 2, ch. 81-318; ss. 56, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; ss. 24, 38, 39, ch. 93-216; s. 779, ch. 95-148; s. 31, ch. 99-225; s. 39, ch. 2001-45.

**400.4293 Presuit notice; investigation; notification of violation of residents' rights or alleged negligence; claims evaluation procedure; informal discovery; review; settlement offer; mediation.**--

(1) As used in this section, the term:

(a) "Claim for residents' rights violation or negligence" means a negligence claim alleging injury to or the death of a resident arising out of an asserted violation of the rights of a resident under s. 400.428 or an asserted deviation from the applicable standard of care.

(b) "Insurer" means any self-insurer authorized under s. 627.357, liability insurance carrier, joint underwriting association, or uninsured prospective defendant.

(2) Prior to filing a claim for a violation of a resident's rights or a claim for negligence, a claimant alleging injury to or the death of a resident shall notify each prospective defendant by certified mail, return receipt requested, of an asserted violation of a resident's rights provided in s. 400.428 or deviation from the standard of care. Such notification shall include an identification of the rights the prospective defendant has violated and the negligence alleged to have caused the incident or incidents and a brief description of the injuries sustained by the resident which are reasonably identifiable at the time of notice. The notice shall contain a certificate of counsel that counsel's reasonable investigation gave rise to a good faith belief that grounds exist for an action against each prospective defendant.

(3)(a) No suit may be filed for a period of 75 days after notice is mailed to any prospective defendant. During the 75-day period, the prospective defendants or their insurers shall conduct an evaluation of the claim to determine the liability of each defendant and to evaluate the damages of the claimants. Each defendant or insurer of the defendant shall have a procedure for the prompt evaluation of claims during the 75-day period. The procedure shall include one or more of the following:

1. Internal review by a duly qualified facility risk manager or claims adjuster;

2. Internal review by counsel for each prospective defendant;

3. A quality assurance committee authorized under any applicable state or federal statutes or regulations; or

4. Any other similar procedure that fairly and promptly evaluates the claims.

Each defendant or insurer of the defendant shall evaluate the claim in good faith.

(b) At or before the end of the 75 days, the defendant or insurer of the defendant shall provide the claimant with a written response:

1. Rejecting the claim; or

2. Making a settlement offer.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer of the defendant to reply to the notice within 75 days after receipt shall be deemed a rejection of the claim for purposes of this section.

(4) The notification of a violation of a resident's rights or alleged negligence shall be served within the applicable statute of limitations period; however, during the 75-day period, the statute of limitations is tolled as to all prospective defendants. Upon stipulation by the parties, the 75-day period may be extended and the statute of limitations is tolled during any such extension. Upon receiving written notice by certified mail, return receipt requested, of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(5) No statement, discussion, written document, report, or other work product generated by presuit claims evaluation procedures under this section is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit claims evaluation procedure. Any licensed physician or registered nurse may be retained by either party to provide an opinion regarding the reasonable basis of the claim. The presuit opinions of the expert are not discoverable or admissible in any civil action for any purpose by the opposing party.

(6) Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery as provided in subsection (7).

(7) Informal discovery may be used by a party to obtain unsworn statements and the production of documents or things, as follows:

(a) *Unsworn statements.*--Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(b) *Documents or things.*--Any party may request discovery of relevant documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce relevant and discoverable documents or things within that party's possession or control, if in good faith it can reasonably be done within the timeframe of the claims evaluation process.

(8) Each request for and notice concerning informal discovery pursuant to this section must be in writing, and a copy thereof must be sent to all parties. Such a request or notice must bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice, and the manner of service thereof.

(9) If a prospective defendant makes a written settlement offer, the claimant shall have 15 days from the date of receipt to accept the offer. An offer shall be deemed rejected unless accepted by

delivery of a written notice of acceptance.

(10) To the extent not inconsistent with this part, the provisions of the Florida Mediation Code, Florida Rules of Civil Procedure, shall be applicable to such proceedings.

(11) Within 30 days after the claimant's receipt of defendant's response to the claim, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with the mediation rules of practice and procedures adopted by the Supreme Court. Upon stipulation of the parties, this 30-day period may be extended and the statute of limitations is tolled during the mediation and any such extension. At the conclusion of mediation, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

**History.**--s. 40, ch. 2001-45.

**400.4294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.**--

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility within 10 days, in accordance with the provisions of s. 400.145, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements under this part by the requesting party.

(2) No facility shall be held liable for any civil damages as a result of complying with this section.

**History.**--s. 41, ch. 2001-45.

**400.4295 Certain provisions not applicable to actions under this part.**--An action under this part for a violation of rights or negligence recognized herein is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

**History.**--s. 42, ch. 2001-45.

**400.4296 Statute of limitations.**--

(1) Any action for damages brought under this part shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence; however, in no event shall the action be commenced later than 4 years from the date of the incident or occurrence out of which the cause of action accrued.

(2) In those actions covered by this subsection in which it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event not more than 6 years from the date the incident giving rise to the injury occurred.

(3) This section shall apply to causes of action that have accrued prior to the effective date of this section; however, any such cause of action that would not have been barred under prior law may be brought within the time allowed by prior law or within 2 years after the effective date of this section, whichever is earlier, and will be barred thereafter. In actions where it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event more than 4 years from the effective

date of this section.

**History.**--s. 43, ch. 2001-45.

**400.4297 Punitive damages; pleading; burden of proof.**--

(1) In any action for damages brought under this part, no claim for punitive damages shall be permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. No discovery of financial worth shall proceed until after the pleading concerning punitive damages is permitted.

(2) A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of an employer, principal, corporation, or other legal entity, punitive damages may be imposed for the conduct of an employee or agent only if the conduct of the employee or agent meets the criteria specified in subsection (2) and:

(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;

(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or

(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.

(4) The plaintiff must establish at trial, by clear and convincing evidence, its entitlement to an award of punitive damages. The "greater weight of the evidence" burden of proof applies to a determination of the amount of damages.

(5) This section is remedial in nature and shall take effect upon becoming a law.

**History.**--s. 44, ch. 2001-45.

**400.4298 Punitive damages; limitation.**--

(1)(a) Except as provided in paragraphs (b) and (c), an award of punitive damages may not exceed the greater of:

1. Three times the amount of compensatory damages awarded to each claimant entitled thereto,

consistent with the remaining provisions of this section; or

2. The sum of $1 million.

(b) Where the fact finder determines that the wrongful conduct proven under this section was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant, it may award an amount of punitive damages not to exceed the greater of:

1. Four times the amount of compensatory damages awarded to each claimant entitled thereto, consistent with the remaining provisions of this section; or

2. The sum of $4 million.

(c) Where the fact finder determines that at the time of injury the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there shall be no cap on punitive damages.

(d) This subsection is not intended to prohibit an appropriate court from exercising its jurisdiction under s. 768.74 in determining the reasonableness of an award of punitive damages that is less than three times the amount of compensatory damages.

(e) In any case in which the findings of fact support an award of punitive damages pursuant to paragraph (b) or paragraph (c), the clerk of the court shall refer the case to the appropriate law enforcement agencies, to the state attorney in the circuit where the long-term care facility that is the subject of the underlying civil cause of action is located, and, for multijurisdictional facility owners, to the Office of the Statewide Prosecutor; and such agencies, state attorney, or Office of the Statewide Prosecutor shall initiate a criminal investigation into the conduct giving rise to the award of punitive damages. All findings by the trier of fact which support an award of punitive damages under this paragraph shall be admissible as evidence in any subsequent civil or criminal proceeding relating to the acts giving rise to the award of punitive damages under this paragraph.

(2) The claimant's attorney's fees, if payable from the judgment, are, to the extent that the fees are based on the punitive damages, calculated based on the final judgment for punitive damages. This subsection does not limit the payment of attorney's fees based upon an award of damages other than punitive damages.

(3) The jury may neither be instructed nor informed as to the provisions of this section.

(4) Notwithstanding any other law to the contrary, the amount of punitive damages awarded pursuant to this section shall be equally divided between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund, in accordance with the following provisions:

(a) The clerk of the court shall transmit a copy of the jury verdict to the Chief Financial Officer by certified mail. In the final judgment, the court shall order the percentages of the award, payable as provided herein.

(b) A settlement agreement entered into between the original parties to the action after a verdict has been returned must provide a proportionate share payable to the Quality of Long-Term Care Facility Improvement Trust Fund specified herein. For purposes of this paragraph, a proportionate share is a 50-percent share of that percentage of the settlement amount which the punitive damages portion of the verdict bore to the total of the compensatory and punitive damages in the verdict.

(c) The Department of Financial Services shall collect or cause to be collected all payments due the state under this section. Such payments are made to the Chief Financial Officer and deposited in the appropriate fund specified in this subsection.

(d) If the full amount of punitive damages awarded cannot be collected, the claimant and the other recipient designated pursuant to this subsection are each entitled to a proportionate share of the punitive damages collected.

(5) This section is remedial in nature and shall take effect upon becoming a law.

**History.**--s. 45, ch. 2001-45; s. 419, ch. 2003-261.

**400.431 Closing of facility; notice; penalty.**--

(1) Whenever a facility voluntarily discontinues operation, it shall inform the agency in writing at least 90 days prior to the discontinuance of operation. The facility shall also inform each resident or the next of kin, legal representative, or agency acting on each resident's behalf, of the fact and the proposed time of such discontinuance, following the notification requirements provided in s. 400.428(1)(k). In the event a resident has no person to represent him or her, the facility shall be responsible for referral to an appropriate social service agency for placement.

(2) Immediately upon the notice by the agency of the voluntary or involuntary termination of such operation, the agency shall monitor the transfer of residents to other facilities and ensure that residents' rights are being protected. The department, in consultation with the Department of Children and Family Services, shall specify procedures for ensuring that all residents who receive services are appropriately relocated.

(3) All charges shall be prorated as of the date on which the facility discontinues operation, and if any payments have been made in advance, the payments for services not received shall be refunded to the resident or the resident's guardian within 10 working days of voluntary or involuntary closure of the facility, whether or not such refund is requested by the resident or guardian.

(4) Immediately upon discontinuance of the operation of a facility, the owner shall surrender the license therefor to the agency, and the license shall be canceled.

(5) The agency may levy a fine in an amount no greater than $5,000 upon each person or business entity that owns any interest in a facility that terminates operation without providing notice to the agency and the residents of the facility at least 30 days before operation ceases. This fine shall not be levied against any facility involuntarily closed at the initiation of the agency. The agency shall use the proceeds of the fines to operate the facility until all residents of the facility are relocated and shall deposit any balance of the proceeds into the Health Care Trust Fund established pursuant to s. 400.418.

**History.**--s. 13, ch. 75-233; ss. 12, 25, ch. 80-198; s. 2, ch. 81-318; ss. 57, 79, 83, ch. 83-181; s. 20, ch. 91-263; ss. 25, 38, 39, ch. 93-216; s. 780, ch. 95-148; s. 50, ch. 95-418; s. 123, ch. 99-8.

**400.434 Right of entry and inspection.**--Any duly designated officer or employee of the department, the Department of Children and Family Services, the agency, the Medicaid Fraud Control Unit of the Department of Legal Affairs, the state or local fire marshal, or a member of the state or local long-term care ombudsman council shall have the right to enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with the provisions of this part and of rules or standards in force pursuant thereto. The right of entry and inspection shall also extend to any premises which the agency has reason to believe is being operated or maintained as a facility without a license; but no such entry or inspection of any premises may be made without the permission of the owner or person in charge

thereof, unless a warrant is first obtained from the circuit court authorizing such entry. The warrant requirement shall extend only to a facility which the agency has reason to believe is being operated or maintained as a facility without a license. Any application for a license or renewal thereof made pursuant to this part shall constitute permission for, and complete acquiescence in, any entry or inspection of the premises for which the license is sought, in order to facilitate verification of the information submitted on or in connection with the application; to discover, investigate, and determine the existence of abuse or neglect; or to elicit, receive, respond to, and resolve complaints. Any current valid license shall constitute unconditional permission for, and complete acquiescence in, any entry or inspection of the premises by authorized personnel. The agency shall retain the right of entry and inspection of facilities that have had a license revoked or suspended within the previous 24 months, to ensure that the facility is not operating unlawfully. However, before entering the facility, a statement of probable cause must be filed with the director of the agency, who must approve or disapprove the action within 48 hours. Probable cause shall include, but is not limited to, evidence that the facility holds itself out to the public as a provider of personal care services or the receipt of a complaint by the long-term care ombudsman council about the facility. Data collected by the state or local long-term care ombudsman councils or the state or local advocacy councils may be used by the agency in investigations involving violations of regulatory standards.

**History.**--s. 14, ch. 75-233; s. 1, ch. 77-174; ss. 12, 26, ch. 80-198; s. 2, ch. 81-318; ss. 10, 18, 19, ch. 82-148; ss. 58, 79, 83, ch. 83-181; s. 1, ch. 88-350; s. 24, ch. 93-177; ss. 26, 38, 39, ch. 93-216; s. 51, ch. 95-418; s. 124, ch. 99-8; s. 144, ch. 2000-349; s. 64, ch. 2000-367; s. 46, ch. 2001-45; s. 3, ch. 2004-344.

**400.435 Maintenance of records; reports.** --

(1) Every facility shall maintain, as public information available for public inspection under such conditions as the agency shall prescribe, records containing copies of all inspection reports pertaining to the facility that have been issued by the agency to the facility. Copies of inspection reports shall be retained in the records for 5 years from the date the reports are filed or issued.

(2) Within 60 days after the date of the biennial inspection visit or within 30 days after the date of any interim visit, the agency shall forward the results of the inspection to the local ombudsman council in whose planning and service area, as defined in part II, the facility is located; to at least one public library or, in the absence of a public library, the county seat in the county in which the inspected assisted living facility is located; and, when appropriate, to the district Adult Services and Mental Health Program Offices.

(3) Every facility shall post a copy of the last inspection report of the agency for that facility in a prominent location within the facility so as to be accessible to all residents and to the public. Upon request, the facility shall also provide a copy of the report to any resident of the facility or to an applicant for admission to the facility.

**History.**--ss. 12, 27, ch. 80-198; s. 2, ch. 81-318; ss. 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 1, ch. 88-145; s. 19, ch. 90-347; s. 21, ch. 91-263; ss. 27, 38, 39, ch. 93-216; s. 16, ch. 95-210; s. 57, ch. 2000-139; s. 145, ch. 2000-349; s. 65, ch. 2000-367.

**400.441 Rules establishing standards.** --

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of

Children and Family Services, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for and maintenance of facilities, not in conflict with the provisions of chapter 553, relating to plumbing, heating, cooling, lighting, ventilation, living space, and other housing conditions, which will ensure the health, safety, and comfort of residents and protection from fire hazard, including adequate provisions for fire alarm and other fire protection suitable to the size of the structure. Uniform firesafety standards shall be established and enforced by the State Fire Marshal in cooperation with the agency, the department, and the Department of Health.

1. Evacuation capability determination.--

a. The provisions of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, shall be used for determining the ability of the residents, with or without staff assistance, to relocate from or within a licensed facility to a point of safety as provided in the fire codes adopted herein. An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure. For existing licensed facilities that are not equipped with an automatic fire sprinkler system, the administrator shall evaluate the evacuation capability of residents at least annually. The evacuation capability evaluation for each facility not equipped with an automatic fire sprinkler system shall be validated, without liability, by the State Fire Marshal, by the local fire marshal, or by the local authority having jurisdiction over firesafety, before the license renewal date. If the State Fire Marshal, local fire marshal, or local authority having jurisdiction over firesafety has reason to believe that the evacuation capability of a facility as reported by the administrator may have changed, it may, with assistance from the facility administrator, reevaluate the evacuation capability through timed exiting drills. Translation of timed fire exiting drills to evacuation capability may be determined:

(I) Three minutes or less: prompt.

(II) More than 3 minutes, but not more than 13 minutes: slow.

(III) More than 13 minutes: impractical.

b. The Office of the State Fire Marshal shall provide or cause the provision of training and education on the proper application of Chapter 5, NFPA 101A, 1995 edition, to its employees, to staff of the Agency for Health Care Administration who are responsible for regulating facilities under this part, and to local governmental inspectors. The Office of the State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.

c. The Office of the State Fire Marshal, in cooperation with provider associations, shall provide or cause the provision of a training program designed to inform facility operators on how to properly review bid documents relating to the installation of automatic fire sprinklers. The Office of the State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.

d. The administrator of a licensed facility shall sign an affidavit verifying the number of residents occupying the facility at the time of the evacuation capability evaluation.

2. Firesafety requirements.--

a. Except for the special applications provided herein, effective January 1, 1996, the provisions of the National Fire Protection Association, Life Safety Code, NFPA 101, 1994 edition, Chapter 22 for

new facilities and Chapter 23 for existing facilities shall be the uniform fire code applied by the State Fire Marshal for assisted living facilities, pursuant to s. 633.022.

b. Any new facility, regardless of size, that applies for a license on or after January 1, 1996, must be equipped with an automatic fire sprinkler system. The exceptions as provided in section 22-2.3.5.1, NFPA 101, 1994 edition, as adopted herein, apply to any new facility housing eight or fewer residents. On July 1, 1995, local governmental entities responsible for the issuance of permits for construction shall inform, without liability, any facility whose permit for construction is obtained prior to January 1, 1996, of this automatic fire sprinkler requirement. As used in this part, the term "a new facility" does not mean an existing facility that has undergone change of ownership.

c. Notwithstanding any provision of s. 633.022 or of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, to the contrary, any existing facility housing eight or fewer residents is not required to install an automatic fire sprinkler system, nor to comply with any other requirement in Chapter 23, NFPA 101, 1994 edition, that exceeds the firesafety requirements of NFPA 101, 1988 edition, that applies to this size facility, unless the facility has been classified as impractical to evacuate. Any existing facility housing eight or fewer residents that is classified as impractical to evacuate must install an automatic fire sprinkler system within the timeframes granted in this section.

d. Any existing facility that is required to install an automatic fire sprinkler system under this paragraph need not meet other firesafety requirements of Chapter 23, NFPA 101, 1994 edition, which exceed the provisions of NFPA 101, 1988 edition. The mandate contained in this paragraph which requires certain facilities to install an automatic fire sprinkler system supersedes any other requirement.

e. This paragraph does not supersede the exceptions granted in NFPA 101, 1988 edition or 1994 edition.

f. This paragraph does not exempt facilities from other firesafety provisions adopted under s. 633.022 and local building code requirements in effect before July 1, 1995.

g. A local government may charge fees only in an amount not to exceed the actual expenses incurred by local government relating to the installation and maintenance of an automatic fire sprinkler system in an existing and properly licensed assisted living facility structure as of January 1, 1996.

h. If a licensed facility undergoes major reconstruction or addition to an existing building on or after January 1, 1996, the entire building must be equipped with an automatic fire sprinkler system. Major reconstruction of a building means repair or restoration that costs in excess of 50 percent of the value of the building as reported on the tax rolls, excluding land, before reconstruction. Multiple reconstruction projects within a 5-year period the total costs of which exceed 50 percent of the initial value of the building at the time the first reconstruction project was permitted are to be considered as major reconstruction. Application for a permit for an automatic fire sprinkler system is required upon application for a permit for a reconstruction project that creates costs that go over the 50-percent threshold.

i. Any facility licensed before January 1, 1996, that is required to install an automatic fire sprinkler system shall ensure that the installation is completed within the following timeframes based upon evacuation capability of the facility as determined under subparagraph 1.:

(I) Impractical evacuation capability, 24 months.

(II) Slow evacuation capability, 48 months.

(III) Prompt evacuation capability, 60 months.

The beginning date from which the deadline for the automatic fire sprinkler installation requirement must be calculated is upon receipt of written notice from the local fire official that an automatic fire sprinkler system must be installed. The local fire official shall send a copy of the document indicating the requirement of a fire sprinkler system to the Agency for Health Care Administration.

j. It is recognized that the installation of an automatic fire sprinkler system may create financial hardship for some facilities. The appropriate local fire official shall, without liability, grant two 1-year extensions to the timeframes for installation established herein, if an automatic fire sprinkler installation cost estimate and proof of denial from two financial institutions for a construction loan to install the automatic fire sprinkler system are submitted. However, for any facility with a class I or class II, or a history of uncorrected class III, firesafety deficiencies, an extension must not be granted. The local fire official shall send a copy of the document granting the time extension to the Agency for Health Care Administration.

k. A facility owner whose facility is required to be equipped with an automatic fire sprinkler system under Chapter 23, NFPA 101, 1994 edition, as adopted herein, must disclose to any potential buyer of the facility that an installation of an automatic fire sprinkler requirement exists. The sale of the facility does not alter the timeframe for the installation of the automatic fire sprinkler system.

l. Existing facilities required to install an automatic fire sprinkler system as a result of construction-type restrictions in Chapter 23, NFPA 101, 1994 edition, as adopted herein, or evacuation capability requirements shall be notified by the local fire official in writing of the automatic fire sprinkler requirement, as well as the appropriate date for final compliance as provided in this subparagraph. The local fire official shall send a copy of the document to the Agency for Health Care Administration.

m. Except in cases of life-threatening fire hazards, if an existing facility experiences a change in the evacuation capability, or if the local authority having jurisdiction identifies a construction-type restriction, such that an automatic fire sprinkler system is required, it shall be afforded time for installation as provided in this subparagraph.

Facilities that are fully sprinkled and in compliance with other firesafety standards are not required to conduct more than one of the required fire drills between the hours of 11 p.m. and 7 a.m., per year. In lieu of the remaining drills, staff responsible for residents during such hours may be required to participate in a mock drill that includes a review of evacuation procedures. Such standards must be included or referenced in the rules adopted by the State Fire Marshal. Pursuant to s. 633.022(1)(b), the State Fire Marshal is the final administrative authority for firesafety standards established and enforced pursuant to this section. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

3. Resident elopement requirements.--Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the department after consultation with the Department of Community Affairs. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive

emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Department of Community Affairs. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over fire safety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health.

(e) License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(f) Inspections, complaint investigations, moratoriums, classification of deficiencies, levying and enforcement of penalties, and use of income from fees and fines.

(g) The enforcement of the resident bill of rights specified in s. 400.428.

(h) The care and maintenance of residents, which must include, but is not limited to:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The arrangement for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication;

6. The nutritional needs of residents;

7. Resident records; and

8. Internal risk management and quality assurance.

(i) Facilities holding a limited nursing, extended congregate care, or limited mental health license.

(j) The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(k) The use of physical or chemical restraints. The use of physical restraints is limited to half-bed

rails as prescribed and documented by the resident's physician with the consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.

(2) In adopting any rules pursuant to this part, the department, in conjunction with the agency, shall make distinct standards for facilities based upon facility size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Rules developed pursuant to this section shall not restrict the use of shared staffing and shared programming in facilities that are part of retirement communities that provide multiple levels of care and otherwise meet the requirements of law and rule. Except for uniform firesafety standards, the department shall adopt by rule separate and distinct standards for facilities with 16 or fewer beds and for facilities with 17 or more beds. The standards for facilities with 16 or fewer beds shall be appropriate for a noninstitutional residential environment, provided that the structure is no more than two stories in height and all persons who cannot exit the facility unassisted in an emergency reside on the first floor. The department, in conjunction with the agency, may make other distinctions among types of facilities as necessary to enforce the provisions of this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the department and the agency relative to the physical characteristics of facilities and the types of care offered therein.

(3) The department shall submit a copy of proposed rules to the Speaker of the House of Representatives, the President of the Senate, and appropriate committees of substance for review and comment prior to the promulgation thereof.

(a) Rules promulgated by the department shall encourage the development of homelike facilities which promote the dignity, individuality, personal strengths, and decisionmaking ability of residents.

(b) The agency, in consultation with the department, may waive rules promulgated pursuant to this part in order to demonstrate and evaluate innovative or cost-effective congregate care alternatives which enable individuals to age in place. Such waivers may be granted only in instances where there is reasonable assurance that the health, safety, or welfare of residents will not be endangered. To apply for a waiver, the licensee shall submit to the agency a written description of the concept to be demonstrated, including goals, objectives, and anticipated benefits; the number and types of residents who will be affected, if applicable; a brief description of how the demonstration will be evaluated; and any other information deemed appropriate by the agency. Any facility granted a waiver shall submit a report of findings to the agency and the department within 12 months. At such time, the agency may renew or revoke the waiver or pursue any regulatory or statutory changes necessary to allow other facilities to adopt the same practices. The department may by rule clarify terms and establish waiver application procedures, criteria for reviewing waiver proposals, and procedures for reporting findings, as necessary to implement this subsection.

(4) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in facilities which have a good record of past performance. However, a full inspection shall be conducted in facilities which have had a history of class I or class II violations, uncorrected class III violations, confirmed ombudsman council complaints, or confirmed licensure complaints, within the previous licensure period immediately preceding the inspection or when a potentially serious problem is identified during the abbreviated inspection. The agency, in consultation with the department, shall develop the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules. The department, in consultation with the agency, shall report annually to the Legislature concerning its implementation of this subsection. The report shall include, at a minimum, the key quality-of-care standards which have been developed; the number of facilities identified as being eligible for the abbreviated inspection; the number of facilities which have received the abbreviated inspection and, of those, the number that were converted to full inspection; the number and type of subsequent complaints received by the agency or department on facilities which have had abbreviated inspections; any recommendations for modification to this subsection; any plans by the agency to modify its implementation of this subsection; and any other information which the department believes should be reported.

(5) A fee shall be charged by the department to any person requesting a copy of this part or rules promulgated under this part. Such fees shall not exceed the actual cost of duplication and postage.

**History.**--s. 16, ch. 75-233; ss. 12, 29, ch. 80-198; s. 2, ch. 81-318; ss. 59, 79, 83, ch. 83-181; s. 7, ch. 85-145; s. 1, ch. 86-87; s. 13, ch. 87-371; s. 20, ch. 89-294; s. 22, ch. 91-263; s. 25, ch. 93-177; s. 26, ch. 93-211; ss. 28, 38, 39, ch. 93-216; ss. 12, 20, 52, ch. 95-418; s. 27, ch. 97-100; s. 99, ch. 97-101; s. 5, ch. 98-148; s. 15, ch. 99-332; s. 47, ch. 2001-45; s. 7, ch. 2004-298; s. 2, ch. 2004-386.

**400.442 Pharmacy and dietary services.**--

(1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations, including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 400.419, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

(2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening.

(3) The agency shall employ at least two pharmacists licensed pursuant to chapter 465 among its personnel who biennially inspect assisted living facilities licensed under this part, to participate in biennial inspections or consult with the agency regarding deficiencies relating to medicinal drugs or over-the-counter preparations.

(4) The department may by rule establish procedures and specify documentation as necessary to implement this section.

**History.**--s. 1, ch. 89-218; s. 1, ch. 90-192; s. 23, ch. 91-263; ss. 29, 38, 39, ch. 93-216; s. 17, ch. 95-210; s. 18, ch. 98-80; s. 6, ch. 98-148.

**400.444 Construction and renovation; requirements.**--

(1) The requirements for the construction and renovation of a facility shall comply with the provisions of chapter 553 which pertain to building construction standards, including plumbing, electrical code, glass, manufactured buildings, accessibility for persons with disabilities, and the state minimum building code and with the provisions of s. 633.022, which pertain to uniform firesafety standards.

(2) Upon notification by the local authority having jurisdiction over life-threatening violations which seriously threaten the health, safety, or welfare of a resident of a facility, the agency shall take action as specified in s. 400.414.

(3) The department may adopt rules to establish procedures and specify the documentation necessary to implement this section.

**History.**--s. 17, ch. 75-233; s. 3, ch. 79-152; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 30, 38, 39, ch. 93-216; s. 14, ch. 95-418; s. 7, ch. 98-148.

**400.4445 Compliance with local zoning requirements.**--No facility licensed under this part may commence any construction which will expand the size of the existing structure unless the licensee first submits to the agency proof that such construction will be in compliance with applicable local zoning requirements. Facilities with a licensed capacity of less than 15 persons shall comply with the provisions of chapter 419.

**History.**--s. 2, ch. 85-251; s. 24, ch. 91-263; ss. 31, 39, ch. 93-216.

**400.447 Prohibited acts; penalties for violation.**--

(1) It is unlawful for any person or public body to offer or advertise to the public, in any way by any medium whatever, personal services as defined in this act, without obtaining a valid current license. It is unlawful for any holder of a license issued pursuant to the provisions of this act to advertise or hold out to the public that it holds a license for a facility other than that for which it actually holds a license.

(2) It is unlawful for any holder of a license issued pursuant to the provisions of this act to withhold from the agency any evidence of financial instability, including, but not limited to, bad checks, delinquent accounts, nonpayment of withholding taxes, unpaid utility expenses, nonpayment for essential services, or adverse court action concerning the financial viability of the facility or any other facility licensed under part II or part III of this chapter which is owned by the licensee.

(3) Any person found guilty of violating subsection (1) or subsection (2) commits a misdemeanor of the second degree, punishable as provided in s. 775.083. Each day of continuing violation shall be considered a separate offense.

(4) While a facility is under construction, the owner may advertise to the public prior to obtaining a license. Facilities that are certified under chapter 651 shall comply with the advertising provisions of s. 651.095 rather than those provided for in this subsection.

(5) A freestanding facility shall not advertise or imply that any part of it is a nursing home. For the purpose of this subsection, "freestanding facility" means a facility that is not operated in conjunction with a nursing home to which residents of the facility are given priority when nursing care is required. A person who violates this subsection is subject to fine as specified in s. 400.419.

(6) Any facility which is affiliated with any religious organization or which has a name implying

religious affiliation shall include in its advertising whether or not it is affiliated with any religious organization and, if so, which organization.

(7) A facility licensed under this part which is not part of a facility authorized under chapter 651 shall include the facility's license number as given by the agency in all advertising. A company or person owning more than one facility shall include at least one license number per advertisement. All advertising shall include the term "assisted living facility" before the license number.

**History.**--s. 18, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 14, ch. 87-371; s. 25, ch. 91-263; ss. 32, 38, 39, ch. 93-216; s. 18, ch. 95-210; s. 217, ch. 99-13.

**400.449 Resident records; penalties for alteration.**--

(1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges.

**History.**--s. 48, ch. 2001-45.

**400.451 Existing facilities to be given reasonable time to comply with rules and standards.**--Any facility as defined in this part which is in operation at the time of promulgation of any applicable rules or standards adopted or amended pursuant to this part may be given a reasonable time, not to exceed 6 months, within which to comply with such rules and standards.

**History.**--s. 19, ch. 75-233; ss. 12, 33, ch. 80-198; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 26, ch. 91-263; ss. 38, 39, ch. 93-216.

**400.452 Staff training and educational programs; core educational requirement.**--

[1](1) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the Department of Elderly Affairs by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

[1](2) The department shall establish a competency test and a minimum required score to indicate successful completion of the training and educational requirements. The competency test must be developed by the department in conjunction with the agency and providers. The required training and education must cover at least the following topics:

(a) State law and rules relating to assisted living facilities.

(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.

(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.

(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.

(g) Care of persons with Alzheimer's disease and related disorders.

(3) Effective January 1, 2004, a new facility administrator must complete the required training and education, including the competency test, within a reasonable time after being employed as an administrator, as determined by the department. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 400.419. Administrators licensed in accordance with chapter 468, part II, are exempt from this requirement. Other licensed professionals may be exempted, as determined by the department by rule.

(4) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

(5) Staff involved with the management of medications and assisting with the self-administration of medications under s. 400.4256 must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training.

(6) Other facility staff shall participate in training relevant to their job duties as specified by rule of the department.

(7) If the department or the agency determines that there are problems in a facility that could be reduced through specific staff training or education beyond that already required under this section, the department or the agency may require, and provide, or cause to be provided, the training or education of any personal care staff in the facility.

(8) The department shall adopt rules related to these training requirements, the competency test, necessary procedures, and competency test fees.

**History.**--ss. 12, 34, ch. 80-198; s. 2, ch. 81-318; ss. 60, 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; s. 3, ch. 85-251; s. 21, ch. 89-294; s. 27, ch. 91-263; ss. 33, 38, 39, ch. 93-216; s. 19, ch. 95-210; ss. 15, 26, 53, ch. 95-418; s. 16, ch. 97-82; s. 29, ch. 97-100; s. 19, ch. 98-80; s. 25, ch. 2003-57; s. 3, ch. 2003-405.

**[1]Note.**--As amended by s. 3, ch. 2003-405, passed in Special Session A, 2003. This material was also amended by s. 25, ch. 2003-57, passed in the 2003 Regular Session. As amended by s. 25, ch. 2003-57, subsection (1) and the introductory paragraph of subsection (2) read:

(1) The department shall ensure that the administrators and other assisted living facility staff have met training and education requirements that enable them to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(2) The department shall establish a core educational requirement. Successful completion of the core educational requirement must include successful completion of a competency test. The core educational requirement must cover at least the following topics:

**400.453 Consultation by the agency.**--

(1) The area offices of licensure and certification of the agency shall provide consultation to the following upon request:

(a) A licensee of a facility.

(b) A person interested in obtaining a license to operate a facility under this part.

(2) As used in this section, "consultation" includes:

(a) An explanation of the requirements of this part and rules adopted pursuant thereto;

(b) An explanation of the license application and renewal procedures;

(c) The provision of a checklist of general local and state approvals required prior to constructing or developing a facility and a listing of the types of agencies responsible for such approvals;

(d) An explanation of benefits and financial assistance available to a recipient of supplemental security income residing in a facility;

(e) Any other information which the agency deems necessary to promote compliance with the requirements of this part; and

(f) A preconstruction review of a facility to ensure compliance with agency rules and this part.

(3) The agency may charge a fee commensurate with the cost of providing consultation under this section.

**History.**--ss. 15, 19, ch. 87-371; s. 22, ch. 89-294; ss. 34, 38, 39, ch. 93-216.

**400.454 Collection of information; local subsidy.**--

(1) To enable the department to collect the information requested by the Legislature regarding the actual cost of providing room, board, and personal care in facilities, the department is authorized to conduct field visits and audits of facilities as may be necessary. The owners of randomly sampled facilities shall submit such reports, audits, and accountings of cost as the department may require by rule; provided that such reports, audits, and accountings shall be the minimum necessary to implement the provisions of this section. Any facility selected to participate in the study shall cooperate with the department by providing cost of operation information to interviewers.

(2) Local governments or organizations may contribute to the cost of care of local facility residents by further subsidizing the rate of state-authorized payment to such facilities. Implementation of local subsidy shall require departmental approval and shall not result in reductions in the state supplement.

**History.**--ss. 12, 35, ch. 80-198; s. 2, ch. 81-318; ss. 75, 79, 83, ch. 83-181; s. 53, ch. 83-218; ss. 38, 39, ch. 93-216.

**PART IV**

**HOME HEALTH AGENCIES**

**400.461 Short title; purpose.**--

(1) This part, consisting of ss. 400.461-400.518, may be cited as the "Home Health Services Act."

(2) The purpose of this part is to provide for the licensure of every home health agency and to provide for the development, establishment, and enforcement of basic standards that will ensure the safe and adequate care of persons receiving health services in their own homes.

**History.**--ss. 36, 37, ch. 75-233; s. 2, ch. 81-318; ss. 61, 79, 83, ch. 83-181; s. 1, ch. 88-219; s. 1, ch. 90-319; ss. 1, 23, ch. 93-214; s. 47, ch. 98-171.

**400.462 Definitions.**--As used in this part, the term:

(1) "Administrator" means a direct employee of the home health agency or a related organization, or of a management company that has a contract to manage the home health agency, to whom the governing body has delegated the responsibility for day-to-day administration of the home health agency. The administrator must be a licensed physician, physician assistant, or registered nurse licensed to practice in this state or an individual having at least 1 year of supervisory or

administrative experience in home health care or in a facility licensed under chapter 395 or under part II or part III of this chapter. An administrator may manage a maximum of five licensed home health agencies located within one agency service district or within an immediately contiguous county. If the home health agency is licensed under this chapter and is part of a retirement community that provides multiple levels of care, an employee of the retirement community may administer the home health agency and up to a maximum of four entities licensed under this chapter that are owned, operated, or managed by the same corporate entity. An administrator shall designate, in writing, for each licensed entity, a qualified alternate administrator to serve during absences.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Certified nursing assistant" means any person who has been issued a certificate under part II of chapter 464. The licensed home health agency or licensed nurse registry shall ensure that the certified nursing assistant employed by or under contract with the home health agency or licensed nurse registry is adequately trained to perform the tasks of a home health aide in the home setting.

(4) "Client" means an elderly, handicapped, or convalescent individual who receives personal care services, companion services, or homemaker services in the individual's home or place of residence.

(5) "Companion" or "sitter" means a person who cares for an elderly, handicapped, or convalescent individual and accompanies such individual on trips and outings and may prepare and serve meals to such individual. A companion may not provide hands-on personal care to a client.

(6) "Department" means the Department of Children and Family Services.

(7) "Director of nursing" means a registered nurse and direct employee of the agency or related business entity who is a graduate of an approved school of nursing and is licensed in this state; who has at least 1 year of supervisory experience as a registered nurse in a licensed home health agency, a facility licensed under chapter 395, or a facility licensed under part II or part III of this chapter; and who is responsible for overseeing the professional nursing and home health aid delivery of services of the agency. An employee may be the director of nursing of a maximum of five licensed home health agencies operated by a related business entity and located within one agency service district or within an immediately contiguous county. If the home health agency is licensed under this chapter and is part of a retirement community that provides multiple levels of care, an employee of the retirement community may serve as the director of nursing of the home health agency and of up to four entities licensed under this chapter which are owned, operated, or managed by the same corporate entity. A director of nursing shall designate, in writing, for each licensed entity, a qualified alternate registered nurse to serve during the absence of the director of nursing.

(8) "Home health agency" means an organization that provides home health services and staffing services.

(9) "Home health agency personnel" means persons who are employed by or under contract with a home health agency and enter the home or place of residence of patients at any time in the course of their employment or contract.

(10) "Home health services" means health and medical services and medical supplies furnished by an organization to an individual in the individual's home or place of residence. The term includes organizations that provide one or more of the following:

(a) Nursing care.

(b) Physical, occupational, respiratory, or speech therapy.

(c) Home health aide services.

(d) Dietetics and nutrition practice and nutrition counseling.

(e) Medical supplies, restricted to drugs and biologicals prescribed by a physician.

(11) "Home health aide" means a person who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, or assists in administering medications as permitted in rule and for which the person has received training established by the agency under s. 400.497(1).

(12) "Homemaker" means a person who performs household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities for an elderly, handicapped, or convalescent individual. A homemaker may not provide hands-on personal care to a client.

(13) "Home infusion therapy provider" means an organization that employs, contracts with, or refers a licensed professional who has received advanced training and experience in intravenous infusion therapy and who administers infusion therapy to a patient in the patient's home or place of residence.

(14) "Home infusion therapy" means the administration of intravenous pharmacological or nutritional products to a patient in his or her home.

(15) "Nurse registry" means any person that procures, offers, promises, or attempts to secure health-care-related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, who are compensated by fees as independent contractors, including, but not limited to, contracts for the provision of services to patients and contracts to provide private duty or staffing services to health care facilities licensed under chapter 395 or this chapter or other business entities.

(16) "Organization" means a corporation, government or governmental subdivision or agency, partnership or association, or any other legal or commercial entity, any of which involve more than one health care professional discipline or a health care professional and a home health aide or certified nursing assistant. The term does not include an entity that provides services using only volunteers or only individuals related by blood or marriage to the patient or client.

(17) "Patient" means any person who receives home health services in his or her home or place of residence.

(18) "Personal care" means assistance to a patient in the activities of daily living, such as dressing, bathing, eating, or personal hygiene, and assistance in physical transfer, ambulation, and in administering medications as permitted by rule.

(19) "Physician" means a person licensed under chapter 458, chapter 459, chapter 460, or chapter 461.

(20) "Skilled care" means nursing services or therapeutic services delivered by a health care professional who is licensed under part I of chapter 464; part I, part III, or part V of chapter 468; or chapter 486 and who is employed by or under contract with a licensed home health agency or is referred by a licensed nurse registry.

(21) "Staffing services" means services provided to a health care facility or other business entity on

a temporary basis by licensed health care personnel, including certified nursing assistants and home heath aides who are employed by, or work under the auspices of, a licensed home health agency or who are registered with a licensed nurse registry.

**History.**--s. 38, ch. 75-233; s. 2, ch. 81-318; ss. 62, 79, 83, ch. 83-181; s. 12, ch. 85-167; s. 1, ch. 87-123; s. 2, ch. 88-219; s. 1, ch. 88-323; s. 1, ch. 90-101; s. 31, ch. 90-306; s. 2, ch. 90-319; s. 25, ch. 91-57; s. 28, ch. 91-263; ss. 2, 23, ch. 93-214; s. 781, ch. 95-148; s. 56, ch. 95-228; s. 126, ch. 99-8; s. 1, ch. 99-332; ss. 102, 156, ch. 2000-318; s. 77, ch. 2000-349.

**400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.** --

(1) Any home health agency must be licensed by the agency to operate in this state. A license issued to a home health agency, unless sooner suspended or revoked, expires 1 year after its date of issuance.

(2) If the licensed home health agency operates related offices, each related office outside the county where the main office is located must be separately licensed. The counties where the related offices are operating must be specified on the license in the main office.

(3) Any home infusion therapy provider shall be licensed as a home health agency. Any infusion therapy provider currently authorized to receive Medicare reimbursement under a DME - Part B Provider number for the provision of infusion therapy shall be licensed as a noncertified home health agency. Such a provider shall continue to receive that specified Medicare reimbursement without being certified so long as the reimbursement is limited to those items authorized pursuant to the DME - Part B Provider Agreement and the agency is licensed in compliance with the other provisions of this part.

(4)(a) An organization may not provide, offer, or advertise home health services to the public unless the organization has a valid license or is specifically exempted under this part. An organization that offers or advertises to the public any service for which licensure or registration is required under this part must include in the advertisement the license number or regulation number issued to the organization by the agency. The agency shall assess a fine of not less than $100 to any licensee or registrant who fails to include the license or registration number when submitting the advertisement for publication, broadcast, or printing. The holder of a license issued under this part may not advertise or indicate to the public that it holds a home health agency or nurse registry license other than the one it has been issued.

(b) A person who violates paragraph (a) is subject to an injunctive proceeding under s. 400.515. A violation of paragraph (a) is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act.

(c) A person who violates the provisions of paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Any person who commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation constitutes a separate offense.

(5) The following are exempt from the licensure requirements of this part:

(a) A home health agency operated by the Federal Government.

(b) Home health services provided by a state agency, either directly or through a contractor with:

1. The Department of Elderly Affairs.

2. The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or followup treatment, or for the purpose of monitoring and tracking disease.

3. Services provided to persons who have developmental disabilities, as defined in s. 393.063.

4. Companion and sitter organizations that were registered under s. 400.509(1) on January 1, 1999, and were authorized to provide personal services under s. 393.063(33) under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding the provisions of this act.

5. The Department of Children and Family Services.

(c) A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to patients in their homes.

(d) A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

(e) An individual who acts alone, in his or her individual capacity, and who is not employed by or affiliated with a licensed home health agency or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

(f) The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

(g) The delivery of nursing home services for which the nursing home is licensed under part II of this chapter, to serve its residents in its facility.

(h) The delivery of assisted living facility services for which the assisted living facility is licensed under part III of this chapter, to serve its residents in its facility.

(i) The delivery of hospice services for which the hospice is licensed under part VI of this chapter, to serve hospice patients admitted to its service.

(j) A hospital that provides services for which it is licensed under chapter 395.

(k) The delivery of community residential services for which the community residential home is licensed under chapter 419, to serve the residents in its facility.

(l) A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

(m) Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

(n) The delivery of adult family care home services for which the adult family care home is licensed under part VII of this chapter, to serve the residents in its facility.

**History.**--s. 39, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 29, ch. 91-263; ss. 3, 23, ch. 93-214; s. 782, ch. 95-148; ss. 41, 129, ch. 95-418; s. 100, ch. 97-101; s. 2, ch. 99-332; s. 18, ch. 2000-153; s. 59, ch. 2000-256; ss. 17, 103, ch. 2000-318; s. 5, ch. 2000-338; s. 37, ch. 2001-62; s. 92, ch. 2004-267.

**400.471 Application for license; fee; provisional license; temporary permit.**--

(1) Application for an initial license or for renewal of an existing license must be made under oath to the agency on forms furnished by it and must be accompanied by the appropriate license fee as provided in subsection (8). The agency must take final action on an initial licensure application within 60 days after receipt of all required documentation.

(2) The applicant must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided, either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of professional staff to be employed; and

(c) Proof of financial ability to operate.

(3) An applicant for initial licensure must demonstrate financial ability to operate by submitting a balance sheet and income and expense statement for the first 2 years of operation which provide evidence of having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant shall have demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. All documents required under this subsection must be prepared in accordance with generally accepted accounting principles, and the financial statement must be signed by a certified public accountant.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the administrator, or a similarly titled person who is responsible for the day-to-day operation of the licensed home health agency, and the financial officer, or similarly titled individual who is responsible for the financial operation of the licensed home health agency.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency reasonably suspects that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Financial Services Commission and the Office of Insurance Regulation pursuant to chapter 651 as part of an application for a certificate of authority to operate a continuing care retirement community is acceptable in fulfillment of the Department of Law Enforcement and Federal Bureau of Investigation background check.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results

from the Federal Bureau of Investigation. A standard license may be granted to the licensee upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the licensee or potential licensee from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interest under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant, administrator, or financial officer has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from participation in this state's Medicaid program, or the Medicaid program of any other state, or from participation in the Medicare program or any other governmental or private health care or health insurance program.

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(5) The home health agency must also obtain and maintain the following insurance coverages in an amount of not less than $250,000 per claim, and the home health agency must submit proof of coverage with an initial application for licensure and with each annual application for license renewal:

(a) Malpractice insurance as defined in s. 624.605(1)(k);

(b) Liability insurance as defined in s. 624.605(1)(b).

(6) Ninety days before the expiration date, an application for renewal must be submitted to the agency under oath on forms furnished by it, and a license must be renewed if the applicant has met the requirements established under this part and applicable rules. The home health agency must file with the application satisfactory proof that it is in compliance with this part and applicable rules. If there is evidence of financial instability, the home health agency must submit satisfactory proof of its financial ability to comply with the requirements of this part.

(7) When transferring the ownership of a home health agency, the transferee must submit an application for a license at least 60 days before the effective date of the transfer. If the home health agency is being leased, a copy of the lease agreement must be filed with the application.

(8) The license fee and annual renewal fee required of a home health agency are nonrefundable. The agency shall set the fees in an amount that is sufficient to cover its costs in carrying out its responsibilities under this part, but not to exceed $1,000. However, state, county, or municipal governments applying for licenses under this part are exempt from the payment of license fees. All fees collected under this part must be deposited in the Health Care Trust Fund for the administration of this part.

(9) The license must be displayed in a conspicuous place in the administrative office of the home health agency and is valid only while in the possession of the person to which it is issued. The license may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily, and is valid only for the home health agency and location for which originally issued.

(10) A home health agency against whom a revocation or suspension proceeding is pending at the time of license renewal may be issued a provisional license effective until final disposition by the agency of such proceedings. If judicial relief is sought from the final disposition, the court that has jurisdiction may issue a temporary permit for the duration of the judicial proceeding.

(11) The agency may not issue a license designated as certified to a home health agency that fails to satisfy the requirements of a Medicare certification survey from the agency.

(12) The agency may not issue a license to a home health agency that has any unpaid fines assessed under this part.

**History.**--s. 41, ch. 75-233; s. 7, ch. 77-400; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 45, ch. 87-92; s. 4, ch. 90-319; ss. 4, 23, ch. 93-214; s. 30, ch. 97-100; ss. 48, 71, ch. 98-171; s. 127, ch. 99-8; s. 218, ch. 99-13; s. 3, ch. 99-332; s. 19, ch. 2000-153; s. 2, ch. 2000-256; ss. 3, 157, ch. 2000-318; s. 78, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 420, ch. 2003-261; s. 47, ch. 2004-267.

**400.474 Denial, suspension, revocation of license; injunction; grounds; penalties.**--

(1) The agency may deny, revoke, or suspend a license, or impose an administrative fine in the manner provided in chapter 120, or initiate injunctive proceedings under s. 400.515.

(2) Any of the following actions by a home health agency or its employee is grounds for disciplinary action by the agency:

(a) Violation of this part or of applicable rules.

(b) An intentional, reckless, or negligent act that materially affects the health or safety of a patient.

(c) Knowingly providing home health services in an unlicensed assisted living facility or unlicensed adult family-care home, unless the home health agency or employee reports the unlicensed facility

or home to the agency within 72 hours after providing the services.

(3) The agency may impose the following penalties for operating without a license upon an applicant or owner who has in the past operated, or who currently operates, a licensed home health agency.

(a) If a home health agency that is found to be operating without a license wishes to apply for a license, the home health agency may submit an application only after the agency has verified that the home health agency no longer operates an unlicensed home health agency.

(b) Any person, partnership, or corporation that violates paragraph (a) and that previously operated a licensed home health agency or concurrently operates both a licensed home health agency and an unlicensed home health agency commits a felony of the third degree punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If an owner has an interest in more than one home health agency and fails to license any one of those home health agencies, the agency must issue a cease and desist order for the activities of the unlicensed home health agency and impose a moratorium on any or all of the licensed related home health agencies until the unlicensed home health agency is licensed.

(c) If any home health agency meets the criteria in paragraph (a) or paragraph (b) and that home health agency has received any government reimbursement for services provided by an unlicensed home health agency, the agency shall make a fraud referral to the appropriate government reimbursement program.

(4) The agency may deny, revoke, or suspend the license of a home health agency, or may impose on a home health agency administrative fines not to exceed the aggregate sum of $5,000 if:

(a) The agency is unable to obtain entry to the home health agency to conduct a licensure survey, complaint investigation, surveillance visit, or monitoring visit.

(b) An applicant or a licensed home health agency has falsely represented a material fact in the application, or has omitted from the application any material fact, including, but not limited to, the fact that the controlling or ownership interest is held by any officer, director, agent, manager, employee, affiliated person, partner, or shareholder who is not eligible to participate.

(c) An applicant, owner, or person who has a 5 percent or greater interest in a licensed entity:

1. Has been previously found by any licensing, certifying, or professional standards board or agency to have violated the standards or conditions that relate to home health-related licensure or certification, or to the quality of home health-related services provided; or

2. Has been or is currently excluded, suspended, terminated from, or has involuntarily withdrawn from, participation in the Medicaid program of this state or any other state, the Medicare program, or any other governmental health care or health insurance program.

**History.**--s. 42, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 5, 23, ch. 93-214; s. 20, ch. 98-80; s. 4, ch. 99-332.

**400.4785 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.**--

(1) A home health agency must provide the following staff training:

(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with participants who have Alzheimer's disease or dementia-related

disorders.

(b) In addition to the information provided under paragraph (a), newly hired home health agency personnel who will be providing direct care to patients must complete 2 hours of training in Alzheimer's disease and dementia-related disorders within 9 months after beginning employment with the agency. This training must include, but is not limited to, an overview of dementia, a demonstration of basic skills in communicating with persons who have dementia, the management of problem behaviors, information about promoting the client's independence in activities of daily living, and instruction in skills for working with families and caregivers.

(c) For certified nursing assistants, the required 2 hours of training shall be part of the total hours of training required annually.

(d) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 2 hours.

(e) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.

(f) The Department of Elderly Affairs, or its designee, must approve the required training. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 2-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.

(g) Upon completing the training listed in this section, the employee shall be issued a certificate that states that the training mandated under this section has been received. The certificate shall be dated and signed by the training provider. The certificate is evidence of completion of this training, and the employee is not required to repeat this training if the employee changes employment to a different home health agency.

(h) An employee who is hired on or after July 1, 2005, must complete the training required by this section.

(i) A licensed home health agency whose unduplicated census during the most recent calendar year was comprised of at least 90 percent of individuals aged 21 years or younger at the date of admission is exempt from the training requirements in this section.

(2) An agency licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The agency must give a copy of all such advertisements or a copy of the document to each person who requests information about the agency and must maintain a copy of all such advertisements and documents in its records. The Agency for Health Care Administration shall examine all such advertisements and documents in the agency's records as part of the license renewal procedure.

**History.**--s. 3, ch. 93-105; s. 2, ch. 2003-271.

**400.484 Right of inspection; deficiencies; fines.** --

(1) Any duly authorized officer or employee of the agency may make such inspections and investigations as are necessary in order to determine the state of compliance with this part and with applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a home health agency without a license, but such inspection of any

such business may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part or for license renewal constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application.

(2) The agency shall impose fines for various classes of deficiencies in accordance with the following schedule:

(a) A class I deficiency is any act, omission, or practice that results in a patient's death, disablement, or permanent injury, or places a patient at imminent risk of death, disablement, or permanent injury. Upon finding a class I deficiency, the agency may impose an administrative fine in the amount of $5,000 for each occurrence and each day that the deficiency exists. In addition, the agency may immediately revoke the license, or impose a moratorium on the admission of new patients, until the factors causing the deficiency have been corrected.

(b) A class II deficiency is any act, omission, or practice that has a direct adverse effect on the health, safety, or security of a patient. Upon finding a class II deficiency, the agency may impose an administrative fine in the amount of $1,000 for each occurrence and each day that the deficiency exists. In addition, the agency may suspend the license, or impose a moratorium on the admission of new patients, until the deficiency has been corrected.

(c) A class III deficiency is any act, omission, or practice that has an indirect, adverse effect on the health, safety, or security of a patient. Upon finding an uncorrected or repeated class III deficiency, the agency may impose an administrative fine not to exceed $500 for each occurrence and each day that the uncorrected or repeated deficiency exists.

(d) A class IV deficiency is any act, omission, or practice related to required reports, forms, or documents which does not have the potential of negatively affecting patients. These violations are of a type that the agency determines do not threaten the health, safety, or security of patients. Upon finding an uncorrected or repeated class IV deficiency, the agency may impose an administrative fine not to exceed $200 for each occurrence and each day that the uncorrected or repeated deficiency exists.

(3) In addition to any other penalties imposed pursuant to this section or part, the agency may assess costs related to an investigation that results in a successful prosecution, excluding costs associated with an attorney's time.

**History.**--s. 45, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 8, 23, ch. 93-214; s. 5, ch. 99-332; s. 158, ch. 2000-318.

**400.487 Home health service agreements; physician's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.**--

(1) Services provided by a home health agency must be covered by an agreement between the home health agency and the patient or the patient's legal representative specifying the home health services to be provided, the rates or charges for services paid with private funds, and the method of payment. A home health agency providing skilled care must make an assessment of the patient's needs within 48 hours after the start of services.

(2) When required by the provisions of chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician for a patient who is to receive skilled care must establish treatment orders. The treatment orders must be signed by the physician within 30 days after the start of care and must be reviewed, as frequently as the patient's illness requires, by the physician in consultation with home health agency personnel that provide services to the patient.

(3) A home health agency shall arrange for supervisory visits by a registered nurse to the home of a

patient receiving home health aide services in accordance with the patient's direction and approval.

(4) Each patient has the right to be informed of and to participate in the planning of his or her care. Each patient must be provided, upon request, a copy of the plan of care established and maintained for that patient by the home health agency.

(5) When nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by qualified personnel who are on the payroll of, and to whom an IRS payroll form W-2 will be issued by, the home health agency. Services provided by others under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

(6) The skilled care services provided by a home health agency, directly or under contract, must be supervised and coordinated in accordance with the plan of care.

(7) Home health agency personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Home health personnel and agencies shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and rules adopted by the agency.

**History.**--s. 46, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 4, ch. 88-219; s. 1, ch. 90-61; ss. 9, 23, ch. 93-214; s. 783, ch. 95-148; s. 3, ch. 96-222; s. 5, ch. 99-331; s. 6, ch. 99-332; s. 159, ch. 2000-318.

**400.488 Assistance with self-administration of medication.**--

(1) For purposes of this section, the term:

(a) "Informed consent" means advising the patient, or the patient's surrogate, guardian, or attorney in fact, that the patient may be receiving assistance with self-administration of medication from an unlicensed person.

(b) "Unlicensed person" means an individual not currently licensed to practice nursing or medicine who is employed by or under contract to a home health agency and who has received training with respect to assisting with the self-administration of medication as provided by agency rule.

(2) Patients who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a patient whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a patient or the patient's surrogate, guardian, or attorney in fact. For purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, and topical ophthalmic, otic, and nasal dosage forms, including solutions, suspensions, sprays, and inhalers.

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is

stored and bringing it to the patient.

(b) In the presence of the patient, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

(f) Keeping a record of when a patient receives assistance with self-administration under this section.

(4) Assistance with self-administration does not include:

(a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

(b) The preparation of syringes for injection or the administration of medications by any injectable route.

(c) Administration of medications through intermittent positive pressure breathing machines or a nebulizer.

(d) Administration of medications by way of a tube inserted in a cavity of the body.

(e) Administration of parenteral preparations.

(f) Irrigations or debriding agents used in the treatment of a skin condition.

(g) Rectal, urethral, or vaginal preparations.

(h) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent patient.

(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

(5) Assistance with the self-administration of medication by an unlicensed person as described in this section does not constitute administration as defined in s. 465.003.

(6) The agency may by rule establish procedures and interpret terms as necessary to administer this section.

**History.**--s. 7, ch. 99-332.

**400.491 Clinical records.**--

(1) The home health agency must maintain for each patient who receives skilled care a clinical record that includes pertinent past and current medical, nursing, social and other therapeutic information, the treatment orders, and other such information as is necessary for the safe and adequate care of the patient. When home health services are terminated, the record must show the date and reason for termination. Such records are considered patient records under s. 456.057, and must be maintained by the home health agency for 5 years following termination of services. If a patient transfers to another home health agency, a copy of his or her record must be provided to the other home health agency upon request.

(2) The home health agency must maintain for each client who receives nonskilled care a service provision plan. Such records must be maintained by the home health agency for 1 year following termination of services.

**History.**--s. 47, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 10, 23, ch. 93-214; s. 784, ch. 95-148; s. 25, ch. 98-166; s. 8, ch. 99-332; s. 20, ch. 2000-153; s. 16, ch. 2000-160.

**400.492 Provision of services during an emergency.**--Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies, including a backup system; identifying resources necessary to continue essential care or services or referrals to other organizations subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records.

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county.

**History.**--s. 12, ch. 2000-140.

**400.494 Information about patients confidential.**--

(1) Information about patients received by persons employed by, or providing services to, a home health agency or received by the licensing agency through reports or inspection shall be confidential and exempt from the provisions of s. 119.07(1) and shall not be disclosed to any person other than the patient without the written consent of that patient or the patient's guardian.

(2) This section does not apply to information lawfully requested by the Medicaid Fraud Control Unit of the Department of Legal Affairs.

**History.**--s. 48, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 20, ch. 90-347; s. 23, ch. 93-214; s. 229, ch. 96-406; s. 4, ch. 2000-163.

**400.495 Notice of toll-free telephone number for central abuse hotline.**--On or before the first day home health services are provided to a patient, any home health agency or nurse registry licensed under this part must inform the patient and his or her immediate family, if appropriate, of the right to report abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse hotline must be provided to patients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free ~~(phone number)~~." The Agency for Health Care Administration shall adopt rules that provide for 90 days' advance notice of a change in the toll-free telephone number and that outline due process procedures, as provided under chapter 120, for home health agency personnel and nurse registry personnel who are reported to the central abuse hotline. Home health agencies and nurse registries shall establish appropriate policies and procedures for providing such notice to patients.

**History.**--ss. 5, 9, ch. 88-219; ss. 11, 23, ch. 93-214; s. 785, ch. 95-148; s. 79, ch. 2000-349.

**400.497 Rules establishing minimum standards.**--The agency shall adopt, publish, and enforce rules to implement this part, including, as applicable, ss. 400.506 and 400.509, which must provide reasonable and fair minimum standards relating to:

[1](1) The home health aide competency test and home health aide training. The agency shall create the home health aide competency test and establish the curriculum and instructor qualifications for home health aide training. Licensed home health agencies may provide this training and shall furnish documentation of such training to other licensed home health agencies upon request. Successful passage of the competency test by home health aides may be substituted for the training required under this section and any rule adopted pursuant thereto.

(2) Shared staffing. The agency shall allow shared staffing if the home health agency is part of a retirement community that provides multiple levels of care, is located on one campus, is licensed under this chapter, and otherwise meets the requirements of law and rule.

(3) The criteria for the frequency of onsite licensure surveys.

(4) Licensure application and renewal.

(5) The requirements for onsite and electronic accessibility of supervisory personnel of home health agencies.

(6) Information to be included in patients' records.

(7) Geographic service areas.

(8) Preparation of a comprehensive emergency management plan pursuant to s. 400.492.

(a) The Agency for Health Care Administration shall adopt rules establishing minimum criteria for the plan and plan updates, with the concurrence of the Department of Health and in consultation

with the Department of Community Affairs.

(b) The rules must address the requirements in s. 400.492. In addition, the rules shall provide for the maintenance of patient-specific medication lists that can accompany patients who are transported from their homes.

(c) The plan is subject to review and approval by the county health department. During its review, the county health department shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan:

1. The local emergency management agency.

2. The Agency for Health Care Administration.

3. The local chapter of the American Red Cross or other lead sheltering agency.

4. The district office of the Department of Children and Family Services.

The county health department shall complete its review within 60 days after receipt of the plan and shall either approve the plan or advise the home health agency of necessary revisions.

(d) For any home health agency that operates in more than one county, the Department of Health shall review the plan, after consulting with all of the county health departments, the agency, and all the local chapters of the American Red Cross or other lead sheltering agencies in the areas of operation for that particular home health agency. The Department of Health shall complete its review within 90 days after receipt of the plan and shall either approve the plan or advise the home health agency of necessary revisions. The Department of Health shall make every effort to avoid imposing differing requirements based on differences between counties on the home health agency.

(e) The requirements in this subsection do not apply to:

1. A facility that is certified under chapter 651 and has a licensed home health agency used exclusively by residents of the facility; or

2. A retirement community that consists of residential units for independent living and either a licensed nursing home or an assisted living facility, and has a licensed home health agency used exclusively by the residents of the retirement community, provided the comprehensive emergency management plan for the facility or retirement community provides for continuous care of all residents with special needs during an emergency.

**History.**--s. 49, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 6, ch. 88-219; s. 4, ch. 89-354; s. 6, ch. 90-319; s. 38, ch. 90-347; s. 26, ch. 91-57; s. 31, ch. 91-263; ss. 12, 23, ch. 93-214; s. 786, ch. 95-148; s. 9, ch. 99-332; s. 13, ch. 2000-140; s. 160, ch. 2000-318.

**[1]Note.**--As amended by s. 160, ch. 2000-318. Subsection (1) was also amended by s. 13, ch. 2000-140, but the amendment was drawn to the text of subsection (1) as it read prior to amendment by s. 9, ch. 99-332. Subsection (1), *Florida Statutes 1997,* as amended by s. 13, ch. 2000-140, only, reads:

(1) Scope of home health services to be provided, which shall include services to be provided during emergency evacuation and sheltering.

**400.506 Licensure of nurse registries; requirements; penalties.**--

(1) A nurse registry is exempt from the licensing requirements of a home health agency but must be licensed as a nurse registry. Each operational site of the nurse registry must be licensed, unless there is more than one site within a county. If there is more than one site within a county, only one license per county is required. Each operational site must be listed on the license.

(2) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the nurse registry, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the registry, including billings for patient care and services. The applicant shall comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has probable cause to believe that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been

found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke the license if any applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(3) Application for license must be made to the Agency for Health Care Administration on forms furnished by it and must be accompanied by the appropriate licensure fee, as established by rule and not to exceed the cost of regulation under this part. The licensure fee for nurse registries may not exceed $1,000 and must be deposited in the Health Care Trust Fund.

(4) The Agency for Health Care Administration may deny, revoke, or suspend a license or impose an administrative fine in the manner provided in chapter 120 against a nurse registry that:

(a) Fails to comply with this section or applicable rules.

(b) Commits an intentional, reckless, or negligent act that materially affects the health or safety of a person receiving services.

(5) A license issued for the operation of a nurse registry, unless sooner suspended or revoked, expires 1 year after its date of issuance. Sixty days before the expiration date, an application for renewal must be submitted to the Agency for Health Care Administration on forms furnished by it. The Agency for Health Care Administration shall renew the license if the applicant has met the requirements of this section and applicable rules. A nurse registry against which a revocation or suspension proceeding is pending at the time of license renewal may be issued a conditional license effective until final disposition by the Agency for Health Care Administration of such proceedings. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional license for the duration of the judicial proceeding.

(6) The Agency for Health Care Administration may institute injunctive proceedings under s. 400.515.

(7) A person that offers or advertises to the public that it provides any service for which licensure is required under this section must include in such advertisement the license number issued to it by the Agency for Health Care Administration.

(8) It is unlawful for a person to offer or advertise to the public services as defined by rule without obtaining a valid license from the Agency for Health Care Administration. It is unlawful for any holder of a license to advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds a license. A person who violates this subsection is subject to injunctive proceedings under s. 400.515.

(9) Any duly authorized officer or employee of the Agency for Health Care Administration may make such inspections and investigations as are necessary to respond to complaints or to determine the state of compliance with this section and applicable rules.

(a) If, in responding to a complaint, an agent or employee of the Agency for Health Care Administration has reason to believe that a crime has been committed, he or she shall notify the appropriate law enforcement agency.

(b) If, in responding to a complaint, an agent or employee of the Agency for Health Care Administration has reason to believe that abuse, neglect, or exploitation has occurred, according to the definitions in chapter 415, he or she shall file a report under chapter 415.

(10)(a) A nurse registry may refer for contract in private residences registered nurses and licensed practical nurses registered and licensed under part I of chapter 464, certified nursing assistants certified under part II of chapter 464, home health aides who present documented proof of successful completion of the training required by rule of the agency, and companions or homemakers for the purposes of providing those services authorized under s. 400.509(1). Each person referred by a nurse registry must provide current documentation that he or she is free from communicable diseases.

(b) A certified nursing assistant or home health aide may be referred for a contract to provide care to a patient in his or her home only if that patient is under a physician's care. A certified nursing assistant or home health aide referred for contract in a private residence shall be limited to assisting a patient with bathing, dressing, toileting, grooming, eating, physical transfer, and those normal daily routines the patient could perform for himself or herself were he or she physically capable. A certified nursing assistant or home health aide may not provide medical or other health care services that require specialized training and that may be performed only by licensed health care professionals. The nurse registry shall obtain the name and address of the attending physician and send written notification to the physician within 48 hours after a contract is concluded that a certified nursing assistant or home health aide will be providing care for that patient.

(c) A registered nurse shall make monthly visits to the patient's home to assess the patient's condition and quality of care being provided by the certified nursing assistant or home health aide. Any condition which in the professional judgment of the nurse requires further medical attention shall be reported to the attending physician and the nurse registry. The assessment shall become a part of the patient's file with the nurse registry and may be reviewed by the agency during their survey procedure.

(11) A person who is referred by a nurse registry for contract in private residences and who is not a nurse licensed under part I of chapter 464 may perform only those services or care to clients that the person has been certified to perform or trained to perform as required by law or rules of the Agency for Health Care Administration or the Department of Business and Professional Regulation. Providing services beyond the scope authorized under this subsection constitutes the unauthorized practice of medicine or a violation of the Nurse Practice Act and is punishable as provided under chapter 458, chapter 459, or part I of chapter 464.

(12) Each nurse registry must require every applicant for contract to complete an application form providing the following information:

(a) The name, address, date of birth, and social security number of the applicant.

(b) The educational background and employment history of the applicant.

(c) The number and date of the applicable license or certification.

(d) When appropriate, information concerning the renewal of the applicable license, registration, or certification.

(13) Each nurse registry must comply with the procedures set forth in s. 400.512 for maintaining records of the employment history of all persons referred for contract and is subject to the

standards and conditions set forth in that section. However, an initial screening may not be required for persons who have been continuously registered with the nurse registry since September 30, 1990.

(14) The nurse registry must maintain the application on file, and that file must be open to the inspection of the Agency for Health Care Administration. The nurse registry must maintain on file the name and address of the client to whom the nurse or other nurse registry personnel is sent for contract and the amount of the fee received by the nurse registry. A nurse registry must maintain the file that includes the application and other applicable documentation for 3 years after the date of the last file entry of client-related information.

(15) Nurse registries shall assist persons who would need assistance and sheltering during evacuations because of physical, mental, or sensory disabilities in registering with the appropriate local emergency management agency pursuant to s. 252.355.

(16) Each nurse registry shall prepare and maintain a comprehensive emergency management plan that is consistent with the criteria in this subsection and with the local special needs plan. The plan shall be updated annually. The plan shall specify how the nurse registry shall facilitate the provision of continuous care by persons referred for contract to persons who are registered pursuant to s. 252.355 during an emergency that interrupts the provision of care or services in private residencies.

(a) All persons referred for contract who care for persons registered pursuant to s. 252.355 must include in the patient record a description of how care will be continued during a disaster or emergency that interrupts the provision of care in the patient's home. It shall be the responsibility of the person referred for contract to ensure that continuous care is provided.

(b) Each nurse registry shall maintain a current prioritized list of patients in private residences who are registered pursuant to s. 252.355 and are under the care of persons referred for contract and who need continued services during an emergency. This list shall indicate, for each patient, if the client is to be transported to a special needs shelter and if the patient is receiving skilled nursing services. Nurse registries shall make this list available to county health departments and to local emergency management agencies upon request.

(c) Each person referred for contract who is caring for a patient who is registered pursuant to s. 252.355 shall provide a list of the patient's medication and equipment needs to the nurse registry. Each person referred for contract shall make this information available to county health departments and to local emergency management agencies upon request.

(d) Each person referred for contract shall not be required to continue to provide care to patients in emergency situations that are beyond the person's control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records.

(e) The comprehensive emergency management plan required by this subsection is subject to review and approval by the county health department. During its review, the county health department shall ensure that, at a minimum, the local emergency management agency, the Agency for Health Care Administration, and the local chapter of the American Red Cross or other lead sheltering agency are given the opportunity to review the plan. The county health department shall complete its review within 60 days after receipt of the plan and shall either approve the plan or advise the nurse registry of necessary revisions.

(f) The Agency for Health Care Administration shall adopt rules establishing minimum criteria for the comprehensive emergency management plan and plan updates required by this subsection, with the concurrence of the Department of Health and in consultation with the Department of Community Affairs.

(17) All persons referred for contract in private residences by a nurse registry must comply with the following requirements for a plan of treatment:

(a) When, in accordance with the privileges and restrictions imposed upon a nurse under part I of chapter 464, the delivery of care to a patient is under the direction or supervision of a physician or when a physician is responsible for the medical care of the patient, a medical plan of treatment must be established for each patient receiving care or treatment provided by a licensed nurse in the home. The original medical plan of treatment must be timely signed by the physician and reviewed by him or her in consultation with the licensed nurse at least every 2 months. Any additional order or change in orders must be obtained from the physician and reduced to writing and timely signed by the physician. The delivery of care under a medical plan of treatment must be substantiated by the appropriate nursing notes or documentation made by the nurse in compliance with nursing practices established under part I of chapter 464.

(b) Whenever a medical plan of treatment is established for a patient, the initial medical plan of treatment, any amendment to the plan, additional order or change in orders, and copy of nursing notes must be filed in the office of the nurse registry.

(18) The nurse registry must comply with the notice requirements of s. 400.495, relating to abuse reporting.

(19) In addition to any other penalties imposed pursuant to this section or part, the agency may assess costs related to an investigation that results in a successful prosecution, excluding costs associated with an attorney's time. If the agency imposes such an assessment and the assessment is not paid, and if challenged is not the subject of a pending appeal, prior to the renewal of the license, the license shall not be issued until the assessment is paid or arrangements for payment of the assessment are made.

(20) The Agency for Health Care Administration shall adopt rules to implement this section.

**History.**--ss. 2, 4, ch. 90-101; s. 27, ch. 91-57; ss. 13, 23, ch. 93-214; s. 51, ch. 94-218; s. 1056, ch. 95-148; ss. 49, 71, ch. 98-171; s. 10, ch. 99-332; s. 14, ch. 2000-140; s. 21, ch. 2000-153; ss. 104, 161, ch. 2000-318; s. 80, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 48, ch. 2004-267.

**400.509 Registration of particular service providers exempt from licensure; certificate of registration; regulation of registrants.**--

(1) Any organization that provides companion services or homemaker services and does not provide a home health service to a person is exempt from licensure under this part. However, any organization that provides companion services or homemaker services must register with the agency.

(2) Registration consists of annually filing with the agency, under oath, on forms provided by it, the following information:

(a) If the registrant is a firm or partnership, the name, address, date of birth, and social security number of every member.

(b) If the registrant is a corporation or association, its name and address; the name, address, date of birth, and social security number of each of its directors and officers; and the name and address of each person having at least a 5 percent interest in the corporation or association.

(c) The name, address, date of birth, and social security number of each person employed by or under contract with the organization.

(3) The agency shall charge a registration fee of $25 to be submitted with the information required under subsection (2).

(4) Each applicant for registration must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 1 standards for screening set forth in chapter 435, of every individual who will have contact with the client. The agency shall require background screening of the managing employee or other similarly titled individual who is responsible for the operation of the entity, and of the financial officer or other similarly titled individual who is responsible for the financial operation of the entity, including billings for client services in accordance with the level 2 standards for background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is affiliated with the applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a).

(d) A provisional registration may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the abuse-registry background check through the agency and the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation. A standard registration may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and if a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 which was committed by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization who serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation's or organization's board of directors, and has no financial interest and no family members having a financial interest in the corporation or organization, if the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A registration may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless

an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke the registration of any applicant who:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for licensure renewal must contain the information required under paragraphs (e) and (f).

(5) Each registrant must obtain the employment or contract history of persons who are employed by or under contract with the organization and who will have contact at any time with patients or clients in their homes by:

(a) Requiring such persons to submit an employment or contractual history to the registrant; and

(b) Verifying the employment or contractual history, unless through diligent efforts such verification is not possible. The agency shall prescribe by rule the minimum requirements for establishing that diligent efforts have been made.

There is no monetary liability on the part of, and no cause of action for damages arises against, a former employer of a prospective employee of or prospective independent contractor with a registrant who reasonably and in good faith communicates his or her honest opinions about the former employee's or contractor's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

(6) On or before the first day on which services are provided to a patient or client, any registrant under this part must inform the patient or client and his or her immediate family, if appropriate, of the right to report abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse hotline must be provided to patients or clients in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free (phone number)." Registrants must establish appropriate policies and procedures for providing such notice to patients or clients.

(7) The provisions of s. 400.512 regarding screening apply to any person or business entity registered under this section on or after October 1, 1994.

(8) Upon verification that all requirements for registration have been met, the Agency for Health Care Administration shall issue a certificate of registration valid for no more than 1 year.

(9) The Agency for Health Care Administration may deny, suspend, or revoke the registration of a person that:

(a) Fails to comply with this section or applicable rules.

(b) Commits an intentional, reckless, or negligent act that materially affects the health or safety of a person receiving services.

(10) The Agency for Health Care Administration may institute injunctive proceedings under s. 400.515.

(11) A person that offers or advertises to the public a service for which registration is required must include in its advertisement the registration number issued by the Agency for Health Care Administration.

(12) It is unlawful for a person to offer or advertise to the public services, as defined by rule, without obtaining a certificate of registration from the Agency for Health Care Administration. It is unlawful for any holder of a certificate of registration to advertise or hold out to the public that he or she holds a certificate of registration for other than that for which he or she actually holds a certificate of registration. Any person who violates this subsection is subject to injunctive proceedings under s. 400.515.

(13) Any duly authorized officer or employee of the Agency for Health Care Administration has the right to make such inspections and investigations as are necessary in order to respond to complaints or to determine the state of compliance with this section and applicable rules.

(a) If, in responding to a complaint, an officer or employee of the Agency for Health Care Administration has reason to believe that a crime has been committed, he or she shall notify the appropriate law enforcement agency.

(b) If, in responding to a complaint, an officer or employee of the Agency for Health Care Administration has reason to believe that abuse, neglect, or exploitation has occurred, according to the definitions in chapter 415, he or she shall file a report under chapter 415.

(14) In addition to any other penalties imposed pursuant to this section or part, the agency may assess costs related to an investigation that results in a successful prosecution, excluding costs associated with an attorney's time. If the agency imposes such an assessment and the assessment is not paid, and if challenged is not the subject of a pending appeal, prior to the renewal of the registration, the registration shall not be issued until the assessment is paid or arrangements for payment of the assessment are made.

(15) The Agency for Health Care Administration shall adopt rules to administer this section.

**History.**--ss. 2, 3, ch. 87-123; s. 3, ch. 88-219; s. 66, ch. 91-221; s. 30, ch. 91-263; ss. 6, 23, ch. 93-214; s. 787, ch. 95-148; s. 11, ch. 99-332; s. 162, ch. 2000-318; s. 81, ch. 2000-349; s. 15, ch. 2004-267.

**Note.**--Former s. 400.478.

**400.512 Screening of home health agency personnel; nurse registry personnel; and companions and homemakers.**--The agency shall require employment or contractor screening as provided in chapter 435, using the level 1 standards for screening set forth in that chapter, for home health agency personnel; persons referred for employment by nurse registries; and persons employed by companion or homemaker services registered under s. 400.509.

(1)(a) The Agency for Health Care Administration may, upon request, grant exemptions from disqualification from employment or contracting under this section as provided in s. 435.07, except for health care practitioners licensed by the Department of Health or a regulatory board within that department.

(b) The appropriate regulatory board within the Department of Health, or that department itself when there is no board, may, upon request of the licensed health care practitioner, grant exemptions from disqualification from employment or contracting under this section as provided in s. 435.07.

(2) The administrator of each home health agency, the managing employee of each nurse registry, and the managing employee of each companion or homemaker service registered under s. 400.509

must sign an affidavit annually, under penalty of perjury, stating that all personnel hired, contracted with, or registered on or after October 1, 1994, who enter the home of a patient or client in their service capacity have been screened and that its remaining personnel have worked for the home health agency or registrant continuously since before October 1, 1994.

(3) As a prerequisite to operating as a home health agency, nurse registry, or companion or homemaker service under s. 400.509, the administrator or managing employee, respectively, must submit to the agency his or her name and any other information necessary to conduct a complete screening according to this section. The agency shall submit the information to the Department of Law Enforcement for state processing. The agency shall review the record of the administrator or manager with respect to the offenses specified in this section and shall notify the owner of its findings. If disposition information is missing on a criminal record, the administrator or manager, upon request of the agency, must obtain and supply within 30 days the missing disposition information to the agency. Failure to supply missing information within 30 days or to show reasonable efforts to obtain such information will result in automatic disqualification.

(4) Proof of compliance with the screening requirements of chapter 435 shall be accepted in lieu of the requirements of this section if the person has been continuously employed or registered without a breach in service that exceeds 180 days, the proof of compliance is not more than 2 years old, and the person has been screened by the Department of Law Enforcement. A home health agency, nurse registry, or companion or homemaker service registered under s. 400.509 shall directly provide proof of compliance to another home health agency, nurse registry, or companion or homemaker service registered under s. 400.509. The recipient home health agency, nurse registry, or companion or homemaker service registered under s. 400.509 may not accept any proof of compliance directly from the person who requires screening. Proof of compliance with the screening requirements of this section shall be provided upon request to the person screened by the home health agencies; nurse registries; or companion or homemaker services registered under s. 400.509.

(5) There is no monetary liability on the part of, and no cause of action for damages arises against, a licensed home health agency, licensed nurse registry, or companion or homemaker service registered under s. 400.509, that, upon notice that the employee or contractor has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.03 or under any similar statute of another jurisdiction, terminates the employee or contractor, whether or not the employee or contractor has filed for an exemption with the agency in accordance with chapter 435 and whether or not the time for filing has expired.

(6) The costs of processing the statewide correspondence criminal records checks must be borne by the home health agency; the nurse registry; or the companion or homemaker service registered under s. 400.509, or by the person being screened, at the discretion of the home health agency, nurse registry, or s. 400.509 registrant.

(7)(a) It is a misdemeanor of the first degree, punishable under s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person's qualifications to be an employee under this section;

2. Operate or attempt to operate an entity licensed or registered under this part with persons who do not meet the minimum standards for good moral character as contained in this section; or

3. Use information from the criminal records obtained under this section for any purpose other than screening that person for employment as specified in this section or release such information to any other person for any purpose other than screening for employment under this section.

(b) It is a felony of the third degree, punishable under s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment under this section.

**History.**--s. 14, ch. 93-214; s. 21, ch. 94-134; s. 21, ch. 94-135; s. 1057, ch. 95-148; s. 17, ch. 95-152; s. 14, ch. 95-158; s. 1, ch. 95-201; s. 40, ch. 95-228; s. 128, ch. 95-418; s. 11, ch. 96-268; ss. 230, 231, ch. 96-406; s. 12, ch. 99-332; ss. 105, 163, ch. 2000-318; s. 82, ch. 2000-349; s. 24, ch. 2004-267.

**400.515 Injunction proceedings.** --The Agency for Health Care Administration may institute injunction proceedings in a court of competent jurisdiction when violation of this part or of applicable rules constitutes an emergency affecting the immediate health and safety of a patient or client.

**History.**--s. 44, ch. 75-233; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 7, 23, ch. 93-214.

**Note.**--Former s. 400.481.

**400.518 Prohibited referrals to home health agencies.**--

(1) A physician licensed under chapter 458 or chapter 459 must comply with s. 456.053.

(2) A hospital or an ambulatory surgical center that has a financial interest in a home health agency is prohibited from requiring any physician on its staff to refer a patient to the home health agency.

(3)(a) A violation of this section is punishable by an administrative fine not to exceed $15,000. The proceeds of such fines must be deposited into the Health Care Trust Fund.

(b) A physician who violates this section is subject to disciplinary action by the appropriate board under s. 458.331(2) or s. 459.015(2). A hospital or ambulatory surgical center that violates this section is subject to the rules adopted by the agency under s. 395.0185(2).

**History.**--s. 17, ch. 93-214; s. 26, ch. 98-166; s. 17, ch. 2000-160.

**PART V**

**ADULT DAY CARE CENTERS**

400.55 Purpose.

400.551 Definitions.

400.552 Applicability.

400.553 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed nursing home facilities.

400.554 License requirement; fee; exemption; display.

400.555 Application for license.

400.556 Denial, suspension, revocation of license; administrative fines; investigations and

**400.55 Purpose.**--The purpose of this part is to develop, establish, and enforce basic standards for adult day care centers in order to assure that a program of therapeutic social and health activities and services is provided to adults who have functional impairments, in a protective environment that provides as noninstitutional an atmosphere as possible.

**History.**--s. 1, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 1, 17, ch. 93-215.

**400.551 Definitions.**--As used in this part, the term:

(1) "Adult day care center" or "center" means any building, buildings, or part of a building, whether operated for profit or not, in which is provided through its ownership or management, for a part of a day, basic services to three or more persons who are 18 years of age or older, who are not related to the owner or operator by blood or marriage, and who require such services.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Basic services" include, but are not limited to, providing a protective setting that is as noninstitutional as possible; therapeutic programs of social and health activities and services; leisure activities; self-care training; rest; nutritional services; and respite care.

(4) "Department" means the Department of Elderly Affairs.

(5) "Multiple or repeated violations" means 2 or more violations that present an imminent danger to the health, safety, or welfare of participants or 10 or more violations within a 5-year period that threaten the health, safety, or welfare of the participants.

(6) "Operator" means the person having general administrative charge of an adult day care center.

(7) "Owner" means the owner of an adult day care center.

(8) "Participant" means a recipient of basic services or of supportive and optional services provided by an adult day care center.

(9) "Supportive and optional services" include, but are not limited to, speech, occupational, and physical therapy; direct transportation; legal consultation; consumer education; and referrals for followup services.

**History.**--s. 2, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 2, 17, ch. 93-215; s. 55, ch. 95-418.

**400.552 Applicability.**--Any facility that comes within the definition of an adult day care center which is not exempt under s. 400.553 must be licensed by the agency as an adult day care center.

**History.**--s. 3, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 3, 17, ch. 93-215.

**400.553 Exemptions; monitoring of adult day care center programs colocated with assisted living facilities or licensed nursing home facilities.**--

(1) The following are exempt from this part:

(a) Any facility, institution, or other place that is operated by the Federal Government or any agency thereof.

(b) Any freestanding inpatient hospice facility that is licensed by the state and which provides day care services to hospice patients only.

(2) A licensed assisted living facility, a licensed hospital, or a licensed nursing home facility may provide services during the day which include, but are not limited to, social, health, therapeutic, recreational, nutritional, and respite services, to adults who are not residents. Such a facility need not be licensed as an adult day care center; however, the agency must monitor the facility during the regular inspection and at least biennially to ensure adequate space and sufficient staff. If an assisted living facility, a hospital, or a nursing home holds itself out to the public as an adult day care center, it must be licensed as such and meet all standards prescribed by statute and rule.

**History.**--s. 4, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; s. 6, ch. 88-235; ss. 4, 17, ch. 93-215; s. 20, ch. 95-210.

**400.554 License requirement; fee; exemption; display.**--

(1) It is unlawful to operate an adult day care center without first obtaining from the agency a license authorizing such operation. The agency is responsible for licensing adult day care centers in accordance with this part.

(2) Separate licenses are required for centers operated on separate premises, even though operated under the same management. Separate licenses are not required for separate buildings on the same premises.

(3) The biennial license fee required of a center shall be determined by the department, but may not exceed $150.

(4) County-operated or municipally operated centers applying for licensure under this part are exempt from the payment of license fees.

(5) The license for a center shall be displayed in a conspicuous place inside the center.

(6) A license is valid only in the possession of the individual, firm, partnership, association, or corporation to which it is issued and is not subject to sale, assignment, or other transfer, voluntary or involuntary; nor is a license valid for any premises other than the premises for which originally issued.

**History.**--s. 5, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 5, 17, ch. 93-215.

**400.555 Application for license.**--

(1) An application for a license to operate an adult day care center must be made to the agency on forms furnished by the agency and must be accompanied by the appropriate license fee unless the applicant is exempt from payment of the fee as provided in s. 400.554(4).

(2) The applicant for licensure must furnish:

(a) A description of the physical and mental capabilities and needs of the participants to be served and the availability, frequency, and intensity of basic services and of supportive and optional services to be provided;

(b) Satisfactory proof of financial ability to operate and conduct the center in accordance with the requirements of this part, which must include, in the case of an initial application, a 1-year operating plan and proof of a 3-month operating reserve fund; and

(c) Proof of adequate liability insurance coverage.

(d) Proof of compliance with level 2 background screening as required under s. 400.5572.

(e) A description and explanation of any exclusions, permanent suspensions, or terminations of the application from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicare or Medicaid programs shall be accepted in lieu of this submission.

**History.**--s. 6, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 6, 17, ch. 93-215; s. 50, ch. 98-171.

**400.556 Denial, suspension, revocation of license; administrative fines; investigations and inspections.**--

(1) The agency may deny, revoke, or suspend a license under this part or may impose an administrative fine against the owner of an adult day care center or its operator or employee in the manner provided in chapter 120.

(2) Each of the following actions by the owner of an adult day care center or by its operator or employee is a ground for action by the agency against the owner of the center or its operator or employee:

(a) An intentional or negligent act materially affecting the health or safety of center participants.

(b) A violation of this part or of any standard or rule under this part.

(c) A failure of persons subject to level 2 background screening under s. 400.4174(1) to meet the screening standards of s. 435.04, or the retention by the center of an employee subject to level 1 background screening standards under s. 400.4174(2) who does not meet the screening standards of s. 435.03 and for whom exemptions from disqualification have not been provided by the agency.

(d) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of center participants.

(e) Multiple or repeated violations of this part or of any standard or rule adopted under this part.

(f) Exclusion, permanent suspension, or termination of the owner, if an individual, officer, or board member of the adult day care center, if the owner is a firm, corporation, partnership, or association, or any person owning 5 percent or more of the center, from the Medicare or Medicaid program.

(3) The agency is responsible for all investigations and inspections conducted pursuant to this part.

**History.**--s. 7, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 7, 17, ch. 93-215; s. 40, ch. 96-169; s. 51, ch. 98-171; s. 143, ch. 98-403; s. 16, ch. 2004-267.

**400.5565 Administrative fines; interest.**--

(1)(a) If the agency determines that an adult day care center is not operated in compliance with this part or with rules adopted under this part, the agency, notwithstanding any other administrative action it takes, shall make a reasonable attempt to discuss with the owner each violation and recommended corrective action prior to providing the owner with written notification. The agency may request the submission of a corrective action plan for the center which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(b) The owner of a center or its operator or employee found in violation of this part or of rules adopted under this part may be fined by the agency. A fine may not exceed $500 for each violation. In no event, however, may such fines in the aggregate exceed $5,000.

(c) The failure to correct a violation by the date set by the agency, or the failure to comply with an approved corrective action plan, is a separate violation for each day such failure continues, unless the agency approves an extension to a specific date.

(d) If the owner of a center or its operator or employee appeals an agency action under this section and the fine is upheld, the violator shall pay the fine, plus interest at the legal rate specified in s. 687.01 for each day that the fine remains unpaid after the date set by the agency for payment of the fine.

(2) In determining whether to impose a fine and in fixing the amount of any fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a participant will result or has resulted, the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or rules were violated.

(b) Actions taken by the owner or operator to correct violations.

(c) Any previous violations.

(d) The financial benefit to the center of committing or continuing the violation.

**History.**--ss. 64, 83, ch. 83-181; ss. 8, 17, ch. 93-215.

**400.557 Expiration of license; renewal; conditional license or permit.**--

(1) A license issued for the operation of an adult day care center, unless sooner suspended or revoked, expires 2 years after the date of issuance. The agency shall notify a licensee at least 120 days before the expiration date that license renewal is required to continue operation. The notification must be provided electronically or by mail delivery. At least 90 days prior to the expiration date, an application for renewal must be submitted to the agency. A license shall be renewed, upon the filing of an application on forms furnished by the agency, if the applicant has first met the requirements of this part and of the rules adopted under this part. The applicant must file with the application satisfactory proof of financial ability to operate the center in accordance with the requirements of this part and in accordance with the needs of the participants to be served and an affidavit of compliance with the background screening requirements of s. 400.5572.

(2) A licensee against whom a revocation or suspension proceeding is pending at the time for license renewal may be issued a conditional license effective until final disposition by the agency of the proceeding. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional permit effective for the duration of the judicial proceeding.

(3) The agency may issue a conditional license to an applicant for license renewal or change of ownership if the applicant fails to meet all standards and requirements for licensure. A conditional license issued under this subsection must be limited to a specific period not exceeding 6 months, as determined by the agency, and must be accompanied by an approved plan of correction.

**History.**--s. 8, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 9, 17, ch. 93-215; s. 52, ch. 98-171; s. 27, ch. 2003-57.

**400.5571 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.**--

(1) An adult day care center licensed under this part must provide the following staff training:

(a) Upon beginning employment with the facility, each employee must receive basic written information about interacting with participants who have Alzheimer's disease or dementia-related disorders.

(b) In addition to the information provided under paragraph (a), newly hired adult day care center personnel who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.

(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the participant's independence in activities of daily living, and instruction in skills for working with families and caregivers.

(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.

(e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.

(f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.

(g) The Department of Elderly Affairs or its designee must approve the 1-hour and 3-hour training provided to employees and direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.

(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different adult day care center or to an assisted living facility, nursing home, home health agency, or hospice. The direct caregiver must comply with other applicable continuing education requirements.

(i) An employee who is hired on or after July 1, 2004, must complete the training required by this section.

(2) A center licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The center must give a copy of all such advertisements or a copy of the document to each person who requests information about the center and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the center's records as part of the license renewal procedure.

**History.**--s. 4, ch. 93-105; s. 3, ch. 2003-271.

**400.5572 Background screening.**--

(1)(a) Level 2 background screening must be conducted on each of the following persons, who shall be considered employees for the purposes of conducting screening under chapter 435:

1. The adult day care center owner if an individual, the operator, and the financial officer.

2. An officer or board member if the owner of the adult day care center is a firm, corporation, partnership, or association, or any person owning 5 percent or more of the facility, if the agency has probable cause to believe that such person has been convicted of any offense prohibited by s. 435.04. For each officer, board member, or person owning 5 percent or more who has been convicted of any such offense, the facility shall submit to the agency a description and explanation of the conviction at the time of license application. This subparagraph does not apply to a board member of a not-for-profit corporation or organization if the board member serves solely in a voluntary capacity, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the board member and facility submit a statement affirming that the board member's relationship to the facility satisfies the requirements of this subparagraph.

(b) Proof of compliance with level 2 screening standards which has been submitted within the previous 5 years to meet any facility or professional licensure requirements of the agency or the Department of Health satisfies the requirements of this subsection.

(c) The agency may grant a provisional license to an adult day care center applying for an initial license when each individual required by this subsection to undergo screening has completed the Department of Law Enforcement background check, but has not yet received results from the Federal Bureau of Investigation, or when a request for an exemption from disqualification has been

submitted to the agency pursuant to s. 435.07, but a response has not been issued.

(2) The owner or administrator of an adult day care center must conduct level 1 background screening as set forth in chapter 435 on all employees hired on or after October 1, 1998, who provide basic services or supportive and optional services to the participants. Such persons satisfy this requirement if:

(a) Proof of compliance with level 1 screening requirements obtained to meet any professional license requirements in this state is provided and accompanied, under penalty of perjury, by a copy of the person's current professional license and an affidavit of current compliance with the background screening requirements.

(b) The person required to be screened has been continuously employed, without a breach in service that exceeds 180 days, in the same type of occupation for which the person is seeking employment and provides proof of compliance with the level 1 screening requirement which is no more than 2 years old. Proof of compliance must be provided directly from one employer or contractor to another, and not from the person screened. Upon request, a copy of screening results shall be provided to the person screened by the employer retaining documentation of the screening.

(c) The person required to be screened is employed by a corporation or business entity or related corporation or business entity that owns, operates, or manages more than one facility or agency licensed under this chapter, and for whom a level 1 screening was conducted by the corporation or business entity as a condition of initial or continued employment.

**History.**--ss. 53, 71, ch. 98-171; s. 83, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 49, ch. 2004-267.

**400.5575 Disposition of fees and administrative fines.**--Fees and fines received by the agency under this part shall be deposited in the Health Care Trust Fund established pursuant to s. 408.16. These funds may be used to offset the costs of the licensure program, including the costs of conducting background investigations, verifying information submitted, and processing applications.

**History.**--ss. 65, 83, ch. 83-181; ss. 10, 17, ch. 93-215; s. 173, ch. 98-166.

**400.558 Injunctive relief.**--

(1) The agency may institute an action for injunctive relief in a court of competent jurisdiction to:

(a) Enforce the provisions of this part or any standard, rule, or order issued or entered into pursuant to this part; or

(b) Terminate the operation of an adult day care center for:

1. Failure to take preventive or corrective measures in accordance with an order of the agency;

2. Failure to abide by a final order of the agency; or

3. Violation of any provision of this part or of any rule or standard adopted pursuant to this part, which violation constitutes an emergency requiring immediate action.

(2) The court may grant temporary or permanent injunctive relief.

**History.**--s. 9, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 11, 17, ch. 93-215.

**400.559 Closing or change of owner or operator of center.** --

(1) Before operation of an adult day care center may be voluntarily discontinued, the operator must inform the agency in writing at least 60 days prior to the discontinuance of operation. The operator must also, at such time, inform each participant of the fact and the proposed date of such discontinuance.

(2) Immediately upon discontinuance of the operation of a center, the owner or operator shall surrender the license for the center to the agency, and the license shall be canceled by the agency.

(3) If a center has a change of ownership, the new owner shall apply to the agency for a new license at least 60 days before the date of the change of ownership.

(4) If a center has a change of operator, the new operator shall notify the agency in writing within 30 days after the change of operator.

**History.**--s. 10, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 12, 17, ch. 93-215.

**400.56 Right of entry and inspection.**--Any duly designated officer or employee of the agency or department has the right to enter the premises of any adult day care center licensed pursuant to this part, at any reasonable time, in order to determine the state of compliance with this part and the rules or standards in force pursuant to this part. The right of entry and inspection also extends to any premises that the agency has reason to believe are being operated as a center without a license, but no entry or inspection of any unlicensed premises may be made without the permission of the owner or operator unless a warrant is first obtained from the circuit court authorizing entry or inspection. Any application for a center license or license renewal made pursuant to this part constitutes permission for, and complete acquiescence in, any entry or inspection of the premises for which the license is sought in order to facilitate verification of the information submitted on or in connection with the application.

**History.**--s. 11, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 13, 17, ch. 93-215.

**400.562 Rules establishing standards.** --

(1) The Department of Elderly Affairs, in conjunction with the agency, shall adopt rules to implement the provisions of this part. The rules must include reasonable and fair standards. Any conflict between these standards and those that may be set forth in local, county, or municipal ordinances shall be resolved in favor of those having statewide effect. Such standards must relate to:

(a) The maintenance of adult day care centers with respect to plumbing, heating, lighting, ventilation, and other building conditions, including adequate meeting space, to ensure the health, safety, and comfort of participants and protection from fire hazard. Such standards may not conflict with chapter 553 and must be based upon the size of the structure and the number of participants.

(b) The number and qualifications of all personnel employed by adult day care centers who have responsibilities for the care of participants.

(c) All sanitary conditions within adult day care centers and their surroundings, including water supply, sewage disposal, food handling, and general hygiene, and maintenance of sanitary conditions, to ensure the health and comfort of participants.

(d) Basic services provided by adult day care centers.

(e) Supportive and optional services provided by adult day care centers.

(f) Data and information relative to participants and programs of adult day care centers, including, but not limited to, the physical and mental capabilities and needs of the participants, the availability, frequency, and intensity of basic services and of supportive and optional services provided, the frequency of participation, the distances traveled by participants, the hours of operation, the number of referrals to other centers or elsewhere, and the incidence of illness.

(g) Components of a comprehensive emergency management plan, developed in consultation with the Department of Health, the Agency for Health Care Administration, and the Department of Community Affairs.

(2) Pursuant to s. 119.07, the agency may charge a fee for furnishing a copy of this part, or of the rules adopted under this part, to any person upon request for the copy.

(3) Pursuant to rules adopted by the department, the agency may conduct an abbreviated biennial inspection of key quality-of-care standards, in lieu of a full inspection, of a center that has a record of good performance. However, the agency must conduct a full inspection of a center that has had one or more confirmed complaints within the licensure period immediately preceding the inspection or which has a serious problem identified during the abbreviated inspection. The agency shall develop the key quality-of-care standards, taking into consideration the comments and recommendations of the Department of Elderly Affairs and of provider groups. These standards shall be included in rules adopted by the Department of Elderly Affairs.

**History.**--ss. 13, 18, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 14, 17, ch. 93-215; s. 56, ch. 95-418; s. 61, ch. 2001-45.

**400.563 Construction and renovation; requirements.**--The requirements for the construction and the renovation of a center must comply with the provisions of chapter 553 which pertain to building construction standards, including plumbing, electrical code, glass, manufactured buildings, accessibility by physically handicapped persons, and the state minimum building codes.

**History.**--s. 14, ch. 78-336; s. 4, ch. 79-152; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 15, 17, ch. 93-215.

**400.564 Prohibited acts; penalty for violation.**--

(1)(a) It is unlawful for any person or public body to offer or advertise to the public, in any way, by any medium whatever, adult day care center basic services without having a license under this part.

(b) It is unlawful for any holder of a license issued under this part to advertise or hold out to the public that it holds a license for an adult day care center other than the one for which it actually holds a license.

(2) Any person that violates paragraph (1)(a) or paragraph (1)(b) is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083. Each day of continuing violation is considered a separate offense.

**History.**--s. 15, ch. 78-336; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 16, 17, ch. 93-215.

**PART VI**

**HOSPICES**

**400.6005 Legislative findings and intent.**--The Legislature finds that terminally ill individuals and their families, who are no longer pursuing curative medical treatment, should have the opportunity to select a support system that permits the patient to exercise maximum independence and dignity during the final days of life. The Legislature finds that hospice care provides a cost-effective and less intrusive form of medical care while meeting the social, psychological, and spiritual needs of terminally ill patients and their families. The intent of this part is to provide for the development, establishment, and enforcement of basic standards to ensure the safe and adequate care of persons receiving hospice services.

**History.**--s. 1, ch. 93-179.

**400.601 Definitions.**--As used in this part, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Department" means the Department of Elderly Affairs.

(3) "Hospice" means a centrally administered corporation not for profit, as defined in chapter 617, providing a continuum of palliative and supportive care for the terminally ill patient and his or her family.

(4) "Hospice care team" means an interdisciplinary team of qualified professionals and volunteers who, in consultation with the patient, the patient's family, and the patient's primary or attending physician, collectively assess, coordinate, and provide the appropriate palliative and supportive

care to hospice patients and their families.

(5) "Hospice residential unit" means a homelike living facility, other than a facility licensed under other parts of this chapter or under chapter 395, that is operated by a hospice for the benefit of its patients and is considered by a patient who lives there to be his or her primary residence.

(6) "Hospice services" means items and services furnished to a patient and family by a hospice, or by others under arrangements with such a program, in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility.

(7) "Palliative care" means services or interventions which are not curative but are provided for the reduction or abatement of pain and human suffering.

(8) "Patient" means the terminally ill individual receiving hospice services.

(9) "Plan of care" means a written assessment by the hospice of each patient's and family's needs and preferences, and the services to be provided by the hospice to meet those needs.

(10) "Terminally ill" means that the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course.

**History.**--s. 1, ch. 79-186; s. 1, ch. 80-64; s. 256, ch. 81-259; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 2, 14, ch. 93-179; s. 788, ch. 95-148; s. 57, ch. 95-418.

**400.602 Licensure required; prohibited acts; exemptions; display, transferability of license.** --

(1)(a) It is unlawful to operate or maintain a hospice without first obtaining a license from the agency.

(b) It is unlawful for any person or legal entity not licensed as a hospice under this part to use the word "hospice" in its name, or to offer or advertise hospice services or hospice-like services in such a way as to mislead a person to believe that the offeror is a hospice licensed under this part.

(2) Services provided by a hospital, nursing home, or other health care facility, health care provider, or caregiver, or under the Community Care for the Elderly Act, do not constitute a hospice unless the facility, provider, or caregiver establishes a separate and distinct administrative program to provide home, residential, and homelike inpatient hospice services.

(3)(a) A separately licensed hospice may not use a name which is substantially the same as the name of another hospice licensed under this part.

(b) A licensed hospice which intends to change its name or address must notify the agency at least 60 days before making the change.

(4) The license shall be displayed in a conspicuous place inside the hospice program office; shall be valid only in the possession of the person or public agency to which it is issued; shall not be subject to sale, assignment, or other transfer, voluntary or involuntary; and shall not be valid for any hospice other than the hospice for which originally issued.

(5) Notwithstanding s. 400.601(3), any hospice operating in corporate form exclusively as a hospice, incorporated on or before July 1, 1978, may be transferred to a for-profit or not-for-profit entity, and may transfer the license to that entity.

(6) Notwithstanding s. 400.601(3), at any time after July 1, 1995, any entity entitled to licensure under subsection (5) may obtain a license for up to two additional hospices in accordance with the other requirements of this part and upon receipt of any certificate of need that may be required under the provisions of ss. 408.031-408.045.

**History.**--s. 3, ch. 79-186; s. 2, ch. 80-64; s. 2, ch. 81-271; s. 2, ch. 81-318; ss. 66, 79, 83, ch. 83-181; s. 10, ch. 89-527; ss. 3, 14, ch. 93-179; s. 58, ch. 95-418; s. 11, ch. 97-270.

**400.6045 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.**--

(1) A hospice licensed under this part must provide the following staff training:

(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or dementia-related disorders.

(b) In addition to the information provided under paragraph (a), employees who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.

(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the patient's independence in activities of daily living, and instruction in skills for working with families and caregivers.

(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.

(e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.

(f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.

(g) The Department of Elderly Affairs or its designee must approve the required 1-hour and 3-hour training provided to employees or direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.

(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different hospice or to a home health agency, assisted living facility, nursing home, or adult day care center.

(i) An employee who is hired on or after July 1, 2003, must complete the required training by July

1, 2004, or by the deadline specified in this section, whichever is later.

(2) A hospice licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The hospice must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the hospice and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the hospice's records as part of the license renewal procedure.

**History.**--s. 5, ch. 93-105; s. 4, ch. 2003-271.

**400.605 Administration; forms; fees; rules; inspections; fines.**--

(1) The department, in consultation with the agency, shall by rule establish minimum standards and procedures for a hospice. The rules must include:

(a) License application procedures and requirements.

(b) The qualifications of professional and ancillary personnel to ensure the provision of appropriate and adequate hospice care.

(c) Standards and procedures for the administrative management of a hospice.

(d) Standards for hospice services that ensure the provision of quality patient care.

(e) Components of a patient plan of care.

(f) Procedures relating to the implementation of advanced directives and do-not-resuscitate orders.

(g) Procedures for maintaining and ensuring confidentiality of patient records.

(h) Standards for hospice care provided in freestanding inpatient facilities that are not otherwise licensed medical facilities and in residential care facilities such as nursing homes, assisted living facilities, adult family care homes, and hospice residential units and facilities.

(i) Physical plant standards for hospice residential and inpatient facilities and units.

(j) Components of a comprehensive emergency management plan, developed in consultation with the Department of Health, the Department of Elderly Affairs, and the Department of Community Affairs.

(k) Standards and procedures relating to the establishment and activities of a quality assurance and utilization review committee.

(l) Components and procedures relating to the collection of patient demographic data and other information on the provision of hospice care in this state.

(2) The agency shall:

(a) Prepare and furnish all forms necessary under the provisions of this part in relation to applications for licensure or licensure renewals.

(b) Collect from the applicant at the time of filing an application for a license or at the time of renewal of a license a fee which must be reasonably calculated to cover the cost of regulation under this part, but may not exceed $600 per program. All fees collected under this part shall be deposited in the Health Care Trust Fund for the administration of this part.

(c) Issue hospice licenses to all applicants which meet the provisions of this part and applicable rules.

(d) Conduct annual licensure inspections of all licensees, except that licensure inspections may be conducted biennially for hospices having a 3-year record of substantial compliance.

(e) Conduct such inspections and investigations as are necessary in order to determine the state of compliance with the provisions of this part and adopted rules. The right of inspection also extends to any program that the agency has reason to believe is offering or advertising itself as a hospice without a license, but no inspection may be made without the permission of the owner or person in charge thereof unless a warrant is first obtained from a circuit court authorizing such inspection. An application for a license or license renewal made pursuant to this part constitutes permission for an inspection of the hospice for which the license is sought in order to facilitate verification of the information submitted on or in connection with the application.

(f) Impose an administrative fine for any violation of the provisions of this part.

**History.**--s. 2, ch. 79-186; s. 2, ch. 81-318; ss. 69, 79, 83, ch. 83-181; s. 13, ch. 91-282; ss. 4, 14, ch. 93-179; s. 59, ch. 95-418; s. 1, ch. 99-139; s. 15, ch. 2000-140.

**400.606 License; application; renewal; conditional license or permit; certificate of need.**--

(1) A license application must be filed on a form provided by the agency and must be accompanied by the appropriate license fee as well as satisfactory proof that the hospice is in compliance with this part and any rules adopted by the department and proof of financial ability to operate and conduct the hospice in accordance with the requirements of this part. The initial application must be accompanied by a plan for the delivery of home, residential, and homelike inpatient hospice services to terminally ill persons and their families. Such plan must contain, but need not be limited to:

(a) The estimated average number of terminally ill persons to be served monthly.

(b) The geographic area in which hospice services will be available.

(c) A listing of services which are or will be provided, either directly by the applicant or through contractual arrangements with existing providers.

(d) Provisions for the implementation of hospice home care within 3 months after licensure.

(e) Provisions for the implementation of hospice homelike inpatient care within 12 months after licensure.

(f) The number and disciplines of professional staff to be employed.

(g) The name and qualifications of any existing or potential contractee.

(h) A plan for attracting and training volunteers.

(i) The projected annual operating cost of the hospice.

(j) A statement of financial resources and personnel available to the applicant to deliver hospice care.

If the applicant is an existing health care provider, the application must be accompanied by a copy of the most recent profit-loss statement and, if applicable, the most recent licensure inspection report.

(2) Each applicant must submit to the agency with its application a description and explanation of any exclusions, permanent suspensions, or terminations from the Medicaid or Medicare programs of the owner, if an individual; of any officer or board member of the hospice, if the owner is a firm, corporation, partnership, or association; or of any person owning 5 percent or more of the hospice. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs may be accepted in lieu of this submission.

(3) A license issued for the operation of a hospice, unless sooner suspended or revoked, shall expire automatically 1 year from the date of issuance. Sixty days prior to the expiration date, a hospice wishing to renew its license shall submit an application for renewal to the agency on forms furnished by the agency. The agency shall renew the license if the applicant has first met the requirements established under this part and all applicable rules and has provided the information described under this section in addition to the application. However, the application for license renewal shall be accompanied by an update of the plan for delivery of hospice care only if information contained in the plan submitted pursuant to subsection (1) is no longer applicable.

(4) A hospice against which a revocation or suspension proceeding is pending at the time of license renewal may be issued a conditional license by the agency effective until final disposition of such proceeding. If judicial relief is sought from the final agency action, the court having jurisdiction may issue a conditional permit for the duration of the judicial proceeding.

(5) The agency shall not issue a license to a hospice that fails to receive a certificate of need under the provisions of ss. 408.031-408.045. A licensed hospice is a health care facility as that term is used in s. 408.039(5) and is entitled to initiate or intervene in an administrative hearing.

(6) A freestanding hospice facility that is primarily engaged in providing inpatient and related services and that is not otherwise licensed as a health care facility shall be required to obtain a certificate of need. However, a freestanding hospice facility with six or fewer beds shall not be required to comply with institutional standards such as, but not limited to, standards requiring sprinkler systems, emergency electrical systems, or special lavatory devices.

**History.**--s. 6, ch. 79-186; s. 5, ch. 81-271; s. 2, ch. 81-318; ss. 70, 79, 83, ch. 83-181; s. 47, ch. 87-92; ss. 5, 14, ch. 93-179; s. 60, ch. 95-418; s. 54, ch. 98-171.

**400.6065 Background screening.**--

(1) Upon receipt of a completed application under s. 400.606, the agency shall require level 2 background screening on each of the following persons, who shall be considered employees for the purposes of conducting screening under chapter 435:

(a) The hospice administrator and financial officer.

(b) An officer or board member if the hospice is a firm, corporation, partnership, or association, or any person owning 5 percent or more of the hospice if the agency has probable cause to believe that such officer, board member, or owner has been convicted of any offense prohibited by s. 435.04. For each officer, board member, or person owning 5 percent or more who has been convicted of any such offense, the hospice shall submit to the agency a description and explanation of the conviction at the time of license application. This paragraph does not apply to a board member of a not-for-profit corporation or organization if the board member serves solely in a

voluntary capacity, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the board member and the corporation or organization submit a statement affirming that the board member's relationship to the corporation or organization satisfies the requirements of this paragraph.

(2) Proof of compliance with level 2 screening standards which has been submitted within the previous 5 years to meet any facility or professional licensure requirements of the agency or the Department of Health satisfies the requirements of this section.

(3) The agency may grant a provisional license to a hospice applying for an initial license when each individual required by this section to undergo screening has completed the Department of Law Enforcement background check, but has not yet received results from the Federal Bureau of Investigation.

(4) The agency shall require employment or contractor screening as provided in chapter 435, using the level 1 standards for screening set forth in that chapter, for hospice personnel.

(5) The agency may grant exemptions from disqualification from employment under this section as provided in s. 435.07.

(6) The administration of each hospice must sign an affidavit annually, under penalty of perjury, stating that all personnel employed or contracted with on or after October 1, 1998, who provide hospice services in a facility, or who enter the home of a patient in their service capacity, have been screened.

(7) Proof of compliance with the screening requirements of chapter 435 shall be accepted in lieu of the requirements of this section if the person has been continuously employed or registered without a breach in service that exceeds 180 days, the proof of compliance is not more than 2 years old, and the person has been screened, at the discretion of the hospice.

(8)(a) It is a misdemeanor of the first degree, punishable under s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to such person's qualifications to be employed or contracted with under this section;

2. Operate or attempt to operate an entity licensed under this part with persons who do not meet the minimum standards for good moral character as contained in this section; or

3. Use information from the criminal records obtained under this section for any purpose other than screening as specified in this section, or release such information to any other person for any purpose other than screening under this section.

(b) It is a felony of the third degree, punishable under s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment under this section.

**History.**--ss. 55, 71, ch. 98-171; s. 22, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 17, ch. 2004-267.

**400.607 Denial, suspension, or revocation of license; imposition of administrative fine; grounds; injunctions.** --

(1) The agency may deny, revoke, or suspend a license or impose an administrative fine, which may not exceed $5,000 per violation, in the manner provided in chapter 120.

(2) Any of the following actions by a licensed hospice or any of its employees shall be grounds for action by the agency against a hospice:

(a) A violation of the provisions of this part or applicable rules.

(b) An intentional or negligent act materially affecting the health or safety of a patient.

(3) The agency may deny or revoke a license upon a determination that:

(a) Persons subject to level 2 background screening under s. 400.6065 do not meet the screening standards of s. 435.04, and exemptions from disqualification have not been provided by the agency.

(b) An officer, board member, or person owning 5 percent or more of the hospice has been excluded, permanently suspended, or terminated from the Medicare or Medicaid programs.

(4) If, 3 months after the date of obtaining a license, or at any time thereafter, a hospice does not have in operation the home-care component of hospice care, the agency shall immediately revoke the license of such hospice.

(5) If, 12 months after the date of obtaining a license pursuant to s. 400.606, or at any time thereafter, a hospice does not have in operation the inpatient components of hospice care, the agency shall immediately revoke the license of such hospice.

(6) The agency may institute a civil action in a court of competent jurisdiction to seek injunctive relief to enforce compliance with this part or any rule adopted pursuant to this part.

(7) The remedies set forth in this section are independent of and cumulative to other remedies provided by law.

**History.**--s. 7, ch. 79-186; s. 2, ch. 81-318; ss. 71, 79, 83, ch. 83-181; ss. 6, 14, ch. 93-179; s. 56, ch. 98-171; s. 50, ch. 2004-267.

**400.6085 Contractual services.**--A hospice may contract out for some elements of its services. However, the core services, as set forth in s. 400.609(1), with the exception of physician services, shall be provided directly by the hospice. Any contract entered into between a hospice and a health care facility or service provider must specify that the hospice retains the responsibility for planning, coordinating, and prescribing hospice care and services for the hospice patient and family. A hospice that contracts for any hospice service is prohibited from charging fees for services provided directly by the hospice care team that duplicate contractual services provided to the patient and family.

(1) A contract for hospice services, including inpatient services, must:

(a) Identify the nature and scope of services to be provided.

(b) Require that direct patient care shall be maintained, supervised, and coordinated by the hospice care team.

(c) Limit the services to be provided to only those expressly authorized by the hospice in writing.

(d) Delineate the roles of hospice staff and contract staff in the admission process and patient assessment.

(e) Identify methods for ensuring continuity of hospice care.

(f) Plan for joint quality assurance.

(g) Specify the written documentation, including patient records, required of contract staff.

(h) Specify qualifications of persons providing the contract services.

(i) Specify the effective dates for the contract.

(2) With respect to contractual arrangements for inpatient hospice care:

(a) Licensed beds designated for inpatient hospice care through contract between an existing health care facility and a hospice shall not be required to be delicensed from one type of health care in order to enter into a contract with a hospice, nor shall the physical plant of any facility licensed pursuant to chapter 395 or part II of this chapter be required to be altered, except that a homelike atmosphere may be required.

(b) Hospices contracting for inpatient care beds shall not be required to obtain an additional certificate of need for the number of such designated beds. Such beds shall remain licensed to the health care facility and be subject to the appropriate inspections.

(c) Staffing standards for inpatient hospice care provided through a contract may not exceed the staffing standards required under the license held by the contractee.

(d) Under no circumstances may a hospice place a patient requiring inpatient care in a health care facility that is under a moratorium, has had its license revoked, or has a conditional license, accreditation, or rating. However, a hospice may continue to provide care or initiate care for a terminally ill person already residing in such a facility.

**History.**--s. 7, ch. 93-179; s. 219, ch. 99-13; s. 2, ch. 99-139.

**400.609 Hospice services.** --Each hospice shall provide a continuum of hospice services which afford the patient and the family of the patient a range of service delivery which can be tailored to specific needs and preferences of the patient and family at any point in time throughout the length of care for the terminally ill patient and during the bereavement period. These services must be available 24 hours a day, 7 days a week, and must include:

(1) SERVICES.--

(a) The hospice care team shall directly provide the following core services: nursing services, social work services, pastoral or counseling services, dietary counseling, and bereavement counseling services. Physician services may be provided by the hospice directly or through contract. A hospice may also use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances.

(b) Each hospice must also provide or arrange for such additional services as are needed to meet the palliative and support needs of the patient and family. These services may include, but are not limited to, physical therapy, occupational therapy, speech therapy, massage therapy, home health

aide services, infusion therapy, provision of medical supplies and durable medical equipment, day care, homemaker and chore services, and funeral services.

(2) HOSPICE HOME CARE.--Hospice care and services provided in a private home shall be the primary form of care. The goal of hospice home care shall be to provide adequate training and support to encourage self-sufficiency and allow patients and families to maintain the patient comfortably at home for as long as possible. The services of the hospice home care program shall be of the highest quality and shall be provided by the hospice care team.

(3) HOSPICE RESIDENTIAL CARE.--Hospice care and services, to the extent practicable and compatible with the needs and preferences of the patient, may be provided by the hospice care team to a patient living in an assisted living facility, adult family care home, nursing home, hospice residential unit or facility, or other nondomestic place of permanent or temporary residence. A resident or patient living in an assisted living facility, adult family care home, nursing home, or other facility subject to state licensing who has been admitted to a hospice program shall be considered a hospice patient, and the hospice program shall be responsible for coordinating and ensuring the delivery of hospice care and services to such person pursuant to the standards and requirements of this part and rules adopted under this part.

(4) HOSPICE INPATIENT CARE.--The inpatient component of care is a short-term adjunct to hospice home care and hospice residential care and shall be used only for pain control, symptom management, or respite care. The total number of inpatient days for all hospice patients in any 12-month period may not exceed 20 percent of the total number of hospice days for all the hospice patients of the licensed hospice. Hospice inpatient care shall be under the direct administration of the hospice, whether the inpatient facility is a freestanding hospice facility or part of a facility licensed pursuant to chapter 395 or part II of this chapter. The facility or rooms within a facility used for the hospice inpatient component of care shall be arranged, administered, and managed in such a manner as to provide privacy, dignity, comfort, warmth, and safety for the terminally ill patient and the family. Every possible accommodation must be made to create as homelike an atmosphere as practicable. To facilitate overnight family visitation within the facility, rooms must be limited to no more than double occupancy; and, whenever possible, both occupants must be hospice patients. There must be a continuum of care and a continuity of caregivers between the hospice home program and the inpatient aspect of care to the extent practicable and compatible with the preferences of the patient and his or her family. Fees charged for hospice inpatient care, whether provided directly by the hospice or through contract, must be made available upon request to the Agency for Health Care Administration. The hours for daily operation and the location of the place where the services are provided must be determined, to the extent practicable, by the accessibility of such services to the patients and families served by the hospice.

(5) BEREAVEMENT COUNSELING.--The hospice bereavement program must be a comprehensive program, under professional supervision, that provides a continuum of formal and informal supportive services to the family for a minimum of 1 year after the patient's death. This subsection does not constitute an additional exemption from chapter 490 or chapter 491.

**History.**--s. 9, ch. 79-186; s. 7, ch. 81-271; s. 2, ch. 81-318; ss. 73, 79, 83, ch. 83-181; s. 5, ch. 91-48; s. 67, ch. 91-221; s. 97, ch. 92-33; ss. 8, 14, ch. 93-179; s. 789, ch. 95-148; s. 21, ch. 95-210; s. 3, ch. 99-139.

**400.6095 Patient admission; assessment; plan of care; discharge; death.**--

(1) Each hospice shall make its services available to all terminally ill persons and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances. A hospice shall not impose any value or belief system on its patients or their families and shall respect the values and belief systems of its patients and their families.

(2) Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal

illness by a physician licensed pursuant to chapter 458 or chapter 459 and shall be dependent on the expressed request and informed consent of the patient.

(3) At the time of admission, the hospice shall inquire whether advance directives have been executed pursuant to chapter 765, and if not, provide information to the patient concerning the provisions of that chapter. The hospice shall also provide the patient with information concerning patient rights and responsibilities pursuant to s. 381.026.

(4) The admission process shall include a professional assessment of the physical, social, psychological, spiritual, and financial needs of the patient. This assessment shall serve as the basis for the development of a plan of care.

(5) Each hospice, in collaboration with the patient and the patient's primary or attending physician, shall prepare and maintain a plan of care for each patient, and the care provided to a patient must be in accordance with the plan of care. The plan of care shall be made a part of the patient's medical record and shall include, at a minimum:

(a) Identification of the primary caregiver, or an alternative plan of care in the absence of a primary caregiver, to ensure that the patient's needs will be met.

(b) The patient's diagnosis, prognosis, and preferences for care.

(c) Assessment of patient and family needs, identification of the services required to meet those needs, and plans for providing those services through the hospice care team, volunteers, contractual providers, and community resources.

(d) Plans for instructing the patient and family in patient care.

(e) Identification of the nurse designated to coordinate the overall plan of care for each patient and family.

(f) A description of how needed care and services will be provided in the event of an emergency.

(6) The hospice shall provide an ongoing assessment of the patient and family needs, update the plan of care to meet changing needs, coordinate the care provided with the patient's primary or attending physician, and document the services provided.

(7) In the event a hospice patient chooses to be discharged or transferred to another hospice, the hospice shall arrange for continuing care and services and complete a comprehensive discharge summary for the receiving provider.

(8) The hospice care team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Hospice staff shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and rules adopted by the department. The absence of an order to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

(9) The death of a person enrolled as a hospice patient shall be considered an attended death for the purposes of s. 406.11(1)(a)5. However, a hospice shall report the death to the medical examiner if any unusual or unexpected circumstances are present.

**History.**--s. 9, ch. 93-179; s. 6, ch. 99-331; s. 16, ch. 2000-140; s. 4, ch. 2000-295.

**400.610 Administration and management of a hospice.**--

(1) A hospice shall have a clearly defined organized governing body, consisting of a minimum of seven persons who are representative of the general population of the community served. The governing body shall have autonomous authority and responsibility for the operation of the hospice and shall meet at least quarterly. The governing body shall:

(a) Adopt an annual plan for the operation of the hospice, which shall include a plan for providing for uncompensated care and philanthropic community activities.

(b)1. Prepare and maintain a comprehensive emergency management plan that provides for continuing hospice services in the event of an emergency that is consistent with local special needs plans. The plan shall include provisions for ensuring continuing care to hospice patients who go to special needs shelters. The plan is subject to review and approval by the county health department, except as provided in subparagraph 2. During its review, the county health department shall ensure that the department, the agency, and the local chapter of the American Red Cross or other lead sheltering agency have an opportunity to review and comment on the plan. The county health department shall complete its review within 60 days after receipt of the plan and shall either approve the plan or advise the hospice of necessary revisions.

2. For any hospice that operates in more than one county, the Department of Health shall review the plan, after consulting with all of the county health departments, the agency, and all the local chapters of the American Red Cross or other lead sheltering agency in the areas of operation for that particular hospice. The Department of Health shall complete its review within 90 days after receipt of the plan and shall either approve the plan or advise the hospice of necessary revisions. The Department of Health shall make every effort to avoid imposing on the hospice differing requirements based on differences between counties.

(c) Adopt an annual budget.

(d) Appoint a director who shall be responsible for the day-to-day management and operation of the hospice and who shall serve as the liaison between the governing body and the hospice staff.

(e) Undertake such additional activities as necessary to ensure that the hospice is complying with the requirements for hospice services as set forth in this part.

(2) Each hospice shall develop and implement a comprehensive quality assurance and utilization review plan to be used for ongoing internal evaluation of the appropriateness and effectiveness of the hospice services provided. Each hospice shall take the corrective actions identified by the review and report a summary of these actions to the governing body at least annually.

(3) Each hospice shall ensure that adequate policies, procedures, and systems are developed and implemented to provide effective delivery of services.

**History.**--s. 10, ch. 79-186; s. 2, ch. 81-318; ss. 74, 79, 83, ch. 83-181; ss. 10, 14, ch. 93-179; s. 17, ch. 2000-140.

**400.6105 Staffing and personnel.**--

(1) Each hospice shall have a medical director licensed pursuant to chapter 458 or chapter 459 who shall have responsibility for directing the medical care and treatment of hospice patients.

(2) Each hospice shall employ a full-time registered nurse licensed pursuant to part I of chapter 464 who shall coordinate the implementation of the plan of care for each patient.

(3) A hospice shall employ a hospice care team or teams who shall participate in the establishment and ongoing review of the patient's plan of care, and be responsible for and supervise the delivery of hospice care and services to the patient. The team shall, at a minimum, consist of a physician licensed pursuant to chapter 458 or chapter 459, a nurse licensed pursuant to part I of chapter 464, a social worker, and a pastoral or other counselor. The composition of the team may vary for each patient and, over time, for the same patient to ensure that all the patient's needs and preferences are met.

(4) A hospice must maintain a trained volunteer staff for the purpose of providing both administrative support and direct patient care.

(5) A hospice may contract with other persons or legal entities to provide additional services beyond those provided by the hospice care team or, to supplement the number of persons on the hospice care team, to ensure that the needs of patients and their families are met. Persons hired on contract shall have the same qualifications as are required of hospice personnel.

(6) Each hospice shall provide ongoing training and support programs for hospice staff and volunteers.

**History.**--s. 11, ch. 93-179; s. 106, ch. 2000-318.

**400.611 Interdisciplinary records of care; confidentiality.**--

(1) An up-to-date, interdisciplinary record of care being given and patient and family status shall be kept. Records shall contain pertinent past and current medical, nursing, social, and other therapeutic information and such other information that is necessary for the safe and adequate care of the patient. Notations regarding all aspects of care for the patient and family shall be made in the record. When services are terminated, the record shall show the date and reason for termination.

(2) Patient records shall be retained for a period of 5 years after termination of hospice services, unless otherwise provided by law. In the case of a patient who is a minor, the 5-year period shall begin on the date the patient reaches or would have reached the age of majority.

(3) Patient records of care are confidential. A hospice may not release a record or any portion thereof, unless:

(a) A patient or legal guardian has given express written informed consent;

(b) A court of competent jurisdiction has so ordered; or

(c) A state or federal agency, acting under its statutory authority, requires submission of aggregate statistical data. Any information obtained from patient records by a state agency pursuant to its statutory authority is confidential and exempt from the provisions of s. 119.07(1).

**History.**--s. 11, ch. 79-186; s. 2, ch. 81-318; ss. 79, 83, ch. 83-181; ss. 12, 14, ch. 93-179; s. 232, ch. 96-406.

## PART VII

## ADULT FAMILY-CARE HOME ACT

**400.616 Short title.**--This part may be cited as the "Adult Family-Care Home Act."

**History.**--ss. 1, 2, ch. 85-195; s. 4, ch. 91-429; s. 2, ch. 93-209; s. 1, ch. 98-338.

**400.617 Legislative intent; purpose.**--

(1) The Legislature encourages the provision of care for disabled adults and frail elders in family-type living arrangements in private homes.

(2) Adult family-care homes provide housing and personal care for disabled adults and frail elders who choose to live with an individual or family in a private home. The adult family-care home provider must live in the home. The purpose of this part is to provide for the health, safety, and welfare of residents of adult family-care homes in the state.

(3) The Legislature recognizes that adult family-care homes are an important part of the continuum of long-term care. The personal care available in these homes, which may be provided directly or through contract or agreement, is intended to help residents remain as independent as possible in order to delay or avoid placement in a nursing home or other institution. Regulations governing adult family-care homes must be sufficiently flexible to allow residents to age in place if resources are available to meet their needs and accommodate their preferences.

(4) The Legislature further finds and declares that licensure under this part is a public trust and a privilege, and not an entitlement. This principle must guide the finder of fact or trier of law at any administrative proceeding or circuit court action initiated by the department to enforce this part.

(5) Rules of the department relating to adult family-care homes shall be as minimal and flexible as possible to ensure the protection of residents while minimizing the obstacles that could inhibit the establishment of adult family-care homes.

**History.**--ss. 1, 2, ch. 85-195; s. 4, ch. 91-429; s. 3, ch. 93-209; s. 2, ch. 98-338.

**400.618 Definitions.**--As used in this part, the term:

(1) "Activities of daily living" means functions and tasks for self-care, including eating, bathing, grooming, dressing, ambulating, and other similar tasks.

(2) "Adult family-care home" means a full-time, family-type living arrangement, in a private home, under which a person who owns or rents the home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders who are not relatives. The following family-type living arrangements are not required to be licensed as an adult family-care home:

(a) An arrangement whereby the person who owns or rents the home provides room, board, and personal services for not more than two adults who do not receive optional state supplementation under s. 409.212. The person who provides the housing, meals, and personal [1]care must own or rent the home and reside therein.

(b) An arrangement whereby the person who owns or rents the home provides room, board, and personal services only to his or her relatives.

(c) An establishment that is licensed as an assisted living facility under part III.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Aging in place" means remaining in a noninstitutional living environment despite the physical or mental changes that may occur in a person who is aging. For aging in place to occur, needed services are added, increased, or adjusted to compensate for a person's physical or mental changes.

(5) "Appropriate placement" means that the resident's needs can be met by the adult family-care home or can be met by services arranged by the adult family-care home or the resident.

(6) "Chemical restraint" means a pharmacologic drug that physically limits, restricts, or deprives an individual of movement or mobility, and is used for discipline or convenience and not required for the treatment of medical symptoms.

(7) "Department" means the Department of Elderly Affairs.

(8) "Disabled adult" means any person between 18 and 59 years of age, inclusive, who is a resident of the state and who has one or more permanent physical or mental limitations that restrict the person's ability to perform the normal activities of daily living.

(9) "Frail elder" means a functionally impaired elderly person who is 60 years of age or older and who has physical or mental limitations that restrict the person's ability to perform the normal activities of daily living and that impede the person's capacity to live independently.

(10) "Personal services" or "personal care" includes individual assistance with or supervision of the activities of daily living and the self-administration of medication, and other similar services.

(11) "Provider" means a person who is licensed to operate an adult family-care home.

(12) "Relative" means an individual who is the father, mother, son, daughter, brother, sister, grandfather, grandmother, great-grandfather, great-grandmother, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, or half sister of a provider.

(13) "Relief person" means an adult designated by the provider to supervise the residents during

the provider's absence.

(14) "Resident" means a person receiving room, board, and personal care in an adult family-care home.

**History.**--ss. 1, 2, ch. 85-195; s. 4, ch. 91-429; s. 4, ch. 93-209; s. 22, ch. 95-210; s. 61, ch. 95-418; s. 21, ch. 98-80; s. 3, ch. 98-338; s. 220, ch. 99-13.

**[1]Note.**--As amended by s. 3, ch. 98-338. Section 21, ch. 98-80, substituted the word "services" for the word "care."

**400.619 Licensure application and renewal.**--

(1) Each person who intends to be an adult family-care home provider must apply for a license from the agency at least 90 days before the applicant intends to operate the adult family-care home.

(2) A person who intends to be an adult family-care home provider must own or rent the adult family-care home that is to be licensed and reside therein.

(3) The agency shall notify a licensee at least 120 days before the expiration date that license renewal is required to continue operation. The notification must be provided electronically or by mail delivery. Application for a license or annual license renewal must be made on a form provided by the agency, signed under oath, and must be accompanied by a licensing fee of $100 per year.

(4) Upon receipt of a completed license application or license renewal, and the fee, the agency shall initiate a level 1 background screening as provided under chapter 435 on the adult family-care home provider, the designated relief person, all adult household members, and all staff members. The agency shall conduct an onsite visit to the home that is to be licensed.

(a) Proof of compliance with level 1 screening standards which has been submitted within the previous 5 years to meet any facility or professional licensure requirements of the agency or the Department of Health satisfies the requirements of this subsection. Such proof must be accompanied, under penalty of perjury, by a copy of the person's current professional license and an affidavit of current compliance with the background screening requirements.

(b) The person required to be screened must have been continuously employed in the same type of occupation for which the person is seeking employment without a breach in service that exceeds 180 days, and proof of compliance with the level 1 screening requirement which is no more than 2 years old must be provided. Proof of compliance shall be provided directly from one employer or contractor to another, and not from the person screened. Upon request, a copy of screening results shall be provided to the person screened by the employer retaining documentation of the screening.

(5) The application must be accompanied by a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from participation in the Medicaid or Medicare programs or any other governmental health care or health insurance program.

(6) Unless the adult family-care home is a community residential home subject to chapter 419, the applicant must provide documentation, signed by the appropriate governmental official, that the home has met local zoning requirements for the location for which the license is sought.

(7) Access to a licensed adult family-care home must be provided at reasonable times for the appropriate officials of the department, the Department of Health, the Department of Children and Family Services, the agency, and the State Fire Marshal, who are responsible for the

development and maintenance of fire, health, sanitary, and safety standards, to inspect the facility to assure compliance with these standards. In addition, access to a licensed adult family-care home must be provided at reasonable times for the local long-term care ombudsman council.

(8) A license is effective for 1 year after the date of issuance unless revoked sooner. Each license must state the name of the provider, the address of the home to which the license applies, and the maximum number of residents of the home. Failure to timely file a license renewal application shall result in a late fee equal to 50 percent of the license fee.

(9) A license is not transferable or applicable to any location or person other than the location and person indicated on the license.

(10) The licensed maximum capacity of each adult family-care home is based on the service needs of the residents and the capability of the provider to meet the needs of the residents. Any relative who lives in the adult family-care home and who is a disabled adult or frail elder must be included in that limitation.

(11) Each adult family-care home must designate at least one licensed space for a resident receiving optional state supplementation. The [1]Department of Children and Family Services shall specify by rule the procedures to be followed for referring residents who receive optional state supplementation to adult family-care homes. Those homes licensed as adult foster homes or assisted living facilities prior to January 1, 1994, that convert to adult family-care homes, are exempt from this requirement.

(12) The agency may issue a conditional license to a provider for the purpose of bringing the adult family-care home into compliance with licensure requirements. A conditional license must be limited to a specific period, not exceeding 6 months. The department shall, by rule, establish criteria for issuing conditional licenses.

(13) All moneys collected under this section must be deposited into the Department of Elderly Affairs Administrative Trust Fund.

(14) The department may adopt rules to establish procedures, identify forms, specify documentation, and clarify terms, as necessary, to administer this section.

**History.**--ss. 1, 2, ch. 85-195; s. 38, ch. 87-225; s. 4, ch. 91-429; s. 5, ch. 93-209; s. 23, ch. 95-210; ss. 62, 130, ch. 95-418; s. 8, ch. 98-148; ss. 57, 71, ch. 98-171; s. 4, ch. 98-338; s. 147, ch. 2000-349; s. 67, ch. 2000-367; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 28, ch. 2003-57; s. 25, ch. 2004-267; s. 8, ch. 2004-298.

**[1]Note.**--As amended by s. 57, ch. 98-171. Section 4, ch. 98-338, substituted the word "department" for the existing reference to the Department of Health and Rehabilitative Services; s. 400.618(7) defines "department" as the Department of Elderly Affairs for purposes of this part.

**400.6194 Denial, revocation, or suspension of a license.**--The agency may deny, suspend, or revoke a license for any of the following reasons:

(1) Failure of any of the persons required to undergo background screening under s. 400.619 to meet the level 1 screening standards of s. 435.03, unless an exemption from disqualification has been provided by the agency.

(2) An intentional or negligent act materially affecting the health, safety, or welfare of the adult family-care home residents.

(3) Submission of fraudulent information or omission of any material fact on a license application

or any other document required by the agency.

(4) Failure to pay an administrative fine assessed under this part.

(5) A violation of this part or adopted rules which results in conditions or practices that directly threaten the physical or emotional health, safety, or welfare of residents.

(6) Failure to correct cited fire code violations that threaten the health, safety, or welfare of residents.

(7) Failure to submit a completed initial license application or to complete an application for license renewal within the specified timeframes.

(8) Exclusion, permanent suspension, or termination of the provider from the Medicare or Medicaid program.

**History.**--ss. 58, 71, ch. 98-171; s. 5, ch. 98-338; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 26, ch. 2004-267.

**400.6196 Violations; penalties.** --

(1) In addition to any other liability or penalty provided by law, the agency may impose a civil penalty on a provider according to the following classification:

(a) Class I violations are those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice that constitutes a class I violation must be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. A class I deficiency is subject to an administrative fine in an amount not less than $500 and not exceeding $1,000 for each violation. A fine may be levied notwithstanding the correction of the deficiency.

(b) Class II violations are those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the residents, other than class I violations. A class II violation is subject to an administrative fine in an amount not less than $250 and not exceeding $500 for each violation. A citation for a class II violation must specify the time within which the violation is required to be corrected. If a class II violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

(c) Class III violations are those conditions or practices related to the operation and maintenance of an adult family-care home or to the care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of residents, other than class I or class II violations. A class III violation is subject to an administrative fine in an amount not less than $100 and not exceeding $250 for each violation. A citation for a class III violation shall specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

(d) Class IV violations are those conditions or occurrences related to the operation and maintenance of an adult family-care home, or related to the required reports, forms, or documents, which do not have the potential of negatively affecting the residents. A provider that does not correct a class IV violation within the time limit specified by the agency is subject to an administrative fine in an amount not less than $50 and not exceeding $100 for each violation. Any class IV violation that is corrected during the time the agency survey is conducted will be identified

as an agency finding and not as a violation.

(2) The agency may impose an administrative fine for violations which do not qualify as class I, class II, class III, or class IV violations. The amount of the fine shall not exceed $250 for each violation or $2,000 in the aggregate. Unclassified violations include:

(a) Violating any term or condition of a license.

(b) Violating any rule adopted under this part.

(c) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of adult family-care home residents.

(d) Exceeding licensed capacity.

(e) Providing services beyond the scope of the license.

(f) Violating a moratorium.

(3) Each day during which a violation occurs constitutes a separate offense.

(4) In determining whether a penalty is to be imposed, and in fixing the amount of any penalty to be imposed, the agency must consider:

(a) The gravity of the violation.

(b) Actions taken by the provider to correct a violation.

(c) Any previous violation by the provider.

(d) The financial benefit to the provider of committing or continuing the violation.

(5) As an alternative to or in conjunction with an administrative action against a provider, the agency may request a plan of corrective action that demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(6) The department shall set forth, by rule, notice requirements and procedures for correction of deficiencies.

(7) Civil penalties paid by a provider must be deposited into the Department of Elderly Affairs Administrative Trust Fund and used to offset the expenses of departmental training and education for adult family-care home providers.

(8) The agency may impose an immediate moratorium on admissions to any adult family-care home if the agency finds that a condition in the home presents a threat to the health, safety, or welfare of its residents. The department may by rule establish facility conditions that constitute grounds for imposing a moratorium and establish procedures for imposing and lifting a moratorium.

**History.**--s. 6, ch. 93-209; s. 64, ch. 95-418; s. 41, ch. 96-169; s. 9, ch. 98-148; s. 6, ch. 98-338; s. 221, ch. 99-13.

**400.621 Rules and standards relating to adult family-care homes.**--

(1) The department, in consultation with the Department of Health, the Department of Children and Family Services, and the agency shall, by rule, establish minimum standards to ensure the health, safety, and well-being of each resident in the adult family-care home. The rules must address:

(a) Requirements for the physical site of the facility and facility maintenance.

(b) Services that must be provided to all residents of an adult family-care home and standards for such services, which must include, but need not be limited to:

1. Room and board.

2. Assistance necessary to perform the activities of daily living.

3. Assistance necessary to administer medication.

4. Supervision of residents.

5. Health monitoring.

6. Social and leisure activities.

(c) Standards and procedures for license application and annual license renewal, advertising, proper management of each resident's funds and personal property and personal affairs, financial ability to operate, medication management, inspections, complaint investigations, and facility, staff, and resident records.

(d) Qualifications, training, standards, and responsibilities for providers and staff.

(e) Compliance with chapter 419, relating to community residential homes.

(f) Criteria and procedures for determining the appropriateness of a resident's placement and continued residency in an adult family-care home. A resident who requires 24-hour nursing supervision may not be retained in an adult family-care home unless such resident is an enrolled hospice patient and the resident's continued residency is mutually agreeable to the resident and the provider.

(g) Procedures for providing notice and assuring the least possible disruption of residents' lives when residents are relocated, an adult family-care home is closed, or the ownership of an adult family-care home is transferred.

(h) Procedures to protect the residents' rights as provided in s. 400.628.

(i) Procedures to promote the growth of adult family-care homes as a component of a long-term care system.

(j) Procedures to promote the goal of aging in place for residents of adult family-care homes.

(2) The department shall by rule provide minimum standards and procedures for emergencies. Pursuant to s. 633.022, the State Fire Marshal, in consultation with the department and the agency, shall adopt uniform firesafety standards for adult family-care homes.

(3) The department shall adopt rules providing for the implementation of orders not to resuscitate. The provider may withhold or withdraw cardiopulmonary resuscitation if presented

with an order not to resuscitate executed pursuant to s. 401.45. The provider shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order and rules adopted by the department.

(4) The provider of any adult family-care home that is in operation at the time any rules are adopted or amended under this part may be given a reasonable time, not exceeding 6 months, within which to comply with the new or revised rules and standards.

**History.**--ss. 1, 2, ch. 85-195; s. 4, ch. 91-429; s. 7, ch. 93-209; s. 24, ch. 95-210; s. 65, ch. 95-418; s. 10, ch. 98-148; s. 7, ch. 98-338; s. 3, ch. 99-179; s. 7, ch. 99-331.

**400.6211 Training and education programs.**--

(1) Each adult family-care home provider shall complete training and education programs.

(2) Training and education programs must include information relating to:

(a) State law and rules governing adult family-care homes, with emphasis on appropriateness of placement of residents in an adult family-care home.

(b) Identifying and reporting abuse, neglect, and exploitation.

(c) Identifying and meeting the special needs of disabled adults and frail elders.

(d) Monitoring the health of residents, including guidelines for prevention and care of pressure ulcers.

(3) Effective January 1, 2004, providers must complete the training and education program within a reasonable time determined by the department. Failure to complete the training and education program within the time set by the department is a violation of this part and subjects the provider to revocation of the license.

(4) If the Department of Children and Family Services, the agency, or the department determines that there are problems in an adult family-care home which could be reduced through specific training or education beyond that required under this section, the agency may require the provider or staff to complete such training or education.

(5) The department may adopt rules as necessary to administer this section.

**History.**--s. 8, ch. 93-209; s. 66, ch. 95-418; s. 11, ch. 98-148; s. 8, ch. 98-338; s. 4, ch. 2003-405.

**400.622 Injunctive proceedings.**--The department, the Department of Children and Family Services, or the agency may institute injunctive proceedings in a court of competent jurisdiction to:

(1) Enforce the provisions of this part or any license requirement, minimum standard, rule, or order issued or entered into under this part; or

(2) Terminate the operation of an adult family-care home when violations of any license requirement, standard, or rule adopted under this part exist which materially affect the health, safety, or welfare of residents.

**History.**--ss. 1, 2, ch. 85-195; s. 39, ch. 87-225; s. 4, ch. 91-429; s. 9, ch. 93-209; s. 67, ch. 95-418; s. 9, ch. 98-338.

**400.625 Residency agreements.**--

(1) Each resident must be covered by a residency agreement, executed before or at the time of admission, between the provider and the resident or the resident's designee or legal representative. Each party to the contract must be provided a duplicate copy or the original agreement, and the provider must keep the residency agreement on file for 5 years after expiration of the agreement.

(2) Each residency agreement must specify the personal care and accommodations to be provided by the adult family-care home, the rates or charges, a requirement of at least 30 days' notice before a rate increase, and any other provisions required by rule of the department.

**History.**--s. 11, ch. 93-209; s. 10, ch. 98-338.

**400.6255 Residents with Alzheimer's disease or other related disorders; certain disclosures.**--An adult family-care home licensed under this part which claims that it provides special care for persons who have Alzheimer's disease or other related disorders must disclose in its advertisements or in a separate document those services that distinguish the care as being especially applicable to, or suitable for, such persons. The home must give a copy of all such advertisements or a copy of the document to each person who requests information about programs and services for persons with Alzheimer's disease or other related disorders offered by the home and must maintain a copy of all such advertisements and documents in its records. The agency shall examine all such advertisements and documents in the home's records as part of the license renewal procedure.

**History.**--s. 6, ch. 93-105; s. 31, ch. 97-100; s. 11, ch. 98-338.

**400.628 Residents' bill of rights.**--

(1) A resident of an adult family-care home may not be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the State Constitution, or the Constitution of the United States solely by reason of status as a resident of the home. Each resident has the right to:

(a) Live in a safe and decent living environment, free from abuse and neglect.

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and privacy.

(c) Keep and use the resident's own clothes and other personal property in the resident's immediate living quarters, so as to maintain individuality and personal dignity, except when the provider can demonstrate that to do so would be unsafe or an infringement upon the rights of other residents.

(d) Have unrestricted private communication, including receiving and sending unopened correspondence, having access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum.

(e) Be free to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.

(f) Manage the resident's own financial affairs unless the resident or the resident's guardian authorizes the provider to provide safekeeping for funds in accordance with procedures equivalent to those provided in s. 400.427.

(g) Share a room with the resident's spouse if both are residents of the home.

(h) Have reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.

(i) Exercise civil and religious liberties, including the right to independent personal decisions. Religious beliefs or practices and attendance at religious services may not be imposed upon a resident.

(j) Have access to adequate and appropriate health care.

(k) Be free from chemical and physical restraints.

(l) Have at least 30 days' notice of relocation or termination of residency from the home unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. If a resident has been adjudicated mentally incompetent, the resident's guardian must be given at least 30 days' notice, except in an emergency, of the relocation of a resident or of the termination of a residency. The reasons for relocating a resident must be set forth in writing.

(m) Present grievances and recommend changes to the provider, to staff, or to any other person without restraint, interference, coercion, discrimination, or reprisal. This right includes the right to have access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The provider shall ensure that residents and their legal representatives are made aware of the rights, obligations, and prohibitions set forth in this part. Residents must also be given the names, addresses, and telephone numbers of the local ombudsman council and the central abuse hotline where they may lodge complaints.

(3) The adult family-care home may not hamper or prevent residents from exercising the rights specified in this section.

(4) A provider or staff of an adult family-care home may not serve notice upon a resident to leave the premises or take any other retaliatory action against any person who:

(a) Exercises any right set forth in this section.

(b) Appears as a witness in any hearing, in or out of the adult family-care home.

(c) Files a civil action alleging a violation of this part or notifies a state attorney or the Attorney General of a possible violation of this part.

(5) Any adult family-care home that terminates the residency of an individual who has participated in activities specified in subsection (4) must show good cause for the termination in a court of competent jurisdiction.

(6) Any person who reports a complaint concerning a suspected violation of this part or the services and conditions in an adult family-care home, or who testifies in any administrative or judicial proceeding arising from such a complaint, is immune from any civil or criminal liability therefor, unless the person acted in bad faith or with malicious purpose or the court finds that there was a complete absence of a justiciable issue of either law or fact raised by the losing party.

**History.**--s. 12, ch. 93-209; s. 790, ch. 95-148; s. 6, ch. 97-82; s. 12, ch. 98-338; ss. 84, 148, ch. 2000-349; s. 68, ch. 2000-367.

**400.629 Civil actions to enforce rights.**--

(1) Any person or resident whose rights as specified in this part are violated has a cause of action against any adult family-care home, provider, or staff responsible for the violation. The action may be brought by the resident or the resident's guardian, or by a person or organization acting on behalf of a resident with the consent of the resident or the resident's guardian, to enforce the right. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual damages, and punitive damages when malicious, wanton, or willful disregard of the rights of others can be shown. Any plaintiff who prevails in any such action is entitled to recover reasonable attorney's fees, costs of the action, and damages, unless the court finds that the plaintiff has acted in bad faith or with malicious purpose or that there was a complete absence of a justiciable issue of either law or fact. A prevailing defendant is entitled to recover reasonable attorney's fees pursuant to s. 57.105. The remedies provided in this section are in addition to other legal and administrative remedies available to a resident or to the agency.

(2) To recover attorney's fees under this section, the following conditions precedent must be met:

(a) Within 120 days after the filing of a responsive pleading or defensive motion to a complaint brought under this section and before trial, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with this paragraph for the purpose of an early resolution of the matter.

1. Within 60 days after the filing of the responsive pleading or defensive motion, the parties shall:

a. Agree on a mediator. If the parties cannot agree on a mediator, the defendant shall immediately notify the court, which shall appoint a mediator within 10 days after such notice.

b. Set a date for mediation.

c. Prepare an order for the court that identifies the mediator, the scheduled date of the mediation, and other terms of the mediation. Absent any disagreement between the parties, the court may issue the order for the mediation submitted by the parties without a hearing.

2. The mediation must be concluded within 120 days after the filing of a responsive pleading or defensive motion. The date may be extended only by agreement of all parties subject to mediation under this subsection.

3. The mediation shall be conducted in the following manner:

a. Each party shall ensure that all persons necessary for complete settlement authority are present at the mediation.

b. Each party shall mediate in good faith.

4. All aspects of the mediation which are not specifically established by this subsection must be conducted according to the rules of practice and procedure adopted by the Supreme Court of this state.

(b) If the parties do not settle the case pursuant to mediation, the last offer of the defendant made at mediation shall be recorded by the mediator in a written report that states the amount of the offer, the date the offer was made in writing, and the date the offer was rejected. If the matter subsequently proceeds to trial under this section and the plaintiff prevails but is awarded an amount in damages, exclusive of attorney's fees, which is equal to or less than the last offer made by the defendant at mediation, the plaintiff is not entitled to recover any attorney's fees.

(c) This subsection applies only to claims for liability and damages and does not apply to actions for injunctive relief.

(d) This subsection applies to all causes of action that accrue on or after October 1, 1999.

(3) Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(4) In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.

**History.**--s. 13, ch. 93-209; s. 13, ch. 98-338; s. 32, ch. 99-225.

**PART VIII**

**INTERMEDIATE, SPECIAL SERVICES, AND TRANSITIONAL LIVING FACILITIES**



**400.701 Intermediate care facilities; intent.**--The Legislature recognizes the need to develop a continuum of long-term care in this state to meet the needs of the elderly and disabled persons. The Legislature finds that there is a gap between the level of care provided in assisted living facilities and in nursing homes. The Legislature finds that exploration of intermediate-level care facilities which would fill the gap between assisted living facilities and nursing homes, where both the federal and state government share the cost of providing care, is an appropriate option to explore in the continuum of care.

**History.**--s. 38, ch. 89-294; s. 25, ch. 95-210.

**400.801 Homes for special services.** --

(1) As used in this section, the term:

(a) "Agency" means the "Agency for Health Care Administration."

(b) "Home for special services" means a site where specialized health care services are provided, including personal and custodial care, but not continuous nursing services.

(2) A person must obtain a license from the agency to operate a home for special services. A license is valid for 1 year.

(3) The application for a license under this section must be made on a form provided by the agency. A nonrefundable license fee of not more than $1,000 must be submitted with the license application.

(4) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the facility, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the facility, including billings for client care and services, in accordance with the level 2 standards for screening set forth in chapter 435. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has probable cause to believe that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(5) Application for license renewal must be submitted 90 days before the expiration of the license.

(6) A change of ownership or control of a home for special services must be reported to the agency in writing at least 60 days before the change is scheduled to take effect.

(7) The agency shall adopt rules for implementing and enforcing this section.

(8)(a) It is unlawful for any person to establish, conduct, manage, or operate a home for special services without obtaining a license from the agency.

(b) It is unlawful for any person to offer or advertise to the public, in any medium whatever, specialized health care services without obtaining a license from the agency.

(c) It is unlawful for a holder of a license issued under this section to advertise or represent to the public that it holds a license for a type of facility other than the facility for which its license is issued.

(9)(a) A violation of any provision of this section or rules adopted by the agency for implementing this section is punishable by payment of an administrative fine not to exceed $5,000.

(b) A violation of subsection (8) or rules adopted under that subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation is a separate offense.

**History.**--s. 35, ch. 93-217; ss. 59, 71, ch. 98-171; s. 85, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 51, ch. 2004-267.

**400.805 Transitional living facilities.**--

(1) As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Health.

(c) "Transitional living facility" means a site where specialized health care services are provided, including, but not limited to, rehabilitative services, community reentry training, aids for independent living, and counseling to spinal-cord-injured persons and head-injured persons. This term does not include a hospital licensed under chapter 395 or any federally operated hospital or facility.

(2)(a) A person must obtain a license from the agency to operate a transitional living facility. A license issued under this section is valid for 1 year.

(b) The application for a license must be made on a form provided by the agency. A nonrefundable license fee of $2,000 and a fee of up to $39.25 per bed must be submitted with the license application.

(c) The agency may not issue a license to an applicant until the agency receives notice from the department as provided in paragraph (6)(b).

(3) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the facility, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the facility, including billings for client care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is an applicant if the agency has probable cause to believe that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include

in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

(4) An application for renewal of license must be submitted 90 days before the expiration of the license. Upon renewal of licensure, each applicant must submit to the agency, under penalty of perjury, an affidavit as set forth in paragraph (3)(d).

(5) A change of ownership or control of a transitional living facility must be reported to the agency in writing at least 60 days before the change is scheduled to take effect.

(6)(a) The agency shall adopt rules in consultation with the department governing the physical plant of transitional living facilities and the fiscal management of transitional living facilities.

(b) The department shall adopt rules in consultation with the agency governing the services provided to clients of transitional living facilities. The department shall enforce all requirements for providing services to the facility's clients. The department must notify the agency when it determines that an applicant for licensure meets the service requirements adopted by the department.

(c) The agency and the department shall enforce requirements under this section, as such requirements relate to them respectively, and their respective adopted rules.

(7)(a) It is unlawful for any person to establish, conduct, manage, or operate a transitional living facility without obtaining a license from the agency.

(b) It is unlawful for any person to offer or advertise to the public, in any medium whatever, services or care defined in paragraph (1)(c) without obtaining a license from the agency.

(c) It is unlawful for a holder of a license issued under this section to advertise or represent to the public that it holds a license for a type of facility other than the facility for which its license is issued.

(8) Any designated officer or employee of the agency, of the state, or of the local fire marshal may enter unannounced upon and into the premises of any facility licensed under this section in order to determine the state of compliance with this section and the rules or standards in force under this section. The right of entry and inspection also extends to any premises that the agency has reason to believe are being operated or maintained as a facility without a license; but such an entry or inspection may not be made without the permission of the owner or person in charge of

the facility unless a warrant that authorizes the entry is first obtained from the circuit court. The warrant requirement extends only to a facility that the agency has reason to believe is being operated or maintained as a facility without a license. An application for a license or renewal thereof which is made under this section constitutes permission for, and acquiescence in, any entry or inspection of the premises for which the license is sought, in order to facilitate verification of the information submitted on or in connection with the application; to discover, investigate, and determine the existence of abuse or neglect; or to elicit, receive, respond to, and resolve complaints. A current valid license constitutes unconditional permission for, and acquiescence in, any entry or inspection of the premises by authorized personnel. The agency retains the right of entry and inspection of facilities that have had a license revoked or suspended within the previous 24 months, to ensure that the facility is not operating unlawfully. However, before the facility is entered, a statement of probable cause must be filed with the director of the agency, who must approve or disapprove the action within 48 hours. Probable cause includes, but is not limited to, evidence that the facility holds itself out to the public as a provider of personal assistance services, or the receipt by the advisory council on brain and spinal cord injuries of a complaint about the facility.

(9) The agency may institute injunctive proceedings in a court of competent jurisdiction for temporary or permanent relief to:

(a) Enforce this section or any minimum standard, rule, or order issued pursuant thereto if the agency's effort to correct a violation through administrative fines has failed or when the violation materially affects the health, safety, or welfare of residents; or

(b) Terminate the operation of a facility if a violation of this section or of any standard or rule adopted pursuant thereto exists which materially affects the health, safety, or welfare of residents.

The Legislature recognizes that, in some instances, action is necessary to protect residents of facilities from immediately life-threatening situations. If it appears by competent evidence or a sworn, substantiated affidavit that a temporary injunction should issue, the court, pending the determination on final hearing, shall enjoin operation of the facility.

(10) The agency may impose an immediate moratorium on admissions to a facility when the agency determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility. If a facility's license is denied, revoked, or suspended, the facility may be subject to the immediate imposition of a moratorium on admissions to run concurrently with licensure denial, revocation, or suspension.

(11)(a) A violation of any provision of this section or rules adopted by the agency or department under this section is punishable by payment of an administrative or a civil penalty fine not to exceed $5,000.

(b) A violation of subsection (7) or rules adopted under that subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of a continuing violation is a separate offense.

**History.**--s. 36, ch. 93-217; s. 1, ch. 98-12; ss. 60, 71, ch. 98-171; s. 16, ch. 99-240; s. 22, ch. 2000-153; s. 86, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 52, ch. 2004-267.

## PART IX

## PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS

**400.901 Legislative intent.**--It is the intent of the Legislature to develop, establish, and enforce licensure and basic standards for prescribed pediatric extended care centers in order to assure that the centers provide the necessary family-centered medical, developmental, physiological, nutritional, psychosocial, and family training services.

**History.**--ss. 1, 17, ch. 87-290; s. 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.201.

**400.902 Definitions.**--As used in this part, the term:

(1) "Prescribed pediatric extended care center," hereinafter referred to as a "PPEC center," means any building or buildings, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide basic nonresidential services to three or more medically dependent or technologically dependent children who are not related to the owner or operator by blood, marriage, or adoption and who require such services. Infants and children considered for admission to a PPEC center must have complex medical conditions that require continual care. Prerequisites for admission are a prescription from the child's attending physician and consent of a parent or guardian.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Basic services" includes, but is not limited to, development, implementation, and monitoring of a comprehensive protocol of care, developed in conjunction with the parent or guardian, which

specifies the medical, nursing, psychosocial, and developmental therapies required by the medically dependent or technologically dependent child served as well as the caregiver training needs of the child's legal guardian.

(4) "Owner or operator" means any individual who has general administrative charge of a PPEC center.

(5) "Medical records" means medical records maintained in accordance with accepted professional standards and practices as specified in the rules implementing this part.

(6) "Medically dependent or technologically dependent child" means a child who because of a medical condition requires continuous therapeutic interventions or skilled nursing supervision which must be prescribed by a licensed physician and administered by, or under the direct supervision of, a licensed registered nurse.

(7) "Supportive services or contracted services" include, but are not limited to, speech therapy, occupational therapy, physical therapy, social work, developmental, child life, and psychological services.

**History.**--ss. 2, 17, ch. 87-290; ss. 1, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.202.

**400.903 PPEC centers to be licensed; exemptions.**--

(1) For the administration of this part, facilities to be licensed by the agency shall include all PPEC centers as defined in this part which are not otherwise exempt as provided in subsection (2).

(2) A facility, institution, or other place operated by the Federal Government or any agency thereof is exempt from the provisions of this part.

**History.**--ss. 3, 4, 17, ch. 87-290; ss. 2, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.203.

**400.905 License required; fee; exemption; display.**--

(1)(a) It is unlawful to operate or maintain a PPEC center without first obtaining from the agency a license authorizing such operation. The agency is responsible for licensing PPEC centers in accordance with the provisions of this part.

(b) Any person who violates paragraph (a) is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(2) Separate licenses are required for PPEC centers maintained on separate premises, even though they are operated under the same management. Separate licenses are not required for separate buildings on the same grounds.

(3) The annual license fee required of a PPEC center shall be in an amount determined by the agency to be sufficient to cover the agency's costs in carrying out its responsibilities under this part, but shall not be less than $500 or more than $1,500.

(4) County-operated or municipally operated PPEC centers applying for licensure under this part are exempt from the payment of license fees.

(5) The license shall be displayed in a conspicuous place inside the PPEC center.

(6) A license shall be valid only in the possession of the individual, firm, partnership, association, or corporation to whom it is issued and shall not be subject to sale, assignment, or other transfer, voluntary or involuntary; nor shall a license be valid for any premises other than that for which originally issued.

(7) Any license granted by the agency shall state the maximum capacity of the facility, the date the license was issued, the expiration date of the license, and any other information deemed necessary by the agency.

**History.**--ss. 5, 17, ch. 87-290; ss. 3, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.205.

**400.906 Initial application for license.** --

(1) Application for a license shall be made to the agency on forms furnished by it and shall be accompanied by the appropriate license fee unless the applicant is exempt from payment of the fee as provided in s. 400.905.

(2) The application shall be under oath and shall contain the following:

(a) The name and address of the applicant and the name by which the facility is to be known. Pursuant thereto:

1. If the applicant is a firm, partnership, or association, the application shall contain the name and address of every member thereof.

2. If the applicant is a corporation, the application shall contain its name and address, the names and addresses of its directors and officers, and the name and address of each person having at least a 10 percent interest in the corporation.

(b) Information which provides a source to establish the suitable character and competency of the applicant in accordance with the provisions of s. 402.305(2) and, if applicable, of the owner or operator, including the name and address of any licensed facility with which the applicant or owner or operator has been affiliated through ownership or employment within 5 years of the date of the application for a license.

(c) The names and addresses of other persons of whom the agency may inquire as to the character and reputation of the applicant and, if applicable, of the owner or operator.

(d) The names and addresses of other persons of whom the agency may inquire as to the financial responsibility of the applicant.

(e) Such other reasonable information as may be required by the agency to evaluate the ability of the applicant to meet the responsibilities entailed under this part.

(f) The location of the facility for which a license is sought and documentation, signed by the appropriate local government official, which states that the applicant has met local zoning requirements.

(3) The applicant for licensure shall furnish satisfactory proof of financial ability to operate and conduct the PPEC center in accordance with the requirements of this part.

(4) The applicant for licensure shall furnish proof of adequate liability insurance coverage or protection.

(5) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the operator, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the center, including billings for patient care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435, as well as the requirements of s. 435.03(3).

(b) The agency may require background screening of any other individual who is an applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an

exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

**History.**--ss. 6, 17, ch. 87-290; ss. 4, 14, ch. 93-66; ss. 22, 71, ch. 98-171; ss. 19, 20, ch. 98-288; s. 87, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 53, ch. 2004-267.

**Note.**--Former s. 391.206.

**400.907 Denial, suspension, revocation of licensure; administrative fines; grounds.**--

(1) The agency may deny, revoke, or suspend a license or impose an administrative fine in the manner provided in chapter 120.

(2) Any of the following actions by a PPEC center or its employee is grounds for action by the agency against a PPEC center or its employee:

(a) An intentional or negligent act materially affecting the health or safety of children in the PPEC center.

(b) A violation of the provisions of this part or of any standards or rules adopted pursuant to this part.

(c) Multiple and repeated violations of this part or of minimum standards or rules adopted pursuant to this part.

(3) The agency shall be responsible for all investigations and inspections conducted pursuant to this part.

**History.**--ss. 7, 17, ch. 87-290; ss. 5, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.207.

**400.908 Administrative fines; disposition of fees and fines.** --

(1)(a) If the agency determines that a PPEC center is being operated without a license or is otherwise not in compliance with rules adopted under this part, the agency, notwithstanding any other administrative action it takes, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner of the PPEC center prior to written notification thereof. The agency may request that the PPEC center submit a corrective action plan which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(b) The agency may fine a PPEC center or employee found in violation of rules adopted pursuant to

this part in an amount not to exceed $500 for each violation. Such fine may not exceed $5,000 in the aggregate.

(c) The failure to correct a violation by the date set by the agency, or the failure to comply with an approved corrective action plan, is a separate violation for each day such failure continues, unless the agency approves an extension to a specific date.

(d) If a PPEC center desires to appeal any agency action under this section and the fine is upheld, the violator shall pay the fine, plus interest at the legal rate specified in s. 687.01, for each day beyond the date set by the agency for payment of the fine.

(2) In determining if a fine is to be imposed and in fixing the amount of any fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a child will result or has resulted, the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or rules were violated.

(b) Actions taken by the owner or operator to correct violations.

(c) Any previous violations.

(d) The financial benefit to the PPEC center of committing or continuing the violation.

(3) Fees and fines received by the agency under this part shall be deposited in the Health Care Trust Fund created in s. 408.16.

**History.**--ss. 8, 17, ch. 87-290; s. 58, ch. 91-221; ss. 6, 14, ch. 93-66; s. 171, ch. 98-166; s. 19, ch. 98-288.

**Note.**--Former s. 391.208.

**400.910 Expiration of license; renewal; conditional license as permit.**--

(1) A license issued for the operation of a PPEC center, unless sooner suspended or revoked, shall expire 1 year after the date of issuance. At least 60 days before the expiration date, an application for renewal shall be submitted to the agency. The agency shall renew the license, upon the filing of an application on forms furnished by the agency, if the applicant has first met the requirements established under this part and all rules adopted pursuant to this part. The PPEC center shall file with the application satisfactory proof of financial ability to operate and conduct the facility in accordance with this part.

(2) A licensee against whom a revocation or suspension proceeding is pending at the time of license renewal may be issued a conditional license effective until final disposition by the agency of such proceedings. If judicial relief is sought from the final disposition, the court having jurisdiction may issue a conditional permit for the duration of the judicial proceeding.

**History.**--ss. 10, 17, ch. 87-290; ss. 7, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.210.

**400.911 Injunction proceedings authorized.**--

(1) The agency may institute injunction proceedings in a court of competent jurisdiction to:

(a) Enforce the provisions of this part or any standard, rule, or order issued or entered into pursuant thereto; or

(b) Terminate the operation of a PPEC center if the licensee has:

1. Not taken preventive or corrective measures in accordance with any order of the agency.

2. Failed to abide by any final order of the agency once it has become effective and binding.

3. Committed a violation of any provision of this part or of any rule adopted pursuant thereto, which violation constitutes an emergency requiring immediate action.

(2) Such injunctive relief may be temporary or permanent.

**History.**--ss. 11, 17, ch. 87-290; ss. 8, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.211.

**400.912 Closing of a PPEC center.** --

(1) Whenever a PPEC center voluntarily discontinues operation, it shall inform the agency in writing at least 30 days before the discontinuance of operation. The PPEC center shall also, at such time, inform each child's legal guardian of the fact and the proposed time of such discontinuance.

(2) Immediately upon discontinuance of the operation of a PPEC center, the owner or operator shall surrender the license therefor to the agency and the license shall be canceled.

**History.**--ss. 12, 17, ch. 87-290; ss. 9, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.212.

**400.913 Right of entry and inspection.**--Any duly designated officer or employee of the agency shall have the right to enter upon and into the premises of any PPEC center licensed pursuant to this part, at any reasonable time, in order to determine the state of compliance with the provisions of this part and of rules or standards in force pursuant thereto. The right of entry and inspection shall also extend to any premises which the agency has reason to believe are being operated or maintained as a PPEC center without a license, but no such entry or inspection of any premises shall be made without the permission of the owner or operator in charge thereof unless a warrant is first obtained from the circuit court authorizing the entry and inspection. Any application for a PPEC center license or renewal made pursuant to this part shall constitute permission for, and complete acquiescence in, any entry or inspection of the premises for which the license is sought in order to facilitate verification of the information submitted on or in connection with the application.

**History.**--ss. 13, 17, ch. 87-290; ss. 10, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.213.

**400.914 Rules establishing standards.** --

(1) Pursuant to the intention of the Legislature to provide safe and sanitary facilities and healthful programs, the agency in conjunction with the Division of Children's Medical Services Prevention and Intervention of the Department of Health shall adopt and publish rules to implement the provisions of this part, which shall include reasonable and fair standards. Any conflict between these standards and those that may be set forth in local, county, or city ordinances shall be resolved in

favor of those having statewide effect. Such standards shall relate to:

(a) The assurance that PPEC services are family centered and provide individualized medical, developmental, and family training services.

(b) The maintenance of PPEC centers, not in conflict with the provisions of chapter 553 and based upon the size of the structure and number of children, relating to plumbing, heating, lighting, ventilation, and other building conditions, including adequate space, which will ensure the health, safety, comfort, and protection from fire of the children served.

(c) The appropriate provisions of the most recent edition of the "Life Safety Code" (NFPA-101) shall be applied.

(d) The number and qualifications of all personnel who have responsibility for the care of the children served.

(e) All sanitary conditions within the PPEC center and its surroundings, including water supply, sewage disposal, food handling, and general hygiene, and maintenance thereof, which will ensure the health and comfort of children served.

(f) Programs and basic services promoting and maintaining the health and development of the children served and meeting the training needs of the children's legal guardians.

(g) Supportive, contracted, other operational, and transportation services.

(h) Maintenance of appropriate medical records, data, and information relative to the children and programs. Such records shall be maintained in the facility for inspection by the agency.

(2) The agency shall adopt rules to ensure that:

(a) No child attends a PPEC center for more than 12 hours within a 24-hour period.

(b) No PPEC center provides services other than those provided to medically or technologically dependent children.

**History.**--ss. 14, 17, ch. 87-290; ss. 11, 14, ch. 93-66; s. 89, ch. 97-101; s. 19, ch. 98-288; s. 128, ch. 99-8; s. 23, ch. 2000-153.

**Note.**--Former s. 391.214.

**400.915 Construction and renovation; requirements.**--The requirements for the construction or renovation of a PPEC center shall comply with:

(1) The provisions of chapter 553, which pertain to building construction standards, including plumbing, electrical code, glass, manufactured buildings, accessibility for the physically disabled;

(2) The minimum standards for physical facilities in rule 10M-12.003, Florida Administrative Code, Child Care Standards; and

(3) The standards or rules adopted pursuant to this part.

**History.**--ss. 15, 17, ch. 87-290; ss. 12, 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.215.

**400.916 Prohibited acts; penalty for violation.**--

(1) It is unlawful for any person or public body to offer or advertise to the public, in any way or by any medium, basic services as defined in this part without obtaining a valid current license. It is unlawful for any holder of a license issued pursuant to this part to advertise or hold out to the public that it holds a license for a PPEC center other than that for which it actually holds a license.

(2) Any person who violates the provisions of subsection (1) is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083. Each day of continuing violation shall be considered a separate offense.

**History.**--ss. 16, 17, ch. 87-290; s. 14, ch. 93-66; s. 19, ch. 98-288.

**Note.**--Former s. 391.216.

**400.917 Disposition of moneys from fines and fees.**--All moneys received from administrative fines pursuant to s. 400.908 and all moneys received from fees collected pursuant to s. 400.905 shall be deposited in the Health Care Trust Fund created in s. 408.16.

**History.**--ss. 9, 17, ch. 87-290; ss. 13, 14, ch. 93-66; s. 172, ch. 98-166; ss. 19, 21, ch. 98-288.

**Note.**--Former s. 391.217.

## PART X

## HOME MEDICAL EQUIPMENT PROVIDERS

400.956 Injunction proceedings.

400.957 Prohibited acts.

**400.92 Legislative intent.**--It is the intent of the Legislature to provide for the licensure of home medical equipment providers and to provide for the development, establishment, and enforcement of basic standards that will ensure quality home medical equipment, products, and services.

**History.**--s. 1, ch. 99-189.

**400.925 Definitions.**--As used in this part, the term:

(1) "Accrediting organizations" means the Joint Commission on Accreditation of Healthcare Organizations or other national accreditation agencies whose standards for accreditation are comparable to those required by this part for licensure.

(2) "Affiliated person" means any person who directly or indirectly manages, controls, or oversees the operation of a corporation or other business entity that is a licensee, regardless of whether such person is a partner, shareholder, owner, officer, director, agent, or employee of the entity.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Applicant" means an individual applicant in the case of a sole proprietorship, or any officer, director, agent, managing employee, general manager, or affiliated person, or any partner or shareholder having an ownership interest equal to 5 percent or greater in the corporation, partnership, or other business entity.

(5) "Consumer" or "patient" means any person who uses home medical equipment in his or her place of residence.

(6) "Department" means the Department of Children and Family Services.

(7) "General manager" means the individual who has the general administrative charge of the premises of a licensed home medical equipment provider.

(8) "Home medical equipment" includes any product as defined by the Federal Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits, or any products reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes oxygen and related respiratory equipment; manual, motorized, or customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner; motorized scooters; personal transfer systems; and specialty beds, for use by a person with a medical need.

(9) "Home medical equipment provider" means any person or entity that sells or rents or offers to sell or rent to or for a consumer:

(a) Any home medical equipment and services; or

(b) Home medical equipment that requires any home medical equipment services.

(10) "Home medical equipment provider personnel" means persons who are employed by or under contract with a home medical equipment provider.

(11) "Home medical equipment services" means equipment management and consumer instruction,

including selection, delivery, setup, and maintenance of equipment, and other related services for the use of home medical equipment in the consumer's regular or temporary place of residence.

(12) "Licensee" means the person or entity to whom a license to operate as a home medical equipment provider is issued by the agency.

(13) "Moratorium" means a mandated temporary cessation or suspension of the sale, rental, or offering of equipment after the imposition of the moratorium. Services related to equipment sold or rented prior to the moratorium must be continued without interruption, unless deemed otherwise by the agency.

(14) "Person" means any individual, firm, partnership, corporation, or association.

(15) "Premises" means those buildings and equipment which are located at the address of the licensed home medical equipment provider for the provision of home medical equipment services, which are in such reasonable proximity as to appear to the public to be a single provider location, and which comply with zoning ordinances.

(16) "Residence" means the consumer's home or place of residence, which may include nursing homes, assisted living facilities, transitional living facilities, adult family-care homes, or other congregate residential facilities.

**History.**--s. 1, ch. 99-189; s. 1, ch. 2001-214; s. 11, ch. 2002-400.

**400.93 Licensure required; exemptions; unlawful acts; penalties.** --

(1) Any person or entity that holds itself out to the public as providing home medical equipment and services or accepts physician orders for home medical equipment and services is subject to licensure under this part.

(2) Any person or entity that holds itself out to the public as providing home medical equipment that typically requires home medical services is subject to licensure under this part.

(3) A home medical equipment provider must be licensed by the agency to operate in this state or to provide home medical equipment and services to consumers in this state. A standard license issued to a home medical equipment provider, unless sooner suspended or revoked, expires 2 years after its effective date.

(4) A separate license is required of all home medical equipment providers operating on separate premises, even if the providers are operated under the same management.

(5) The following are exempt from home medical equipment provider licensure, unless they have a separate company, corporation, or division that is in the business of providing home medical equipment and services for sale or rent to consumers at their regular or temporary place of residence pursuant to the provisions of this part:

(a) Providers operated by the Department of Health or Federal Government.

(b) Nursing homes licensed under part II.

(c) Assisted living facilities licensed under part III, when serving their residents.

(d) Home health agencies licensed under part IV.

(e) Hospices licensed under part VI.

(f) Intermediate care facilities, homes for special services, and transitional living facilities licensed under part VIII.

(g) Hospitals and ambulatory surgical centers licensed under chapter 395.

(h) Manufacturers and wholesale distributors when not selling directly to consumers.

(i) Licensed health care practitioners who utilize home medical equipment in the course of their practice, but do not sell or rent home medical equipment to their patients.

(j) Pharmacies licensed under chapter 465.

(6)(a) It is unlawful for any person to offer or advertise home medical equipment and services to the public unless he or she has a valid license under this part or is exempted from licensure under subsection (5). It is unlawful for any holder of a license issued under this part to advertise or indicate to the public that it holds a home medical equipment provider license other than the one it has been issued.

(b) A person who violates paragraph (a) is subject to an injunctive proceeding under s. 400.956. A violation of paragraph (a) is a deceptive and unfair trade practice and constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act.

(c) A person who violates paragraph (a) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. A person who commits a second or subsequent violation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation constitutes a separate offense.

(d) The following penalties shall be imposed for operating an unlicensed home medical equipment provider:

1. Any person or entity who operates an unlicensed provider commits a felony of the third degree.

2. For any person or entity who has received government reimbursement for services provided by an unlicensed provider, the agency shall make a fraud referral to the appropriate government reimbursement program.

3. For any licensee found to be concurrently operating licensed and unlicensed provider premises, the agency may impose a fine or moratorium, or revoke existing licenses of any or all of the licensee's licensed provider locations until such time as the unlicensed provider premises is licensed.

(e) A provider found to be operating without a license may apply for licensure, and must cease operations until a license is awarded by the agency.

**History.**--s. 1, ch. 99-189; s. 2, ch. 2001-214.

**400.931 Application for license; fee; provisional license; temporary permit.**--

(1) Application for an initial license or for renewal of an existing license must be made under oath to the agency on forms furnished by it and must be accompanied by the appropriate license fee as provided in subsection (12).

(2) The applicant must file with the application satisfactory proof that the home medical equipment provider is in compliance with this part and applicable rules, including:

(a) A report, by category, of the equipment to be provided, indicating those offered either directly by the applicant or through contractual arrangements with existing providers. Categories of equipment include:

1. Respiratory modalities.

2. Ambulation aids.

3. Mobility aids.

4. Sickroom setup.

5. Disposables.

(b) A report, by category, of the services to be provided, indicating those offered either directly by the applicant or through contractual arrangements with existing providers. Categories of services include:

1. Intake.

2. Equipment selection.

3. Delivery.

4. Setup and installation.

5. Patient training.

6. Ongoing service and maintenance.

7. Retrieval.

(c) A listing of those with whom the applicant contracts, both the providers the applicant uses to provide equipment or services to its consumers and the providers for whom the applicant provides services or equipment.

(3) The applicant for initial licensure must demonstrate financial ability to operate, which may be accomplished by the submission of a $50,000 surety bond to the agency.

(4) An applicant for renewal who has demonstrated financial inability to operate must demonstrate financial ability to operate.

(5) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the general manager and the financial officer or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency has probable cause to believe that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of paragraph (a).

(d) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(e) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation's or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this provision.

(f) A license may not be granted to any potential licensee if any applicant, administrator, or financial officer has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(g) The agency may deny or revoke licensure to any potential licensee if any applicant:

1. Has falsely represented a material fact in the application required by paragraphs (d) and (e), or has omitted any material fact from the application required by paragraphs (d) and (e); or

2. Has had prior Medicaid or Medicare action taken against the applicant as set forth in paragraph (d).

(h) Upon licensure renewal, each applicant must submit to the agency, under penalty of perjury, an affidavit of compliance with the background screening provisions of this section.

(6) The home medical equipment provider must also obtain and maintain professional and commercial liability insurance. Proof of liability insurance, as defined in s. 624.605, must be submitted with the application. The agency shall set the required amounts of liability insurance by rule, but the required amount must not be less than $250,000 per claim. In the case of contracted services, it is required that the contractor have liability insurance not less than $250,000 per claim.

(7) A provisional license shall be issued to an approved applicant for initial licensure for a period of 90 days, during which time a survey must be conducted demonstrating substantial compliance with this section. A provisional license shall also be issued pending the results of an applicant's Federal Bureau of Investigation report of background screening confirming that all standards have been met. If substantial compliance is demonstrated, a standard license shall be issued to expire 2 years after the effective date of the provisional license.

(8) Ninety days before the expiration date, an application for license renewal must be submitted to the agency under oath on forms furnished by the agency, and a license shall be renewed if the applicant has met the requirements established under this part and applicable rules. The home medical equipment provider must file with the application satisfactory proof that it is in compliance with this part and applicable rules. The home medical equipment provider must submit

satisfactory proof of its financial ability to comply with the requirements of this part.

(9) When a change of ownership of a home medical equipment provider occurs, the prospective owner must submit an initial application for a license at least 15 days before the effective date of the change of ownership. An application for change of ownership of a license is required when ownership, a majority of the ownership, or controlling interest of a licensed home medical equipment provider is transferred or assigned and when a licensee agrees to undertake or provide services to the extent that legal liability for operation of the home medical equipment provider rests with the licensee. A provisional license shall be issued to the new owner for a period of 90 days, during which time all required documentation must be submitted and a survey must be conducted demonstrating substantial compliance with this section. If substantial compliance is demonstrated, a standard license shall be issued to expire 2 years after the issuance of the provisional license.

(10) When a change of the general manager of a home medical equipment provider occurs, the licensee must notify the agency of the change within 45 days thereof and must provide evidence of compliance with the background screening requirements in subsection (5); except that a general manager who has met the standards for the Department of Law Enforcement background check, but for whom background screening results from the Federal Bureau of Investigation have not yet been received, may be employed pending receipt of the Federal Bureau of Investigation background screening report. An individual may not continue to serve as general manager if the Federal Bureau of Investigation background screening report indicates any violation of background screening standards.

(11) All licensure fees required of a home medical equipment provider are nonrefundable. The agency shall set the fees in an amount that is sufficient to cover its costs in carrying out its responsibilities under this part. However, state, county, or municipal governments applying for licenses under this part are exempt from the payment of license fees. All fees collected under this part must be deposited in the Health Care Trust Fund for the administration of this part.

(12) An applicant for initial licensure, renewal, or change of ownership shall pay a license processing fee not to exceed $300, to be paid by all applicants, and an inspection fee not to exceed $400, to be paid by all applicants except those not subject to licensure inspection by the agency as described in s. 400.933(2).

(13) When a change is reported which requires issuance of a license, a fee must be assessed. The fee must be based on the actual cost of processing and issuing the license.

(14) When a duplicate license is issued, a fee must be assessed, not to exceed the actual cost of duplicating and mailing.

(15) When applications are mailed out upon request, a fee must be assessed, not to exceed the cost of the printing, preparation, and mailing.

(16) The license must be displayed in a conspicuous place in the administrative office of the home medical equipment provider and is valid only while in the possession of the person or entity to which it is issued. The license may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily, and is valid only for the home medical equipment provider and location for which originally issued.

(17) A home medical equipment provider against whom a proceeding for revocation or suspension, or for denial of a renewal application, is pending at the time of license renewal may be issued a provisional license effective until final disposition by the agency of such proceedings. If judicial relief is sought from the final disposition, the court that has jurisdiction may issue a temporary permit for the duration of the judicial proceeding.

**History.**--s. 1, ch. 99-189; s. 88, ch. 2000-349; s. 54, ch. 2004-267.

**400.932 Administrative penalties; injunctions; emergency orders; moratoriums.** --

(1) The agency may deny, revoke, or suspend a license, or impose an administrative fine not to exceed $5,000 per violation, per day, or initiate injunctive proceedings under s. 400.956.

(2) Any of the following actions by a home medical equipment provider or any of its employees is grounds for administrative action or penalties by the agency:

(a) Violation of this part or of applicable rules.

(b) An intentional, reckless, or negligent act that materially affects the health or safety of a patient.

(3) The agency may deny or revoke the license of any applicant that:

(a) Made a false representation or omission of any material fact in making the application, including the submission of an application that conceals the controlling or ownership interest or any officer, director, agent, managing employee, affiliated person, partner, or shareholder who may not be eligible to participate;

(b) Has been previously found by any professional licensing, certifying, or standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided. "Professional licensing, certifying, or standards board or agency" shall include, but is not limited to, practitioners, health care facilities, programs, or services, or residential care, treatment programs, or other human services; or

(c) Has been or is currently excluded, suspended, or terminated from, or has involuntarily withdrawn from, participation in Florida's Medicaid program or any other state's Medicaid program, or participation in the Medicare program or any other governmental or private health care or health insurance program.

(4) The agency may issue an emergency order immediately suspending or revoking a license when it determines that any condition within the responsibility of the home medical equipment provider presents a clear and present danger to public health and safety.

(5) The agency may impose an immediate moratorium on any licensed home medical equipment provider when the agency determines that any condition within the responsibility of the home medical equipment provider presents a threat to public health or safety.

**History.**--s. 1, ch. 99-189.

**400.933 Licensure inspections and investigations.**--

(1) The agency shall make or cause to be made such inspections and investigations as it considers necessary, including:

(a) Licensure inspections.

(b) Inspections directed by the federal Health Care Financing Administration.

(c) Licensure complaint investigations, including full licensure investigations with a review of all licensure standards as outlined in the administrative rules. Complaints received by the agency from individuals, organizations, or other sources are subject to review and investigation by the agency.

(2) The agency shall accept, in lieu of its own periodic inspections for licensure, submission of the following:

(a) The survey or inspection of an accrediting organization, provided the accreditation of the licensed home medical equipment provider is not provisional and provided the licensed home medical equipment provider authorizes release of, and the agency receives the report of, the accrediting organization; or

(b) A copy of a valid medical oxygen retail establishment permit issued by the Department of Health, pursuant to chapter 499.

**History.**--s. 1, ch. 99-189.

**400.934 Minimum standards.**--As a requirement of licensure, home medical equipment providers shall:

(1) Offer and provide home medical equipment and services, as necessary, to consumers who purchase or rent equipment that requires such services.

(2) Provide at least one category of equipment directly, filling orders from its own inventory.

(3) Respond to orders received for other equipment by filling those orders from its own inventory or inventory from other companies with which it has contracted to fill such orders; or customizing or fitting items for sale from supplies purchased under contract.

(4) Maintain trained personnel to coordinate order fulfillment and schedule timely equipment and service delivery.

(5) As necessary in relation to the sophistication of the equipment and services being provided, ensure that delivery personnel are appropriately trained to conduct an environment and equipment compatibility assessment; appropriately and safely set up the equipment; instruct patients and caregivers in the safe operation and client maintenance of the equipment; and recognize when additional education or followup patient compliance monitoring is appropriate.

(6) Ensure that patients are made aware of service hours and emergency service procedures.

(7) At the time of the initial delivery, set up an appropriate followup home medical equipment service schedule as needed for such times as, but not limited to, periodic maintenance, supply delivery, and other related activities.

(8) Arrange for emergency service after normal business hours; provide refresher and review training for appropriate personnel; establish a system for resolution of complaints and service problems; and provide for timely replacement or delivery of disposable or consumable equipment supplies.

(9) Honor all warranties expressed and implied under applicable state law.

(10) Answer any questions or complaints a consumer has about an item or the use of an item that the consumer purchases or rents.

(11) Maintain and repair directly, or through a service contract with another company, items rented to consumers.

(12) Accept returns of substandard or unsuitable items from consumers. As used in this subsection, the term "substandard" means less than full quality for the particular item and the term

"unsuitable" means inappropriate for the consumer at the time it was fitted or sold.

(13) Disclose consumer information to each consumer who rents or purchases items, including all applicable warranty information. This information consists of the provider standards to which the item must conform.

(14) Maintain patient payment and service records in accordance with the requirements of this part.

(15)(a) Designate appropriate staff as intake coordinators, and ensure that order intake personnel are appropriately trained in the types of equipment and products, commonly occurring medical conditions, service procedures, third-party billing, and insurance requirements and coverage.

(b) Train intake coordinators in a basic understanding of the following areas: dealing with patient and caregiver needs; other, nonhome medical equipment provider services as they relate to home medical equipment services and home care patient crisis management.

(16) Establish procedures for maintaining a record of the employment history, including background screening as required by s. 400.953, of all home medical equipment provider personnel. A home medical equipment provider must require its personnel to submit an employment history to the home medical equipment provider and must verify the employment history for at least the previous 5 years, unless through diligent efforts such verification is not possible. There is no monetary liability on the part of, and no cause of action for damages arising against a former employer, a prospective employee, or a prospective independent contractor with a licensed home medical equipment provider, who reasonably and in good faith communicates his or her honest opinions about a former employee's job performance. This subsection does not affect the official immunity of an officer or employee of a public corporation.

(17) Upon request by the consumer or as otherwise required by state law and rules, or federal law and regulations, assist consumers with meeting the necessary filing requirements to obtain third-party payment to which a consumer may be entitled.

(18) Maintain safe premises.

(19) Comply with all other state and federal laws.

**History.**--s. 1, ch. 99-189.

**400.935 Rules establishing minimum standards.**--The agency shall adopt, publish, and enforce rules to implement this part, which must provide reasonable and fair minimum standards relating to:

(1) The qualifications and minimum training requirements of all home medical equipment provider personnel.

(2) License application and renewal.

(3) License and inspection fees.

(4) Financial ability to operate.

(5) The administration of the home medical equipment provider.

(6) Procedures for maintaining patient records.

(7) Ensuring that the home medical equipment and services provided by a home medical equipment provider are in accordance with the plan of treatment established for each patient, when provided as a part of a plan of treatment.

(8) Contractual arrangements for the provision of home medical equipment and services by providers not employed by the home medical equipment provider providing for the consumer's needs.

(9) Physical location and zoning requirements.

(10) Home medical equipment requiring home medical equipment services.

**History.**--s. 1, ch. 99-189.

**400.94 Patient records.** --

(1) The home medical equipment provider must maintain, for each patient, a patient record that includes the home medical equipment and services the home medical equipment provider has provided. Such records must contain:

(a) Any physician's order or certificate of medical necessity, if the equipment was ordered by a physician.

(b) Signed and dated delivery slips verifying delivery.

(c) Notes reflecting all services and maintenance performed, and any equipment exchanges.

(d) The date on which rental equipment was retrieved.

(e) Such other information as is appropriate to specific patients in light of the particular equipment provided to them.

(2) Such records are considered patient records under s. 456.057 and must be maintained by the home medical equipment provider for 5 years following termination of services. If a patient transfers to another home medical equipment provider, a copy of his or her record must be provided to the other home medical equipment provider, upon request.

**History.**--s. 1, ch. 99-189; s. 18, ch. 2000-160.

**400.945 Public records exemption.**--Medical and personal identifying information about patients of a home medical equipment provider which is received by the licensing agency through reports or inspection is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

**History.**--s. 1, ch. 99-317; s. 1, ch. 2004-304.

**400.95 Notice of toll-free telephone number for central abuse hotline.**--On or before the first day home medical equipment is delivered to the patient's home, any home medical equipment provider licensed under this part must inform the consumer and his or her immediate family, if appropriate, of the right to report abusive, neglectful, or exploitative practices. The statewide toll-free telephone number for the central abuse hotline must be provided to consumers in a manner that is clearly legible and must include the words: "To report abuse, neglect, or exploitation, please call toll-free 1-800-962-2873." Home medical equipment providers shall establish appropriate policies and procedures for providing such notice to consumers.

**History.**--s. 1, ch. 99-189; s. 89, ch. 2000-349.

**400.953 Background screening of home medical equipment provider personnel.**--The agency shall require employment screening as provided in chapter 435, using the level 1 standards for screening set forth in that chapter, for home medical equipment provider personnel.

(1) The agency may grant exemptions from disqualification from employment under this section as provided in s. 435.07.

(2) The general manager of each home medical equipment provider must sign an affidavit annually, under penalty of perjury, stating that all home medical equipment provider personnel hired on or after July 1, 1999, who enter the home of a patient in the capacity of their employment have been screened and that its remaining personnel have worked for the home medical equipment provider continuously since before July 1, 1999.

(3) Proof of compliance with the screening requirements of s. 110.1127, s. 393.0655, s. 394.4572, s. 397.451, s. 402.305, s. 402.313, s. 409.175, s. 464.008, or s. 985.407 or this part must be accepted in lieu of the requirements of this section if the person has been continuously employed in the same type of occupation for which he or she is seeking employment without a breach in service that exceeds 180 days, the proof of compliance is not more than 2 years old, and the person has been screened by the Department of Law Enforcement. An employer or contractor shall directly provide proof of compliance to another employer or contractor, and a potential employer or contractor may not accept any proof of compliance directly from the person requiring screening. Proof of compliance with the screening requirements of this section shall be provided, upon request, to the person screened by the home medical equipment provider.

(4) There is no monetary liability on the part of, and no cause of action for damages arising against, a licensed home medical equipment provider that, upon notice that an employee has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.03 or under any similar statute of another jurisdiction, terminates the employee, whether or not the employee has filed for an exemption with the agency and whether or not the time for filing has expired.

(5) The costs of processing the statewide correspondence criminal records checks must be borne by the home medical equipment provider or by the person being screened, at the discretion of the home medical equipment provider.

(6) Neither the agency nor the home medical equipment provider may use the criminal records or juvenile records of a person for any purpose other than determining whether that person meets minimum standards of good moral character for home medical equipment provider personnel.

(7)(a) It is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

1. Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for paid employment a material fact used in making a determination as to the person's qualifications to be an employee under this section;

2. Operate or attempt to operate an entity licensed under this part with persons who do not meet the minimum standards for good moral character as contained in this section; or

3. Use information from the criminal records obtained under this section for any purpose other than screening that person for employment as specified in this section, or release such information to any other person for any purpose other than screening for employment under this section.

(b) It is a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s.

775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment under this section.

**History.**--s. 1, ch. 99-189; s. 90, ch. 2000-349; s. 27, ch. 2004-267.

**400.955 Procedures for screening of home medical equipment provider personnel.**--

(1) A person employed by a home medical equipment provider shall, within 5 working days after starting to work, submit to the home medical equipment provider a complete set of information necessary to conduct a screening under this section. The person must sign an affidavit stating whether he or she meets the minimum standards for good moral character under this section. The home medical equipment provider shall submit the information to the Department of Law Enforcement for processing. If disposition information is missing on a criminal record, it is the responsibility of the person being screened to obtain and supply the missing information within 30 days. Failure to supply the missing information or to show reasonable efforts to obtain such information will result in automatic disqualification for employment.

(2) Home medical equipment provider personnel hired on or after July 1, 1999, must be placed on probationary status pending a determination of compliance with minimum standards for good moral character.

(3) The home medical equipment provider must automatically terminate the employment of any of its personnel found to be in noncompliance with the minimum standards for good moral character under this section, unless such person has obtained an exemption under s. 400.953(1).

(4) The general manager of each home medical equipment provider must sign an affidavit annually, under penalty of perjury, stating that all personnel hired on or after July 1, 1999, have been screened and that its remaining personnel have worked for the home medical equipment provider continuously since before July 1, 1999.

**History.**--s. 1, ch. 99-189; s. 91, ch. 2000-349.

**400.956 Injunction proceedings.** --The agency may institute injunction proceedings in a court of competent jurisdiction when violation of this part or of applicable rules constitutes an emergency affecting the immediate health and safety of a patient or consumer.

**History.**--s. 1, ch. 99-189.

**400.957 Prohibited acts.**--Compliance with state and federal laws regarding prohibited patient referrals and rebates shall be a condition of licensure.

**History.**--s. 1, ch. 99-189.

## PART XI

## INTERMEDIATE CARE FACILITIES FOR DEVELOPMENTALLY DISABLED PERSONS

**400.960 Definitions.**--As used in this part, the term:

(1) "Active treatment" means the provision of services by an interdisciplinary team which are necessary to maximize a client's individual independence or prevent regression or loss of functional status.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Autism" means a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests.

(4) "Cerebral palsy" means a group of disabling symptoms of extended duration which results from damage to the developing brain occurring before, during, or after birth and resulting in the loss or impairment of control over voluntary muscles. The term does not include those symptoms or impairments resulting solely from a stroke.

(5) "Client" means any person determined by the department to be eligible for developmental services.

(6) "Client advocate" means a friend or relative of the client, or of the client's immediate family, who advocates for the best interests of the client in any proceedings under this part in which the client or his or her family has the right or duty to participate.

(7) "Department" means the Department of Children and Family Services.

(8) "Developmental disability" means a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.

(9) "Direct service provider" means a person 18 years of age or older who has direct contact with individuals with developmental disabilities and who is unrelated to the individuals with developmental disabilities.

(10) "Epilepsy" means a chronic brain disorder of various causes which is characterized by recurrent seizures due to excessive discharge of cerebral neurons. When found concurrently with retardation, autism, or cerebral palsy, epilepsy is considered a secondary disability for which the client is eligible to receive services to ameliorate this condition according to the provisions of this part.

(11) "Guardian advocate" means a person appointed by the circuit court to represent a person with developmental disabilities in any proceedings brought pursuant to s. 393.12, and is distinct from a guardian advocate for mentally ill persons under chapter 394.

(12) "Intermediate care facility for the developmentally disabled" means a residential facility licensed and certified in accordance with state law, and certified by the Federal Government, pursuant to the Social Security Act, as a provider of Medicaid services to persons who are developmentally disabled.

(13) "Prader-Willi syndrome" means an inherited condition typified by neonatal hypotonia with failure to thrive, hyperphagia, or an excessive drive to eat which leads to obesity, usually at 18 to 36 months of age, mild to moderate retardation, hypogonadism, short stature, mild facial dysmorphism, and a characteristic neurobehavior.

(14) "Retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the period from conception to age 18. "Significantly subaverage general intellectual functioning," for the purpose of this definition, means performance that is two or more standard deviations from the mean score on a standardized intelligence test specified in rules of the department. "Deficits in adaptive behavior," for the purpose of this definition, means deficits in the effectiveness or degree with which an individual meets the standards of personal independence and social responsibility expected of his or her age, cultural group, and community.

(15) "Spina bifida" means a medical diagnosis of spina bifida cystica or myelomeningocele.

**History.**--s. 9, ch. 99-144.

**400.962 License required; license application.**--

(1) It is unlawful to operate an intermediate care facility for the developmentally disabled without a license.

(2) Separate licenses are required for facilities maintained on separate premises even if operated under the same management. However, a separate license is not required for separate buildings on the same grounds.

(3) The basic license fee collected shall be deposited in the Health Care Trust Fund, established for carrying out the purposes of this chapter.

(4) The license must be conspicuously displayed inside the facility.

(5) A license is valid only in the hands of the individual, firm, partnership, association, or corporation to whom it is issued. A license is not valid for any premises other than those for which it was originally issued and may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily.

(6) An application for a license shall be made to the agency on forms furnished by it and must be accompanied by the appropriate license fee.

(7) The application must be under oath and must contain the following:

(a) The name, address, and social security number of the applicant if an individual; if the applicant is a firm, partnership, or association, its name, address, and employer identification number (EIN), and the name and address of every member; if the applicant is a corporation, its name, address, and employer identification number (EIN), and the name and address of its director

and officers and of each person having at least a 5 percent interest in the corporation; and the name by which the facility is to be known.

(b) The name of any person whose name is required on the application under paragraph (a) and who owns at least a 10 percent interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, and the name and address of the professional service, firm, association, partnership, or corporation in which such interest is held.

(c) The location of the facility for which a license is sought and an indication that such location conforms to the local zoning ordinances.

(d) The name of the persons under whose management or supervision the facility will be operated.

(e) The total number of beds.

(8) The applicant must demonstrate that sufficient numbers of staff, qualified by training or experience, will be employed to properly care for the type and number of residents who will reside in the facility.

(9) The applicant must submit evidence that establishes the good moral character of the applicant, manager, supervisor, and administrator. An applicant who is an individual or a member of a board of directors or officer of an applicant that is a firm, partnership, association, or corporation must not have been convicted, or found guilty, regardless of adjudication, of a crime in any jurisdiction which affects or may potentially affect residents in the facility.

(10)(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. As used in this subsection, the term "applicant" means the facility administrator, or similarly titled individual who is responsible for the day-to-day operation of the licensed facility, and the facility financial officer, or similarly titled individual who is responsible for the financial operation of the licensed facility.

(b) The agency may require background screening for a member of the board of directors of the licensee or an officer or an individual owning 5 percent or more of the licensee if the agency has probable cause to believe that such individual has been convicted of an offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other licensure requirements under this chapter satisfies the requirements of paragraph (a). Proof of compliance with background screening which has been submitted within the previous 5 years to fulfill the requirements of the Financial Services Commission and the Office of Insurance Regulation under chapter 651 as part of an application for a certificate of authority to operate a continuing care retirement community satisfies the requirements for the Department of Law Enforcement and Federal Bureau of Investigation background checks.

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435, but a response has not yet been issued. A license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other

person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation; however, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with disclosure of ownership and control interest requirements of the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation's or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) An application for license renewal must contain the information required under paragraphs (e) and (f).

(11) The applicant must furnish satisfactory proof of financial ability to operate and conduct the facility in accordance with the requirements of this part and all rules adopted under this part, and the agency shall establish standards for this purpose.

**History.**--s. 9, ch. 99-144; s. 92, ch. 2000-349; s. 8, ch. 2000-350; s. 59, ch. 2001-45; s. 421, ch. 2003-261; s. 55, ch. 2004-267.

**400.963 Injunctive proceedings.**--The Agency for Health Care Administration may seek a temporary or permanent injunction to:

(1) Enforce the provisions of this part or any standard, rule, or order issued or entered under this part; or

(2) Terminate the operation of a facility licensed under this part when the facility:

(a) Fails to take preventative or corrective measures in accordance with any order of the agency.

(b) Fails to abide by any final order of the agency.

(c) Commits any violation creating an emergency requiring immediate action.

(3) Terminate the operation of a provider of supports or services who has willfully and knowingly refused to comply with the screening requirement for direct service providers or has refused to terminate direct service providers found not to be in compliance with the requirements for good moral character.

**History.**--s. 9, ch. 99-144.

**400.964 Personnel screening requirement.**--

(1) The agency shall require level 2 background screening as provided in chapter 435 for all employees or prospective employees of facilities licensed under this part who are expected to be, or whose responsibilities are such that they would be considered to be, a direct service provider.

(2) Employers and employees shall comply with the requirements of chapter 435.

(3) Applicants and employees shall be excluded from employment pursuant to s. 435.06.

(4) The applicant is responsible for paying the fees associated with obtaining the required screening. Payment for the screening must be submitted to the agency as prescribed by the agency.

(5) Notwithstanding any other provision of law, persons who have been screened and qualified as required by this section and who have not been unemployed for more than 180 days thereafter, and who under penalty of perjury attest to not having been convicted of a disqualifying offense since the completion of such screening are not required to be rescreened. An employer may obtain, pursuant to s. 435.10, written verification of qualifying screening results from the previous employer or other entity that caused such screening to be performed.

(6) The agency may adopt rules to administer this section.

(7) All employees must comply with the requirements of this section by October 1, 2000. A person employed by a facility licensed pursuant to this part as of the effective date of this act is not required to submit to rescreening if the facility has in its possession written evidence that the person has been screened and qualified according to level 1 standards as specified in s. 435.03. Any current employee who meets the level 1 requirement but does not meet the 5-year residency requirement must provide to the employing facility written attestation under penalty of perjury that the employee has not been convicted of a disqualifying offense in another state or jurisdiction. All applicants hired on or after October 1, 1999, must comply with the requirements of this section.

(8) There is no monetary or unemployment liability on the part of, and no cause of action for damages arises against an employer that, upon notice of a disqualifying offense listed under chapter 435 or an act of domestic violence, terminates the employee, whether or not the employee has filed for an exemption with the Department of Health or the Agency for Health Care Administration.

**History.**--s. 9, ch. 99-144; s. 93, ch. 2000-349; s. 11, ch. 2004-267.

**400.965 Action by agency against licensee; grounds.**--

(1) Any of the following conditions constitute grounds for action by the agency against a licensee:

(a) A misrepresentation of a material fact in the application;

(b) The commission of an intentional or negligent act materially affecting the health or safety of residents of the facility;

(c) A violation of any provision of this part or rules adopted under this part; or

(d) The commission of any act constituting a ground upon which application for a license may be denied.

(2) If the agency has a reasonable belief that any of such conditions exists, it shall:

(a) In the case of an applicant for original licensure, deny the application.

(b) In the case of an applicant for relicensure or a current licensee, take administrative action as provided in s. 400.968 or s. 400.969 or injunctive action as authorized by s. 400.963.

(c) In the case of a facility operating without a license, take injunctive action as authorized in s. 400.963.

**History.**--s. 9, ch. 99-144; s. 36, ch. 2002-400.

**400.966 Receivership proceeding.**--

(1) The agency may petition a court of competent jurisdiction for the appointment of a receiver for an intermediate care facility for the developmentally disabled which is owned and operated by a corporation or partnership when:

(a) Any person is operating the facility without a license and refuses to apply for a license.

(b) The licensee is closing the facility or has informed the agency that it intends to close the facility, and adequate arrangements have not been made to relocate the residents within 7 days, exclusive of weekends and holidays, after the closing of the facility.

(c) The agency determines that conditions exist in the facility which present an imminent danger to the health, safety, or welfare of the residents of the facility or which present a substantial probability that death or serious physical harm would result therefrom. Whenever possible, the agency shall facilitate the continued operation of the program.

(d) The licensee cannot meet its financial obligations to provide food, shelter, care, and utilities. Evidence such as the issuance of bad checks or the accumulation of delinquent bills for such items as personnel salaries, food, drugs, or utilities constitutes prima facie evidence that the ownership of the facility lacks the financial ability to operate the home in accordance with the requirements of this part and all rules adopted under this part.

(2) The petition for receivership shall take precedence over other court business unless the court determines that some other pending proceeding, having similar statutory precedence, has priority.

(3) A hearing must be conducted within 5 days after the filing of the petition, at which time all interested parties must be given the opportunity to present evidence pertaining to the petition. The agency shall notify the owner or operator of the facility named in the petition of its filing and the date set for the hearing.

(4) The court shall grant the petition only upon finding that the health, safety, or welfare of residents of the facility would be threatened if a condition existing at the time the petition was filed is permitted to continue. A receiver may not be appointed ex parte unless the court determines that any of the conditions listed in subsection (1) exist; that the facility owner or operator cannot be found; that all reasonable means of locating the owner or operator and notifying him or her of the petition and hearing have been exhausted; or that the owner or operator after notification of the hearing chooses not to attend. After such findings, the court may appoint any person qualified by education, training, or experience to carry out the responsibilities of receiver pursuant to this section, except that the court may not appoint any owner or affiliate of the facility that is in receivership. Before the appointment as receiver of a person who is the operator, manager, or supervisor of another facility, the court must determine that the person can reasonably operate, manage, or supervise more than one facility. The receiver may be appointed for up to 90 days, with the option of petitioning the court for 30-day extensions. The receiver may be selected from a list of persons qualified to act as receivers developed by the agency and presented to the court with each petition for receivership. Under no circumstances may the agency

or designated agency employee be appointed as a receiver for more than 60 days; however, the agency receiver may petition the court for 30-day extensions. The court shall grant an extension upon a showing of good cause. The agency may petition the court to appoint a substitute receiver.

(5) During the first 60 days of the receivership, the agency may not take action to decertify or revoke the license of a facility unless conditions causing imminent danger to the health and welfare of the residents exist and a receiver has been unable to remove those conditions. After the first 60 days of receivership, and every 60 days thereafter until the receivership is terminated, the agency shall submit to the court the results of an assessment of the ability of the facility to assure the safety and care of the residents. If the conditions at the facility or the intentions of the owner indicate that the purpose of the receivership is to close the facility rather than to facilitate its continued operation, the agency shall place the residents in appropriate alternative residential settings as quickly as possible. If, in the opinion of the court, the agency has not been diligent in its efforts to make adequate arrangements for placement, the court shall find the agency to be in contempt and shall order the agency to submit its plans for moving the residents.

(6) The receiver shall provide for the continued health, safety, and welfare of all residents of the facility and:

(a) Shall exercise those powers and perform those duties set out by the court.

(b) Shall operate the facility in such a manner as to assure the residents' safety and adequate health care for the residents.

(c) Shall take such action as is reasonably necessary to protect or conserve the assets or property of the facility for which the receiver is appointed, or the proceeds from any transfer thereof, and may use them only in the performance of the powers and duties set forth in this section and by order of the court.

(d) Shall honor all leases, mortgages, and secured transactions governing the building in which the facility is located and all goods and fixtures in the building of which the receiver has taken possession, but only to the extent of payments that, in the case of a rental agreement, are for the use of the property during the period of the receivership or that, in the case of a purchase agreement, become due during the period of the receivership.

(e) May use the building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the facility at the time the petition for receivership was filed. The receiver shall collect payments for all goods and services provided to residents or others during the period of the receivership at the same rate of payment charged by the owner at the time the petition for receivership was filed, or at a fair and reasonable rate otherwise approved by the court for private, paying residents. The receiver may apply to the agency for a rate increase for residents under Title XIX of the Social Security Act if the facility is not receiving the state reimbursement cap and if expenditures justify an increase in the rate.

(f) May correct or eliminate any deficiency in the structure, furnishings, or staffing of the facility which endangers the safety or health of residents while they remain in the facility, provided that the total cost of correction does not exceed $3,000. The court may order expenditures for this purpose in excess of $3,000 on application from the receiver after notice to the owner. A hearing may be requested by the owner within 72 hours.

(g) May let contracts and hire agents and employees to carry out the powers and duties of the receiver under this section.

(h) Shall have full power to direct, manage, hire, and discharge employees of the facility subject to any contract rights they may have. The receiver shall hire and pay employees at the rate of

compensation, including benefits, approved by the court. Receivership does not relieve the owner of any obligations to employees which had been made before the appointment of a receiver and were not carried out by the receiver.

(i) Shall be entitled to take possession of all property or assets of residents which are in the possession of a facility or its owner. The receiver shall preserve all such property or assets and all resident records of which the receiver takes possession; and he or she shall provide for the prompt transfer of the property, assets, and records of any resident transferred to the resident's new placement. An inventory list certified by the owner and receiver must be made when the receiver takes possession of the facility.

(7)(a) A person who is served with notice of an order of the court appointing a receiver and of the receiver's name and address shall be liable to pay the receiver for any goods or services provided by the receiver after the date of the order if the person would have been liable for the goods or services had they been supplied by the owner. The receiver shall give a receipt for each payment and shall keep a copy of each receipt on file. The receiver shall deposit accounts received in a separate account and shall use this account for all disbursements.

(b) The receiver may bring an action to enforce the liability created by paragraph (a).

(c) A payment to the receiver of any sum owed to the facility or its owner discharges any obligation to the facility to the extent of the payment.

(8)(a) A receiver may petition the court that he or she not be required to honor any lease, mortgage, secured transaction, or other wholly or partially executory contract entered into by the owner of the facility if the rent, price, or rate of interest required to be paid under the agreement was substantially in excess of a reasonable rent, price, or rate of interest at the time the contract was entered into, or if any material provision of the agreement was unreasonable, when compared to contracts negotiated under similar conditions. Any relief in this form provided by the court shall be limited to the life of the receivership, unless otherwise determined by the court.

(b) If the receiver is in possession of real estate or goods subject to a lease, mortgage, or security interest which the receiver has obtained a court order to avoid under paragraph (a), and if the real estate or goods are necessary for the continued operation of the facility under this section, the receiver may apply to the court to set a reasonable rental, price, or rate of interest to be paid by the receiver during the duration of the receivership. The court shall hold a hearing on the application within 15 days. The receiver shall send notice of the application to any known persons who own the property involved or to the mortgage holders at least 10 days prior to the hearing. The payment by the receiver of the amount determined by the court to be reasonable is a defense to any action brought against the receiver by any person who received such notice, which action is for payment or for possession of the goods or real estate subject to the lease, mortgage, or security interest involved; but the payment does not relieve the owner of the facility of any liability for the difference between the amount paid by the receiver and the amount due under the original lease, mortgage, or security interest involved.

(9) The court shall set the compensation of the receiver, which shall be considered a necessary expense of the receivership.

(10) The court may require a receiver to post a bond.

(11) A receiver may be held liable in a personal capacity only for the receiver's own gross negligence, intentional acts, or breach of fiduciary duty.

(12) The court may terminate a receivership when:

(a) The court determines that the receivership is no longer necessary because the conditions that

gave rise to the receivership no longer exist; or

(b) All of the residents in the facility have been transferred or discharged.

(13) Within 30 days after termination of the receivership, unless this time period is extended by the court, the receiver shall give the court a complete accounting of all property of which the receiver has taken possession, of all funds collected and disbursed, and of the expenses of the receivership.

(14) This section does not relieve any owner, operator, or employee of a facility placed in receivership of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the owner, operator, or employee before the appointment of a receiver, and this section does not suspend during the receivership any obligation of the owner, operator, or employee for payment of taxes or other operating and maintenance expenses of the facility or any obligation of the owner, operator, or employee or any other person for the payment of mortgages or liens. The owner shall retain the right to sell or mortgage any facility under receivership, subject to the approval of the court that ordered the receivership. A receivership imposed under this section is subject to the Resident Protection Trust Fund pursuant to s. 400.063. The owner of a facility placed in receivership by the court is liable for all expenses and costs incurred by the Resident Protection Trust Fund which occur as a result of the receivership.

**History.**--s. 9, ch. 99-144.

**400.967 Rules and classification of deficiencies.**--

(1) It is the intent of the Legislature that rules adopted and enforced under this part include criteria by which a reasonable and consistent quality of resident care may be ensured, the results of such resident care can be demonstrated, and safe and sanitary facilities can be provided.

(2) Pursuant to the intention of the Legislature, the agency, in consultation with the Department of Children and Family Services and the Department of Elderly Affairs, shall adopt and enforce rules to administer this part, which shall include reasonable and fair criteria governing:

(a) The location and construction of the facility; including fire and life safety, plumbing, heating, cooling, lighting, ventilation, and other housing conditions that will ensure the health, safety, and comfort of residents. The agency shall establish standards for facilities and equipment to increase the extent to which new facilities and a new wing or floor added to an existing facility after July 1, 2000, are structurally capable of serving as shelters only for residents, staff, and families of residents and staff, and equipped to be self-supporting during and immediately following disasters. The Agency for Health Care Administration shall work with facilities licensed under this part and report to the Governor and the Legislature by April 1, 2000, its recommendations for cost-effective renovation standards to be applied to existing facilities. In making such rules, the agency shall be guided by criteria recommended by nationally recognized, reputable professional groups and associations having knowledge concerning such subject matters. The agency shall update or revise such criteria as the need arises. All facilities must comply with those lifesafety code requirements and building code standards applicable at the time of approval of their construction plans. The agency may require alterations to a building if it determines that an existing condition constitutes a distinct hazard to life, health, or safety. The agency shall adopt fair and reasonable rules setting forth conditions under which existing facilities undergoing additions, alterations, conversions, renovations, or repairs are required to comply with the most recent updated or revised standards.

(b) The number and qualifications of all personnel, including management, medical nursing, and other personnel, having responsibility for any part of the care given to residents.

(c) All sanitary conditions within the facility and its surroundings, including water supply, sewage disposal, food handling, and general hygiene, which will ensure the health and comfort of

residents.

(d) The equipment essential to the health and welfare of the residents.

(e) A uniform accounting system.

(f) The care, treatment, and maintenance of residents and measurement of the quality and adequacy thereof.

(g) The preparation and annual update of a comprehensive emergency management plan. The agency shall adopt rules establishing minimum criteria for the plan after consultation with the Department of Community Affairs. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Children and Family Services, the Agency for Health Care Administration, and the Department of Community Affairs. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(h) Each licensee shall post its license in a prominent place that is in clear and unobstructed public view at or near the place where residents are being admitted to the facility.

(3) The agency shall adopt rules to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature of the deficiency. The agency shall indicate the classification on the face of the notice of deficiencies as follows:

(a) Class I deficiencies are those which the agency determines present and imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical harm would result therefrom. The condition or practice constituting a class I violation must be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. Notwithstanding s. 400.121(2), a class I deficiency is subject to a civil penalty in an amount not less than $5,000 and not exceeding $10,000 for each deficiency. A fine may be levied notwithstanding the correction of the deficiency.

(b) Class II deficiencies are those which the agency determines have a direct or immediate relationship to the health, safety, or security of the facility residents, other than class I deficiencies. A class II deficiency is subject to a civil penalty in an amount not less than $1,000 and not exceeding $5,000 for each deficiency. A citation for a class II deficiency shall specify the time within which the deficiency must be corrected. If a class II deficiency is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

(c) Class III deficiencies are those which the agency determines to have an indirect or potential relationship to the health, safety, or security of the facility residents, other than class I or class II deficiencies. A class III deficiency is subject to a civil penalty of not less than $500 and not exceeding $1,000 for each deficiency. A citation for a class III deficiency shall specify the time within which the deficiency must be corrected. If a class III deficiency is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.

(4) Civil penalties paid by any licensee under subsection (3) shall be deposited in the Health Care Trust Fund and expended as provided in s. 400.063.

(5) The agency shall approve or disapprove the plans and specifications within 60 days after receipt of the final plans and specifications. The agency may be granted one 15-day extension for the review period, if the secretary of the agency so approves. If the agency fails to act within the specified time, it is deemed to have approved the plans and specifications. When the agency disapproves plans and specifications, it must set forth in writing the reasons for disapproval. Conferences and consultations may be provided as necessary.

(6) The agency may charge an initial fee of $2,000 for review of plans and construction on all projects, no part of which is refundable. The agency may also collect a fee, not to exceed 1 percent of the estimated construction cost or the actual cost of review, whichever is less, for the portion of the review which encompasses initial review through the initial revised construction document review. The agency may collect its actual costs on all subsequent portions of the review and construction inspections. Initial fee payment must accompany the initial submission of plans and specifications. Any subsequent payment that is due is payable upon receipt of the invoice from the agency. Notwithstanding any other provision of law, all money received by the agency under this section shall be deemed to be trust funds, to be held and applied solely for the operations required under this section.

**History.**--s. 9, ch. 99-144; s. 14, ch. 2000-305.

**400.968 Right of entry; protection of health, safety, and welfare.**--

(1) Any designated officer or employee of the agency, of the state, or of the local fire marshal may enter unannounced the premises of any facility licensed under this part in order to determine the state of compliance with this part and the rules or standards in force under this part. The right of entry and inspection also extends to any premises that the agency has reason to believe are being operated or maintained as a facility without a license; but such an entry or inspection may not be made without the permission of the owner or person in charge of the facility unless a warrant that authorizes the entry is first obtained from the circuit court. The warrant requirement extends only to a facility that the agency has reason to believe is being operated or maintained as a facility without a license. An application for a license or renewal thereof which is made under this section constitutes permission for, and acquiescence in, any entry or inspection of the premises for which the license is sought, in order to facilitate verification of the information submitted in connection with the application; to discover, investigate, and determine the existence of abuse or neglect; or to elicit, receive, respond to, and resolve complaints. A current valid license constitutes unconditional permission for, and acquiescence in, any entry or inspection of the premises by authorized personnel. The agency retains the right of entry and inspection of facilities that have had a license revoked or suspended within the previous 24 months, to ensure that the facility is not operating unlawfully. However, before the facility is entered, a statement of probable cause must be filed with the director of the agency, who must approve or disapprove the action within 48 hours.

(2) The agency may institute injunctive proceedings in a court of competent jurisdiction for temporary or permanent relief to:

(a) Enforce this section or any minimum standard, rule, or order issued pursuant thereto if the agency's effort to correct a violation through administrative fines has failed or when the violation materially affects the health, safety, or welfare of residents; or

(b) Terminate the operation of a facility if a violation of this section or of any standard or rule adopted pursuant thereto exists which materially affects the health, safety, or welfare of residents.

The Legislature recognizes that, in some instances, action is necessary to protect residents of facilities from immediately life-threatening situations. If it appears by competent evidence or a sworn, substantiated affidavit that a temporary injunction should issue, the court, pending the determination on final hearing, shall enjoin operation of the facility.

(3) The agency may impose an immediate moratorium on admissions to a facility when the agency determines that any condition in the facility presents a threat to the health, safety, or welfare of the residents in the facility. If a facility's license is denied, revoked, or suspended, the facility may be subject to the immediate imposition of a moratorium on admissions to run concurrently with licensure denial, revocation, or suspension.

**History.**--s. 9, ch. 99-144; s. 37, ch. 2002-400.

**400.9685 Administration of medication.**--

(1) Notwithstanding the provisions of the Nurse Practice Act, part I of chapter 464, unlicensed direct care services staff who are providing services to clients in intermediate care facilities for the developmentally disabled, licensed pursuant to this part, may administer prescribed, prepackaged, premeasured medications under the general supervision of a registered nurse as provided in this section and applicable rules. Training required by this section and applicable rules must be conducted by a registered nurse licensed pursuant to chapter 464 or a physician licensed pursuant to chapter 458 or chapter 459.

(2) Each facility that allows unlicensed direct care service staff to administer medications pursuant to this section must:

(a) Develop and implement policies and procedures that include a plan to ensure the safe handling, storage, and administration of prescription medication.

(b) Maintain written evidence of the expressed and informed consent for each client.

(c) Maintain a copy of the written prescription including the name of the medication, the dosage, and administration schedule.

(d) Maintain documentation regarding the prescription including the name, dosage, and administration schedule, reason for prescription, and the termination date.

(e) Maintain documentation of compliance with required training.

(3) Agency rules shall specify the following as it relates to the administration of medications by unlicensed staff:

(a) Medications authorized and packaging required.

(b) Acceptable methods of administration.

(c) A definition of "general supervision."

(d) Minimum educational requirements of staff.

(e) Criteria of required training and competency that must be demonstrated prior to the administration of medications by unlicensed staff including inservice training.

(f) Requirements for safe handling, storage, and administration of medications.

**History.**--s. 2, ch. 2003-57.

**400.969 Violation of part; penalties.**--

(1) Except as provided in s. 400.967(3), a violation of any provision of this part or rules adopted by the agency under this part is punishable by payment of an administrative or civil penalty not to exceed $5,000.

(2) A violation of this part or of rules adopted under this part is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Each day of a continuing violation is a separate offense.

**History.**--s. 9, ch. 99-144; s. 37, ch. 2002-400.

**Note.**--Former s. 400.968(4).

**PART XII**

**HEALTH CARE SERVICES POOLS**

400.980 Health care services pools.

**400.980 Health care services pools.**--

(1) As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Health care services pool" means any person, firm, corporation, partnership, or association engaged for hire in the business of providing temporary employment in health care facilities, residential facilities, and agencies for licensed, certified, or trained health care personnel including, without limitation, nursing assistants, nurses' aides, and orderlies. However, the term does not include nursing registries, a facility licensed under chapter 400, a health care services pool established within a health care facility to provide services only within the confines of such facility, or any individual contractor directly providing temporary services to a health care facility without use or benefit of a contracting agent.

(2) Each person who operates a health care services pool must register each separate business location with the agency. The agency shall adopt rules and provide forms required for such registration and shall impose a registration fee in an amount sufficient to cover the cost of administering this section. In addition, the registrant must provide the agency with any change of information contained on the original registration application within 14 days prior to the change. The agency may inspect the offices of any health care services pool at any reasonable time for the purpose of determining compliance with this section or the rules adopted under this section.

(3) Each application for registration must include:

(a) The name and address of any person who has an ownership interest in the business, and, in the case of a corporate owner, copies of the articles of incorporation, bylaws, and names and addresses of all officers and directors of the corporation.

(b) Any other information required by the agency.

(4) Each applicant for registration must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 1 standards for screening set forth in chapter 435, of every individual who will have contact with patients. The agency shall require background screening of the managing employee or other similarly titled individual who is responsible for the

operation of the entity, and of the financial officer or other similarly titled individual who is responsible for the financial operation of the entity, including billings for services in accordance with the level 2 standards for background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is affiliated with the applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a).

(d) A provisional registration may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation. A standard registration may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and if a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and controlling interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 which was committed by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization who serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation's or organization's board of directors, and has no financial interest and no family members having a financial interest in the corporation or organization, if the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A registration may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) Failure to provide all required documentation within 30 days after a written request from the agency will result in denial of the application for registration.

(i) The agency must take final action on an application for registration within 60 days after receipt of all required documentation.

(j) The agency may deny, revoke, or suspend the registration of any applicant or registrant who:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

3. Fails to comply with this section or applicable rules.

4. Commits an intentional, reckless, or negligent act that materially affects the health or safety of a person receiving services.

(5) It is a misdemeanor of the first degree, punishable under s. 775.082 or s. 775.083, for any person willfully, knowingly, or intentionally to:

(a) Fail, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose in any application for voluntary or paid employment a material fact used in making a determination as to an applicant's qualifications to be a contractor under this section;

(b) Operate or attempt to operate an entity registered under this part with persons who do not meet the minimum standards of chapter 435 as contained in this section; or

(c) Use information from the criminal records obtained under this section for any purpose other than screening an applicant for temporary employment as specified in this section, or release such information to any other person for any purpose other than screening for employment under this section.

(6) It is a felony of the third degree, punishable under s. 775.082, s. 775.083, or s. 775.084, for any person willfully, knowingly, or intentionally to use information from the juvenile records of a person obtained under this section for any purpose other than screening for employment under this section.

(7) It is unlawful for a person to offer or advertise services, as defined by rule, to the public without obtaining a certificate of registration from the Agency for Health Care Administration. It is unlawful for any holder of a certificate of registration to advertise or hold out to the public that he or she holds a certificate of registration for other than that for which he or she actually holds a certificate of registration. Any person who violates this subsection is subject to injunctive proceedings under s. 400.515.

(8) Each registration shall be for a period of 2 years. The application for renewal must be received by the agency at least 30 days before the expiration date of the registration. An application for a new registration is required within 30 days prior to the sale of a controlling interest in a health care services pool.

(9) A health care services pool may not require an employee to recruit new employees from persons employed at a health care facility to which the health care services pool employee is assigned. Nor shall a health care facility to which employees of a health care services pool are assigned recruit new employees from the health care services pool.

(10) A health care services pool shall document that each temporary employee provided to a health care facility has met the licensing, certification, training, or continuing education requirements, as established by the appropriate regulatory agency, for the position in which he or she will be working.

(11) When referring persons for temporary employment in health care facilities, a health care

services pool shall comply with all pertinent state and federal laws, rules, and regulations relating to health, background screening, and other qualifications required of persons working in a facility of that type.

(12)(a) As a condition of registration and prior to the issuance or renewal of a certificate of registration, a health care services pool applicant must prove financial responsibility to pay claims, and costs ancillary thereto, arising out of the rendering of services or failure to render services by the pool or by its employees in the course of their employment with the pool. The agency shall promulgate rules establishing minimum financial responsibility coverage amounts which shall be adequate to pay potential claims and costs ancillary thereto.

(b) Each health care services pool shall give written notification to the agency within 20 days after any change in the method of assuring financial responsibility or upon cancellation or nonrenewal of professional liability insurance. Unless the pool demonstrates that it is otherwise in compliance with the requirements of this section, the agency shall suspend the registration of the pool pursuant to ss. 120.569 and 120.57. Any suspension under this section shall remain in effect until the pool demonstrates compliance with the requirements of this section.

(c) Proof of financial responsibility must be demonstrated to the satisfaction of the agency, through one of the following methods:

1. Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52;

2. Obtaining and maintaining an unexpired irrevocable letter of credit established pursuant to chapter 675. Such letters of credit shall be nontransferable and nonassignable and shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state; or

3. Obtaining and maintaining professional liability coverage from one of the following:

a. An authorized insurer as defined under s. 624.09;

b. An eligible surplus lines insurer as defined under s. 626.918(2);

c. A risk retention group or purchasing group as defined under s. 627.942; or

d. A plan of self-insurance as provided in s. 627.357.

(d) If financial responsibility requirements are met by maintaining an escrow account or letter of credit, as provided in this section, upon the entry of an adverse final judgment arising from a medical malpractice arbitration award from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the financial institution holding the escrow account or the letter of credit shall pay directly to the claimant the entire amount of the judgment together with all accrued interest or the amount maintained in the escrow account or letter of credit as required by this section, whichever is less, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. If timely payment is not made, the agency shall suspend the registration of the pool pursuant to procedures set forth by the agency through rule. Nothing in this paragraph shall abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment.

(e) Each health care services pool carrying claims-made coverage must demonstrate proof of extended reporting coverage through either tail or nose coverage, in the event the policy is

canceled, replaced, or not renewed. Such extended coverage shall provide coverage for incidents that occurred during the claims-made policy period but were reported after the policy period.

(f) The financial responsibility requirements of this section shall apply to claims for incidents that occur on or after January 1, 1991, or the initial date of registration in this state, whichever is later.

(g) Meeting the financial responsibility requirements of this section must be established at the time of issuance or renewal of a certificate of registration.

(13) The agency shall adopt rules to implement this section, including rules providing for the establishment of:

(a) Minimum standards for the operation and administration of health care personnel pools, including procedures for recordkeeping and personnel.

(b) Fines for the violation of this section in an amount not to exceed $2,500 and suspension or revocation of registration.

(c) Disciplinary sanctions for failure to comply with this section or the rules adopted under this section.

**History.**--s. 1, ch. 89-354; s. 1, ch. 90-158; s. 1, ch. 90-192; s. 30, ch. 90-295; s. 184, ch. 91-108; s. 4, ch. 91-429; s. 52, ch. 94-218; s. 1061, ch. 95-148; s. 128, ch. 96-410; s. 3, ch. 97-264; s. 1, ch. 98-130; s. 24, ch. 2000-349; s. 38, ch. 2001-62; s. 29, ch. 2003-57; s. 18, ch. 2004-267.

**Note.**--Former s. 402.48.

## PART XIII

## HEALTH CARE CLINIC ACT

**400.990 Short title; legislative findings.** --

(1) This part, consisting of ss. 400.990-400.995, may be cited as the "Health Care Clinic Act."

(2) The Legislature finds that the regulation of health care clinics must be strengthened to prevent significant cost and harm to consumers. The purpose of this part is to provide for the licensure, establishment, and enforcement of basic standards for health care clinics and to provide administrative oversight by the Agency for Health Care Administration.

**History.**--s. 4, ch. 2003-411.

**400.9905 Definitions.**--

(1) "Agency" means the Agency for Health Care Administration.

(2) "Applicant" means an individual owner, corporation, partnership, firm, business, association, or other entity that owns or controls, directly or indirectly, 5 percent or more of an interest in the clinic and that applies for a clinic license.

(3) "Chief financial officer" means an individual who has at least a minimum of a bachelor's degree from an accredited university in accounting or finance, or a related field, and who is the person responsible for the preparation of a clinic's billing.

[1](4) "Clinic" means an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider. For purposes of this part, the term does not include and the licensure requirements of this part do not apply to:

(a) Entities licensed or registered by the state under chapter 395; or entities licensed or registered by the state and providing only health care services within the scope of services authorized under their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part XIII, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(b) Entities that own, directly or indirectly, entities licensed or registered by the state pursuant to chapter 395; or entities that own, directly or indirectly, entities licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part XIII, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(c) Entities that are owned, directly or indirectly, by an entity licensed or registered by the state pursuant to chapter 395; or entities that are owned, directly or indirectly, by an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part XIII, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital under chapter 395.

(d) Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state pursuant to chapter 395; or entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state and providing only health care services within the scope of services authorized pursuant to their respective licenses granted under ss. 383.30-383.335, chapter 390, chapter 394, chapter 397, this chapter except part XIII, chapter 463, chapter 465, chapter 466, chapter 478, part I of chapter 483, chapter 484, or chapter 651; end-stage renal disease providers authorized under 42 C.F.R. part 405, subpart U; or providers certified under 42 C.F.R. part 485, subpart B or subpart H; or any entity that provides neonatal or pediatric hospital-based health care services by licensed practitioners solely within a hospital licensed under chapter 395.

(e) An entity that is exempt from federal taxation under 26 U.S.C. s. 501(c)(3) or s. 501(c)(4), any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof.

(f) A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by s. 627.419, that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician.

(g) A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, which are wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner, so long as one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in s. 456.053(3)(b) that provides only services authorized pursuant to s. 456.053(3)(b) may be supervised by a licensee specified in s. 456.053(3)(b).

(h) Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

[2](i) Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459.

(5) "Medical director" means a physician who is employed or under contract with a clinic and who maintains a full and unencumbered physician license in accordance with chapter 458, chapter 459, chapter 460, or chapter 461. However, if the clinic does not provide services pursuant to the respective physician practices acts listed in this subsection, it may appoint a Florida-licensed health care practitioner who does not provide services pursuant to the respective physician practices acts listed in this subsection to serve as a clinic director who is responsible for the clinic's activities. A health care practitioner may not serve as the clinic director if the services provided at the clinic are beyond the scope of that practitioner's license, except that a licensee specified in s. 456.053(3)(b) who provides only services authorized pursuant to s. 456.053(3)(b) may serve as clinic director of an entity providing services as specified in s. 456.053(3)(b).

(6) "Mobile clinic" means a movable or detached self-contained health care unit within or from which direct health care services are provided to individuals and which otherwise meets the definition of a clinic in subsection (4).

(7) "Portable equipment provider" means an entity that contracts with or employs persons to provide portable equipment to multiple locations performing treatment or diagnostic testing of

individuals, that bills third-party payors for those services, and that otherwise meets the definition of a clinic in subsection (4).

**History.**--s. 4, ch. 2003-411; s. 14, ch. 2004-298; ss. 26, 33, ch. 2004-350.

**[1]Note.**--Section 34, ch. 2004-350, provides that "[t]he amendment made by this act to section [400.9905(4)], Florida Statutes, is intended to clarify the legislative intent of this provision as it existed at the time the provision initially took effect as section 456.0375(1)(b), Florida Statutes, and section [400.9905(4)(i)], Florida Statutes, as created by this act, shall operate retroactively to October 1, 2001."

**[2]Note.**--Section 27, ch. 2004-350, provides that "[t]he creation of [s. 400.9905(4)(i)], Florida Statutes, by this act is intended to clarify the legislative intent of this provision as it existed at the time the provision initially took effect as section 456.0375(1)(b), Florida Statutes, and [s. 400.9905 (4)(i)], Florida Statutes, as created by this act, shall operate retroactively to October 1, 2001. Nothing in this section shall be construed as amending, modifying, limiting, or otherwise affecting in any way the legislative intent, scope, terms, prohibition, or requirements of section 456.053, Florida Statutes." Section 15, ch. 2004-298, provides for substantially the same intent and retroactivity.

**[1]400.991 License requirements; background screenings; prohibitions.**--

[2](1)(a) Each clinic, as defined in s. 400.9905, must be licensed and shall at all times maintain a valid license with the agency. Each clinic location shall be licensed separately regardless of whether the clinic is operated under the same business name or management as another clinic.

(b) Each mobile clinic must obtain a separate health care clinic license and must provide to the agency, at least quarterly, its projected street location to enable the agency to locate and inspect such clinic. A portable equipment provider must obtain a health care clinic license for a single administrative office and is not required to submit quarterly projected street locations.

[2](2) The initial clinic license application shall be filed with the agency by all clinics, as defined in s. 400.9905, on or before July 1, 2004. A clinic license must be renewed biennially.

[2](3) Applicants that submit an application on or before July 1, 2004, which meets all requirements for initial licensure as specified in this section shall receive a temporary license until the completion of an initial inspection verifying that the applicant meets all requirements in rules authorized in s. 400.9925. However, a clinic engaged in magnetic resonance imaging services may not receive a temporary license unless it presents evidence satisfactory to the agency that such clinic is making a good faith effort and substantial progress in seeking accreditation required under s. 400.9935.

(4) Application for an initial clinic license or for renewal of an existing license shall be notarized on forms furnished by the agency and must be accompanied by the appropriate license fee as provided in s. 400.9925. The agency shall take final action on an initial license application within 60 days after receipt of all required documentation.

(5) The application shall contain information that includes, but need not be limited to, information pertaining to the name, residence and business address, phone number, social security number, and license number of the medical or clinic director, of the licensed medical providers employed or under contract with the clinic, and of each person who, directly or indirectly, owns or controls 5 percent or more of an interest in the clinic, or general partners in limited liability partnerships.

(6) The applicant must file with the application satisfactory proof that the clinic is in compliance

with this part and applicable rules, including:

(a) A listing of services to be provided either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of each professional staff member to be employed; and

(c) Proof of financial ability to operate. An applicant must demonstrate financial ability to operate a clinic by submitting a balance sheet and an income and expense statement for the first year of operation which provide evidence of the applicant's having sufficient assets, credit, and projected revenues to cover liabilities and expenses. The applicant shall have demonstrated financial ability to operate if the applicant's assets, credit, and projected revenues meet or exceed projected liabilities and expenses. All documents required under this subsection must be prepared in accordance with generally accepted accounting principles, may be in a compilation form, and the financial statement must be signed by a certified public accountant. As an alternative to submitting a balance sheet and an income and expense statement for the first year of operation, the applicant may file a surety bond of at least $500,000 which guarantees that the clinic will act in full conformity with all legal requirements for operating a clinic, payable to the agency. The agency may adopt rules to specify related requirements for such surety bond.

(7) Each applicant for licensure shall comply with the following requirements:

[2](a) As used in this subsection, the term "applicant" means individuals owning or controlling, directly or indirectly, 5 percent or more of an interest in a clinic; the medical or clinic director, or a similarly titled person who is responsible for the day-to-day operation of the licensed clinic; the financial officer or similarly titled individual who is responsible for the financial operation of the clinic; and licensed health care practitioners at the clinic.

[2](b) Upon receipt of a completed, signed, and dated application, the agency shall require background screening of the applicant, in accordance with the level 2 standards for screening set forth in chapter 435. Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of this paragraph. Applicants who own less than 10 percent of a health care clinic are not required to submit fingerprints under this section.

(c) Each applicant must submit to the agency, with the application, a description and explanation of any exclusions, permanent suspensions, or terminations of an applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interest under the Medicaid or Medicare programs may be accepted in lieu of this submission. The description and explanation may indicate whether such exclusions, suspensions, or terminations were voluntary or not voluntary on the part of the applicant.

(d) A license may not be granted to a clinic if the applicant has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, or a violation of insurance fraud under s. 817.234, within the past 5 years. If the applicant has been convicted of an offense prohibited under the level 2 standards or insurance fraud in any jurisdiction, the applicant must show that his or her civil rights have been restored prior to submitting an application.

(e) The agency may deny or revoke licensure if the applicant has falsely represented any material fact or omitted any material fact from the application required by this part.

(8) Requested information omitted from an application for licensure, license renewal, or transfer of ownership must be filed with the agency within 21 days after receipt of the agency's request for omitted information, or the application shall be deemed incomplete and shall be withdrawn from

further consideration.

(9) The failure to file a timely renewal application shall result in a late fee charged to the facility in an amount equal to 50 percent of the current license fee.

**History.**--s. 4, ch. 2003-411; s. 56, ch. 2004-267; s. 16, ch. 2004-298; s. 28, ch. 2004-350.

**[1]Note.**--

A. Section 19, ch. 2004-298, provides that:

"The Agency for Health Care Administration is directed to make refunds to applicants that submitted their health care clinic licensure fees and applications but were subsequently exempted from licensure by this act as follows:

"(1) Seventy-five percent of the application fee if the temporary license has not been issued;

"(2) Fifty percent of the application fee if the temporary license has been issued but the inspection has not been completed; or

"(3) No refund if the inspection has been completed."

B. Section 31, ch. 2004-350, provides that "[t]he agency shall refund 90 percent of the license application fee to applicants that submitted their health care clinic licensure fees and applications but were subsequently exempted from licensure by this act."

C. Section 32, ch. 2004-350, provides that "[a]ny person or entity defined as a clinic under s. 400.9905, Florida Statutes, shall not be in violation of part XIII of chapter 400, Florida Statutes, due to failure to apply for a clinic license by March 1, 2004, as previously required by s. 400.991, Florida Statutes. Payment to any such person or entity by an insurer or other person liable for payment to such person or entity may not be denied on the grounds that the person or entity failed to apply for or obtain a clinic license before March 1, 2004." Section 20, ch. 2004-298, creates substantially the same provision.

**[2]Note.**--Section 16, ch. 2004-298, amended subsections (1), (2), and (3) and paragraphs (7)(a) and (b) "[e]ffective upon this act becoming a law and applicable retroactively to March 1, 2004."

**400.9915 Clinic inspections; emergency suspension; costs.**--

(1) Any authorized officer or employee of the agency shall make inspections of the clinic as part of the initial license application or renewal application. The application for a clinic license issued under this part or for a renewal license constitutes permission for an appropriate agency inspection to verify the information submitted on or in connection with the application or renewal.

(2) An authorized officer or employee of the agency may make unannounced inspections of clinics licensed pursuant to this part as are necessary to determine that the clinic is in compliance with this part and with applicable rules. A licensed clinic shall allow full and complete access to the premises and to billing records or information to any representative of the agency who makes an inspection to determine compliance with this part and with applicable rules.

(3) Failure by a clinic licensed under this part to allow full and complete access to the premises and to billing records or information to any representative of the agency who makes a request to inspect the clinic to determine compliance with this part or failure by a clinic to employ a qualified medical director or clinic director constitutes a ground for emergency suspension of the license by the agency pursuant to s. 120.60(6).

(4) In addition to any administrative fines imposed, the agency may assess a fee equal to the cost of conducting a complaint investigation.

**History.**--s. 4, ch. 2003-411.

**400.992 License renewal; transfer of ownership; provisional license.**--

(1) An application for license renewal must contain information as required by the agency.

(2) Ninety days before the expiration date, an application for renewal must be submitted to the agency.

(3) The clinic must file with the renewal application satisfactory proof that it is in compliance with this part and applicable rules. If there is evidence of financial instability, the clinic must submit satisfactory proof of its financial ability to comply with the requirements of this part.

(4) When transferring the ownership of a clinic, the transferee must submit an application for a license at least 60 days before the effective date of the transfer. An application for change of ownership of a clinic is required only when 45 percent or more of the ownership, voting shares, or controlling interest of a clinic is transferred or assigned, including the final transfer or assignment of multiple transfers or assignments over a 2-year period that cumulatively total 45 percent or greater.

(5) The license may not be sold, leased, assigned, or otherwise transferred, voluntarily or involuntarily, and is valid only for the clinic owners and location for which originally issued.

(6) A clinic against whom a revocation or suspension proceeding is pending at the time of license renewal may be issued a provisional license effective until final disposition by the agency of such proceedings. If judicial relief is sought from the final disposition, the agency that has jurisdiction may issue a temporary permit for the duration of the judicial proceeding.

**History.**--s. 4, ch. 2003-411.

**400.9925 Rulemaking authority; license fees.**--

(1) The agency shall adopt rules necessary to administer the clinic administration, regulation, and licensure program, including rules establishing the specific licensure requirements, procedures, forms, and fees. It shall adopt rules establishing a procedure for the biennial renewal of licenses. The agency may issue initial licenses for less than the full 2-year period by charging a prorated licensure fee and specifying a different renewal date than would otherwise be required for biennial licensure. The rules shall specify the expiration dates of licenses, the process of tracking compliance with financial responsibility requirements, and any other conditions of renewal required by law or rule.

(2) The agency shall adopt rules specifying limitations on the number of licensed clinics and licensees for which a medical director or a clinic director may assume responsibility for purposes of this part. In determining the quality of supervision a medical director or a clinic director can provide, the agency shall consider the number of clinic employees, the clinic location, and the health care services provided by the clinic.

(3) License application and renewal fees must be reasonably calculated by the agency to cover its costs in carrying out its responsibilities under this part, including the cost of licensure, inspection, and regulation of clinics, and must be of such amount that the total fees collected do not exceed the cost of administering and enforcing compliance with this part. Clinic licensure fees are nonrefundable and may not exceed $2,000. The agency shall adjust the license fee annually by not

more than the change in the Consumer Price Index based on the 12 months immediately preceding the increase. All fees collected under this part must be deposited in the Health Care Trust Fund for the administration of this part.

**History.**--s. 4, ch. 2003-411.

**400.993 Unlicensed clinics; penalties; fines; verification of licensure status.**--

(1) It is unlawful to own, operate, or maintain a clinic without obtaining a license under this part.

(2) Any person who owns, operates, or maintains an unlicensed clinic commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(3) Any person found guilty of violating subsection (2) a second or subsequent time commits a felony of the second degree, punishable as provided under s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(4) Any person who owns, operates, or maintains an unlicensed clinic due to a change in this part or a modification in agency rules within 6 months after the effective date of such change or modification and who, within 10 working days after receiving notification from the agency, fails to cease operation or apply for a license under this part commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.

(5) Any clinic that fails to cease operation after agency notification may be fined for each day of noncompliance pursuant to this part.

(6) When a person has an interest in more than one clinic, and fails to obtain a license for any one of these clinics, the agency may revoke the license, impose a moratorium, or impose a fine pursuant to this part on any or all of the licensed clinics until such time as the unlicensed clinic is licensed or ceases operation.

(7) Any person aware of the operation of an unlicensed clinic must report that facility to the agency.

(8) Any health care provider who is aware of the operation of an unlicensed clinic shall report that facility to the agency. Failure to report a clinic that the provider knows or has reasonable cause to suspect is unlicensed shall be reported to the provider's licensing board.

(9) The agency may not issue a license to a clinic that has any unpaid fines assessed under this part.

**History.**--s. 4, ch. 2003-411.

**400.9935 Clinic responsibilities.** --

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(a) Have signs identifying the medical director or clinic director posted in a conspicuous location within the clinic readily visible to all patients.

(b) Ensure that all practitioners providing health care services or supplies to patients maintain a

current active and unencumbered Florida license.

(c) Review any patient referral contracts or agreements executed by the clinic.

(d) Ensure that all health care practitioners at the clinic have active appropriate certification or licensure for the level of care being provided.

(e) Serve as the clinic records owner as defined in s. 456.057.

(f) Ensure compliance with the recordkeeping, office surgery, and adverse incident reporting requirements of chapter 456, the respective practice acts, and rules adopted under this part.

(g) Conduct systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic director shall take immediate corrective action. If the clinic performs only the technical component of magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography, and provides the professional interpretation of such services, in a fixed facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association for Ambulatory Health Care, and the American College of Radiology; and if, in the preceding quarter, the percentage of scans performed by that clinic which was billed to [1]all personal injury protection insurance carriers was less than 15 percent, the chief financial officer of the clinic may, in a written acknowledgment provided to the agency, assume the responsibility for the conduct of the systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful.

(2) Any business that becomes a clinic after commencing operations must, within 5 days after becoming a clinic, file a license application under this part and shall be subject to all provisions of this part applicable to a clinic.

(3) Any contract to serve as a medical director or a clinic director entered into or renewed by a physician or a licensed health care practitioner in violation of this part is void as contrary to public policy. This subsection shall apply to contracts entered into or renewed on or after March 1, 2004.

(4) All charges or reimbursement claims made by or on behalf of a clinic that is required to be licensed under this part, but that is not so licensed, or that is otherwise operating in violation of this part, are unlawful charges, and therefore are noncompensable and unenforceable.

(5) Any person establishing, operating, or managing an unlicensed clinic otherwise required to be licensed under this part, or any person who knowingly files a false or misleading license application or license renewal application, or false or misleading information related to such application or department rule, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(6) Any licensed health care provider who violates this part is subject to discipline in accordance with this chapter and his or her respective practice act.

(7) The agency may fine, or suspend or revoke the license of, any clinic licensed under this part for operating in violation of the requirements of this part or the rules adopted by the agency.

(8) The agency shall investigate allegations of noncompliance with this part and the rules adopted under this part.

(9) Any person or entity providing health care services which is not a clinic, as defined under s. 400.9905, may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that sets forth its name or names and addresses, a statement of

the reasons why it cannot be defined as a clinic, and other information deemed necessary by the agency. An exemption is not transferable. The agency may charge an applicant for a certificate of exemption in an amount equal to $100 or the actual cost of processing the certificate, whichever is less.

(10) The clinic shall display its license in a conspicuous location within the clinic readily visible to all patients.

(11)(a) Each clinic engaged in magnetic resonance imaging services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care, within 1 year after licensure. However, a clinic may request a single, 6-month extension if it provides evidence to the agency establishing that, for good cause shown, such clinic can not be accredited within 1 year after licensure, and that such accreditation will be completed within the 6-month extension. After obtaining accreditation as required by this subsection, each such clinic must maintain accreditation as a condition of renewal of its license.

(b) The agency may deny the application or revoke the license of any entity formed for the purpose of avoiding compliance with the accreditation provisions of this subsection and whose principals were previously principals of an entity that was unable to meet the accreditation requirements within the specified timeframes. The agency may adopt rules as to the accreditation of magnetic resonance imaging clinics.

(12) The agency shall give full faith and credit pertaining to any past variance and waiver granted to a magnetic resonance imaging clinic from rule 64-2002, Florida Administrative Code, by the Department of Health, until September 2004. After that date, such clinic must request a variance and waiver from the agency under s. 120.542.

**History.**--s. 4, ch. 2003-411; s. 17, ch. 2004-298; s. 29, ch. 2004-350.

[1]**Note.**--As amended by s. 29, ch. 2004-350. The amendment by s. 17, ch. 2004-298, uses the phrase "a personal injury protection insurance carrier" instead of the phrase "all personal injury protection insurance carriers."

**400.994 Injunctions.**--

(1) The agency may institute injunctive proceedings in a court of competent jurisdiction in order to:

(a) Enforce the provisions of this part or any minimum standard, rule, or order issued or entered into pursuant to this part if the attempt by the agency to correct a violation through administrative fines has failed; if the violation materially affects the health, safety, or welfare of clinic patients; or if the violation involves any operation of an unlicensed clinic.

(b) Terminate the operation of a clinic if a violation of any provision of this part, or any rule adopted pursuant to this part, materially affects the health, safety, or welfare of clinic patients.

(2) Such injunctive relief may be temporary or permanent.

(3) If action is necessary to protect clinic patients from life-threatening situations, the court may allow a temporary injunction without bond upon proper proof being made. If it appears by competent evidence or a sworn, substantiated affidavit that a temporary injunction should issue, the court, pending the determination on final hearing, shall enjoin operation of the clinic.

**History.**--s. 4, ch. 2003-411.

**400.9945 Agency actions.**--Administrative proceedings challenging agency licensure enforcement action shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

**History.**--s. 4, ch. 2003-411.

**400.995 Agency administrative penalties.**--

(1) The agency may deny the application for a license renewal, revoke or suspend the license, and impose administrative fines of up to $5,000 per violation for violations of the requirements of this part or rules of the agency. In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a patient will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.

(b) Actions taken by the owner, medical director, or clinic director to correct violations.

(c) Any previous violations.

(d) The financial benefit to the clinic of committing or continuing the violation.

(2) Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(3) Any action taken to correct a violation shall be documented in writing by the owner, medical director, or clinic director of the clinic and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated clinic, revoke or deny a clinic's license when a clinic medical director or clinic director knowingly misrepresents actions taken to correct a violation.

(4) For fines that are upheld following administrative or judicial review, the violator shall pay the fine, plus interest at the rate as specified in s. 55.03, for each day beyond the date set by the agency for payment of the fine.

(5) Any unlicensed clinic that continues to operate after agency notification is subject to a $1,000 fine per day.

(6) Any licensed clinic whose owner, medical director, or clinic director concurrently operates an unlicensed clinic shall be subject to an administrative fine of $5,000 per day.

(7) Any clinic whose owner fails to apply for a change-of-ownership license in accordance with s. 400.992 and operates the clinic under the new ownership is subject to a fine of $5,000.

(8) The agency, as an alternative to or in conjunction with an administrative action against a clinic for violations of this part and adopted rules, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner, medical director, or clinic director of the clinic, prior to written notification. The agency, instead of fixing a period within which the clinic shall enter into compliance with standards, may request a plan of corrective action from the clinic which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(9) Administrative fines paid by any clinic under this section shall be deposited into the Health Care Trust Fund.

(10) If the agency issues a notice of intent to deny a license application after a temporary license has been issued pursuant to s. 400.991(3), the temporary license shall expire on the date of the notice and may not be extended during any proceeding for administrative or judicial review pursuant to chapter 120.

**History.**--s. 4, ch. 2003-411; s. 18, ch. 2004-298; s. 30, ch. 2004-350.