

**\*Note that statutes appear in blue, regulations are in black**

## **CHAPTER 59A-4 MINIMUM STANDARDS FOR NURSING HOMES**

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### **59A-4.103 Licensure, Administration and Fiscal Management.**

(1) The licensee or prospective licensee shall make application for an initial, renewal or change of ownership license to operate a nursing home facility and shall provide all of the information required by this rule and Chapter 400, Part II, F.S., on AHCA Form 3110-6001, January, 2002, "Application for Nursing Home Licensure", and AHCA Form 3001-6001, January, 2002, Instructions for Completing Application for Nursing Home Licensure, which is incorporated by reference and AHCA Forms 3110-0011, 3110-0011A, 3110-0011B, 3110-0011C, and 3110-0011D, August, 2001, "Controlling Interest Affidavit for Nursing Homes", which is incorporated by reference and AHCA Form 1332-0001, January, 2002, "Proof of Financial Ability Schedule", which is incorporated by reference, available from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, Tallahassee, Florida 32308.

(2) The licensure fee shall be included with the application. An annual fee is \$50 per bed required as described in Section 400.062(3), F.S., plus the resident protection fee of \$.25 per bed and the Data Collection and Analysis Assessment of \$6.00 per bed as authorized by Section 408.20(1)(b), F.S., Costs of Nursing Home Statistical Unit, March 9, 1994. The Data Collection and Analysis Assessment is waived for facilities having a certificate of authority under Chapter 651, F.S.

(3) Single copies of AHCA forms incorporated by reference within this chapter may be obtained from the AHCA, Long Term Care Section, 2727 Mahan Drive, MS 33, Tallahassee, Florida 32308.

(4) Administration.

(a) The licensee of each nursing home shall have full legal authority and responsibility for the operation of the facility.

(b) The licensee of each facility shall designate one person, who is licensed by the Agency for Health Care Administration, Board of Nursing Home Administrators under Chapter 468, Part II, F.S., as Administrator who oversees the day to day administration and operation of the facility.

(c) Each nursing home shall be organized according to a written table of Organization.

(d) The licensee shall submit a monthly vacant bed report which is incorporated by reference by using AHCA Form 3110-0013, October 2008, "Nursing Home Monthly Bed Vacancy Report", as authorized by Section 400.141, F.S., this form is available from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive MS 33, Tallahassee, FL 32308 or online at: <http://ahca.myflorida.com/>.

(e) Submit Nursing Home Staffing Report which is incorporated by reference by using AHCA Form 3110-0012, October 2008, "Nursing Home Staffing Report", as authorized by Section 400.141, F.S., this form is available from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive MS 33, Tallahassee, FL 32308 or online at: <http://ahca.myflorida.com/>.

(5) Fiscal Management.

(a) The licensee, for each nursing home it operates, shall maintain fiscal records in accordance with the requirements of Chapter 400, Part II, F.S., and these rules.

(b) An accrual or cash system of accounting shall be used to reflect transactions of the business. Records and accounts of transactions, such as, general ledgers and disbursement journals, shall be brought current no less than quarterly and shall be available for review by authorized representatives of appropriate state and Federal agencies.

(c) A licensee shall obtain a surety bond as required by Chapter 400, Part II, F.S., it shall be based on twice the average monthly balance in the resident trust fund during the prior fiscal year or \$5,000, whichever is greater. A licensee who owns more than one nursing home may purchase a single surety bond to cover the residents' funds held in nursing homes located within the same AHCA service district. A surety bond shall contain substantially the same language as is found in AHCA Form 3110-6002, July, 2001, Surety Bond, which is incorporated by reference. The surety bond AHCA 3110-6002, July, 2001, may be obtained from, and shall be filed with the AHCA, 2727 Mahan Drive, Tallahassee, Florida 32308.

(d) A self-insurance pool, which may be an interest bearing account, may be established to provide compensation to any resident suffering financial loss in accordance with the provisions of Section 400.162(5)(c), F.S., as the result of one or more of the member licensees violating any of the provisions of Section 400.162, F.S.

1. Such self-insurance pool shall be administered under the direction of an elected board of trustees. The membership of the board of trustees shall be composed of one representative from each participating licensee.
2. An application for establishing a self-insurance pool shall be made by the trustees to the ahca. Such application shall contain the following information: the names, complete addresses, and affiliation of the trustees; the name and complete address of each licensee participating in the pool; the total dollar amount of the pool; and the name and complete address of the bank in which the account is maintained and the account number. The application shall be accompanied by:

a. An individual application from each licensee applying for membership in the self-insurance pool. Such application shall contain the following information: the name, telephone number, and complete address of the facility; the name, telephone number, and complete address of the licensee, the name of the facility's administrator, manager or supervisor, his license and renewal number; the names of all employees involved in the administration of the resident trust fund account; the average monthly balance in the resident trust fund account during the prior year; the total dollar amount the licensee has deposited in the self-insurance pool; and the name and complete address of the bank in which the account is maintained and the account number.

b. Prima facie evidence showing that each individual member of the pool has deposited an amount equal to twice the average monthly balance of the trust fund account or \$5,000.00 dollars, whichever is greater, in a separate account maintained by the board of trustees in the name of the self-insurance pool in a chartered commercial bank in the State of Florida to secure performance of payment of all lawful awards made against any member or members of the self-insurance pool, Section 400.162(5), F.S., and these rules.

3. After the inception date of the pool, prospective new members of the pool shall submit an application for membership to the board of trustees. Such application shall contain the information specified in subparagraph (5)(b)2. The trustees may approve the application for membership in accordance with these rules. If so approved, the application for membership in accordance with these rules shall be filed with the ahca. Participation in a pool by a particular licensee shall be approved by the ahca if the licensee indicates in its

application that it does meet the requirements of Section 400.162(5), F.S., and these rules and verification is provided to document the financial status indicated on the application.

4. The amount deposited in such an account shall be maintained at all times.

(e) If, at any time during the period for which a license is issued, a licensee who has not purchased a surety bond or entered into a self-insurance agreement is requested to hold funds in trust as provided in Section 400.162(5), F.S., the licensee shall notify the ahca, in writing, of the request, and make application for a surety bond or for participation in a self-insurance agreement within seven 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 and shall be available for review. All notices required by this rule provision shall be sent to the AHCA, 2727 Mahan Drive, Tallahassee, Florida 32308.

*Specific Authority 400.23, 408.810(8) FS. Law Implemented 400.022, 400.0225, 400.071, 400.102, 400.111, 400.1183, 400.121, 400.141, 400.147, 400.151 400.162, 400.179, 400.18, 400.232, 408.20, 408.810(8) FS. History—New 4-1-82, Amended 4-1-84, 8-185, 1-1-86, 11-12-89, 12-25-90, 10-6-91, Formerly 10d-29.103, Amended 4-18-94, 2-6-97, 5-5-02.*

#### **59A-4.106 Facility Policies.**

(1) Admission, retention, transfer, and discharge policies:

(a) Each resident will receive, at the time of admission and as changes are being made and upon request, in a language the resident or his representative understands:

- A copy of the residents' bill of rights conforming to the requirements in Section 400.022, F.S.;
- A copy of the facility's admission and discharge policies; and
- Information regarding advance directives.

— (b) Each resident admitted to the facility shall have a contract in accordance with Section 400.151, F.S., which covers:

1. A list of services and supplies, complete with a list of standard charges, available to the resident, but not covered by the facility's per diem or by Title XVIII and Title XIX of the Social Security Act and the bed reservation and refund policies of the facility.
2. When a resident is in a facility offering continuing care, and is transferred from independent living or assisted living to the nursing home section, a new contract need not be executed; an addendum shall be attached to describe any additional services, supplies or costs not included in the most recent contract that is in effect.

(c) No resident who is suffering from a communicable disease shall be admitted or retained unless the medical director or attending physician certifies that adequate or appropriate isolation measures are available to control transmission of the disease.

(d) Residents may not be retained in the facility who require services beyond those for which the facility is licensed or has the functional ability to provide as determined by the Medical Director and the Director of Nursing in consultation with the facility administrator.

(e) Residents shall be assigned to a bedroom area and shall not be assigned bedroom space in common areas except in an emergency. Emergencies shall be documented and shall be for a limited, specified period of time.

(f) All resident transfers and discharges shall be in accordance with the facility's policies and procedures, provisions of Sections 400.022 and 400.0255, F.S., this rule, and other applicable state and federal laws and will include notices provided to residents which are incorporated by reference by using AHCA Form 3120-0002, 3120-0002A, Revised, May, 2001, "Nursing Home Transfer and Discharge Notice," and 3120-0003, Revised, May, 2001, "Fair Hearing Request for Transfer or Discharge From a Nursing Home," and 3120-0004, Revised, May, 2001, "Long-Term Care Ombudsman Council Request for Review of Nursing Home Discharge and Transfer." These forms may be obtained from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, MS 33, Tallahassee, FL 32308. The Department of Children and Family Services will assist in the arrangement for appropriate continued care, when requested.

(2) Each nursing home facility shall adopt, implement, and maintain written policies and procedures governing all services provided in the facility.

(3) All policies and procedures shall be reviewed at least annually and revised as needed with input from, at minimum, the facility Administrator, Medical Director, and Director of Nursing.

(4) Each facility shall maintain policies and procedures in the following areas:

- (a) Activities;
- (b) Advance directives;
- (c) Consultant services;
- (d) Death of residents in the facility;
- (e) Dental services;
- (f) Staff education, including hiv/aids Training;
- (g) Diagnostic services;
- (h) Dietary services;
- (i) Disaster preparedness;
- (j) Fire prevention and control;
- (k) Housekeeping;
- (l) Infection control;
- (m) Laundry service;
- (n) Loss of power, water, air conditioning or heating;
- (o) Medical director/consultant services;
- (p) Medical records;
- (q) Mental health;
- (r) Nursing services;
- (s) Pastoral services;
- (t) Pharmacy services;
- (u) Podiatry services;
- (v) Resident care planning;
- (w) Resident identification;
- (x) Resident's rights;
- (y) Safety awareness;
- (z) Social services; (aa) Specialized rehabilitative and restorative services; (bb) Volunteer services; and
- (cc) The reporting of accidents or unusual incidents involving any resident, staff member, volunteer or visitor.

This policy shall include reporting within the facility and to the ahca.

(5) Staff Education.

(a) Each nursing home shall develop, implement, and maintain a written staff education plan which ensures a coordinated program for staff education for all facility employees. The staff education plan shall be reviewed at least annually by the quality assurance committee and revised as needed.

(b) The staff education plan shall include both pre-service and in-service programs.

(c) The staff education plan shall ensure that education is conducted annually for all facility employees, at a minimum, in the following areas:

- Prevention and control of infection;
- Fire prevention, life safety, and disaster preparedness;
- Accident prevention and safety awareness program;
- Resident's rights';

5. Federal law, 42 CFR 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference, and state rules and regulations, Chapter 400, Part II, F.S., and this rule;

6. The Florida "Right to Know" Hazardous Materials, Chapter 442, F.S.;

(d) The staff education plan shall ensure that all nonlicensed employees of the nursing home complete an initial educational course on hiv/aids. If the employee does not have a certificate of completion at the time they are hired, they must have two hours within six months of employment or before the staff provides care for an hiv/aids diagnosed resident. All employees shall have a minimum of one hour biennially.

(6) Advance directives.

(a) Each nursing home shall have written policies and procedures, which delineate the nursing home's position with respect to the state law and rules relative to advance directives. The policies shall not condition treatment or admission upon whether or not the individual has executed or waived an advance directive. In the event of conflict between the facility's policies and procedures and the individual's advance directive, provision should be made in accordance with Section 765.308, F.S.

(7) The facility's policy shall include:

(a) Providing each adult individual, at the time of the admission as a resident, with a copy of "Health Care Advance Directives – The Patient's Right to Decide," as prepared by the Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308, effective 1-11-93, which is hereby incorporated by reference, or with a copy of some other substantially similar document which is a written description of Florida's state law regarding advance directives:

(b) Providing each adult individual, at the time of the admission as a resident, with written information concerning the nursing home's policies respecting advance directives; and

(c) The requirement that documentation of the existence of an advance directive be contained in the medical record. A nursing home which is provided with the individual's advance directive shall make the advance directive or a copy thereof a part of the individual's medical record.

*Specific Authority 400.141, 400.141(7), 400.23, 765.110 FS. Law Implemented 400.022, 400.0255, 400.102, 400.141, 400.141(7), 400.151, 400.23, 765.110 FS. History–New 4-1-82, Amended 4-1-84, Formerly 10d-29.106, Amended 4-18-94, 1-10-95, 2-6-97, 5-5*

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**59A-4.107 Physician Services.**

(1) Each nursing home facility shall retain, pursuant to a written agreement, a physician licensed under Chapter 458 or 459, F.S., to serve as Medical Director. In facilities with a licensed capacity of 60 beds or less, pursuant to written agreement, a physician licensed under Chapter 458 or 459, F.S., may serve as Medical Consultant in lieu of a Medical Director.

(2) Each resident or legal representative, shall be allowed to select his or her own private physician.

(3) Verbal orders, including telephone orders, shall be immediately recorded, dated, and signed by the person receiving the order. All verbal treatment orders shall be countersigned by the physician or other health care professional on the next visit to the facility.

(4) Physician orders may be transmitted by facsimile machine. It is not necessary for a physician to re-sign a facsimile order when he visits a facility.

(5) All physician orders shall be followed as prescribed, and if not followed, the reason shall be recorded on the resident's medical record during that shift.

(6) Each resident shall be seen by a physician or another licensed health professional acting within their scope of practice at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. If a physician documents that a resident does not need to be seen on this schedule and there is no other requirement for physician's services that must be met due to title xviii or xix, the resident's physician may document an alternate visitation schedule.

(7) If the physician chooses to designate another health care professional to fulfill the physician's component of resident care, they may do so after the required visit. All responsibilities of a physician, except for the position of medical director, may be carried out by other health care professionals acting within their scope of practice.

(8) Each facility shall have a list of physicians designated to provide emergency services to residents when the resident's attending physician, or designated alternate is not available.

*Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.23, 464.012 FS. History–New 4-1-82, Amended 4-184, Formerly 10d-29.107, Amended 10-5-92, 4-18-94, 1-10-95.*



**59A-4.1075 Medical Director.**

(1) Each facility will have only one physician who is designated as Medical Director.

(2)(a) The Medical Director must be a physician licensed under Chapter 458 or 459, F.S., the nursing home administrator may require that the Medical Director be certified or credentialed through a recognized certifying or credentialing organization.

(b) A Medical Director who does not have hospital privileges shall be certified or credentialed through a recognized certifying or credentialing body, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Medical Directors Association, the Healthcare Facilities Accreditation Program of the American Osteopathic Association, the Bureau of Osteopathic Specialists of the American Osteopathic Association, the Florida Medical Directors Association or a Health maintenance organization licensed in Florida.

(c) A physician must have his/her principal office within 60 miles of all facilities for which he/she serves as Medical Director. Principal office is the office maintained by a physician pursuant to Section 458.351 or 459.026, F.S., and where the physician delivers the majority of medical services. The physician must specify the address of his/her principal office at the time of becoming Medical Director. The agency may approve a request to waive this requirement for rural facilities that exceed this distance requirement. A rural facility is a facility located in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other nursing home facility within the same county.

(d) The facility shall appoint a Medical Director who shall visit the facility at least once a month. The Medical Director shall review all new policies and procedures; review all new incident and new accident reports from the facility to identify clinical risk and safety hazards. The Medical Director shall review the most recent grievance logs for any complaints or concerns related to clinical issues. Each visit must be documented in writing by the Medical Director.

(3) A physician may be Medical Director of a maximum of 10 nursing homes at any one time. The Medical Director, in an emergency where the health of a resident is in jeopardy and the attending physician or covering physician cannot be located, may assume temporary responsibility of the care of the resident and provide the care deemed necessary.

(4) The Medical Director appointed by the facility shall meet at least quarterly with the quality assessment and assurance committee of the facility.

(5) The Medical Director appointed by the facility shall participate in the development of the comprehensive care plan for the resident when he/she is also the attending physician of the resident.

*Specific Authority 400.141 FS. Law Implemented 400.141(2) FS. History—New 8-2-01.*

**59A-4.108 Nursing Services.**

(1) The Administrator of each nursing home will designate one full time registered nurse as a Director of Nursing who shall be responsible and accountable for the supervision and administration of the total nursing services program. When a director of nursing is delegated institutional responsibilities, a full time qualified registered nurse shall be designated to serve as Assistant Director of Nursing. In a facility with a census of 121 or more residents, an RN must be designated as an Assistant Director of Nursing.

(2) Persons designated as Director of Nursing or Assistant Director of Nursing shall serve only one nursing home facility in this capacity, and shall not serve as the administrator of the nursing home facility.

(3) The Director of Nursing shall designate one licensed nurse on each shift to be responsible for the delivery of nursing services during that shift.

(4) The nursing home facility shall have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility will staff, at a minimum, an average of 1.7 hours of certified nursing assistant and .6 hours of licensed nursing staff time for each resident during a 24 hour period.

(5) In multi-story, multi-wing, or multi-station nursing home facilities, there shall be a minimum of one nursing services staff person who is capable of providing direct care on duty at all times on each floor, wing, or station.

(6) No nursing services staff person shall be scheduled for more than 16 hours within a 24 hour period, for



three consecutive days, except in an emergency. Emergencies shall be documented and shall be for a limited, specified period of time.

*Specific Authority 400.022, 400.23 FS. Law Implemented 400.011, 400.022, 400.141, 400.23 FS. History—New 4-1-82, Amended 4-184, 8-1-85, 7-1-88, 7-10-91, Formerly 10D-29.108, Amended 4-18-94.*

#### **59A-4.109 Resident Assessment and Care Plan.**

(1) Each resident admitted to the nursing home facility shall have a plan of care. The plan of care shall consist of:

- (a) Physician's orders, diagnosis, medical history, physical exam and rehabilitative or restorative potential.
- (b) A preliminary nursing evaluation with physician's orders for immediate care, completed on admission.

(c) A complete, comprehensive, accurate and reproducible assessment of each resident's functional capacity which is standardized in the facility, and is completed within 14 days of the resident's admission to the facility and every twelve months, thereafter. The assessment shall be:

- Reviewed no less than once every 3 months,
  - Reviewed promptly after a significant change in the resident's physical or mental condition,
  - Revised as appropriate to assure the continued accuracy of the assessment.
- (2) The facility is responsible to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and social well-being. The care plan must be completed within 7 days after completion of the resident assessment.
- (3) At the resident's option, every effort shall be made to include the resident and family or responsible party, including private duty nurse or nursing assistant, in the development, implementation, maintenance and evaluation of the resident plan of care.
- (4) All staff personnel who provide care, and at the resident's option, private duty nurses or non employees of the facility, shall be knowledgeable of, and have access to, the resident's plan of care.
- (5) A summary of the resident's plan of care and a copy of any advanced directives shall accompany each resident discharged or transferred to another health care facility, licensed under Chapter 400, Part II, F.S., or shall be forwarded to the receiving facility as soon as possible consistent with good medical practice.

*Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.23 FS. History—New 4-1-82, Amended 4-1-84, Formerly 10D-29.109, Amended 4-18-94, 1-10-95.*

#### **59A-4.110 Dietary Services.**

(1) The Administrator must designate one full-time person as a Dietary Services Supervisor. In a facility with a census of 61 or more residents, the duties of the Dietary Services Supervisor shall not include food preparation or service on a regular basis.

(2) The Dietary Services Supervisor shall either be a qualified dietitian or the facility shall obtain consultation from a qualified dietitian. A qualified dietitian is one who:

- (a) Is a registered dietitian as defined by the Commission on Dietetic Registration, March 1, 1994, which is incorporated by reference, the credentialing agency for the American Dietetic Association and is currently registered with the American Dietetic Association; or
- (b) Has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, as defined by the Commission on Dietetic Registration of the American Dietetic Association, March 1, 1994, which is incorporated by reference, has one year of supervisory experience in the dietetic service of a health care facility, and

participates annually in continuing dietetic education.

(3) A Dietary Services Supervisor shall be a person who:

(a) Is a qualified dietitian as defined in paragraphs 59A-4.110(2)(a), (b), F.A.C.; or

(b) Has successfully completed an associate degree program which meets the education standard established by the American Dietetic Association; or

(c) Has successfully completed a Dietetic Assistant correspondence or class room training program, approved by the American Dietetic Association; or

(d) Has successfully completed a course offered by an accredited college or university that provided 90 or more hours of correspondence or classroom instruction in food service supervision, and has prior work experience as a Dietary Supervisor in a health care institution with consultation from a qualified dietitian; or

(e) Has training and experience in food service supervision and management in the military service equivalent in content to the program in paragraph (3)(b), (c) or (d); or

(f) Is a certified dietary manager who has successfully completed the Dietary Manager's Course and is certified through the Certifying Board for Dietary Managers and is maintaining their certification with continuing clock hours at 45 CEU's per three year period.

(4) A one-week supply of a variety of non-perishable food and supplies, that represents a good diet, shall be maintained by the facility.

*Specific Authority 400.022(1)(a), (f), (g), 400.141(5), 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.23 FS. History— New 4-1-82, Amended 4-1-84, 7-1-88, 7-10-91, Formerly 10D-29.110, Amended 4-18-94, 2-6-97.*

#### **59A-4.112 Pharmacy Services.**

(1) The facility shall adopt procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident.

(2) The facility shall employ, or obtain, the services of a state licensed consultant pharmacist. A consultant pharmacist is a pharmacist who is licensed by the Department of Business and Professional Regulation and registered as a consultant pharmacist by the Board of Pharmacy in accordance with Rule 64B16-26.300, F.A.C., and who provides consultation on all aspects of the provision of pharmacy services in the facility.

(3) The consultant pharmacist shall establish a system to accurately record the receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.

(4) The pharmacist shall determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(5) Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, Chapter 499, F.S., and Chapter 64B16, F.A.C.

(6) Drugs and non-prescription medications requiring refrigeration shall be stored in a refrigerator. When stored in a general-use refrigerator, they shall be stored in a separate, covered, waterproof, and labeled receptacle.

(7) All controlled substances shall be disposed of in accordance with state and federal laws. All non-controlled substances may be destroyed in accordance with the facility's policies and procedures. Records of the disposition of all substances shall be maintained in sufficient detail to enable an accurate reconciliation.

(8) Non-controlled substances, in unit dose containers, may be returned to the dispensing pharmacy.

(9) If ordered by the resident's physician, the resident may, upon discharge, take all current prescription drugs with him. An inventory of the drugs released shall be completed, shall be dated, and signed by both the person releasing the drugs and the person receiving the drugs, and shall be placed in the resident's record.

(10) The facility shall maintain an Emergency Medication Kit, the contents of which shall be determined in consultation with the Medical Director, Director of Nursing and Pharmacist, and it shall be in accordance with facility policies and procedures. The kit shall be readily available and shall be kept sealed. All items in the kit shall be properly labeled. The facility shall maintain an accurate log of receipt and disposition of each item in the Emergency Medication Kit. An inventory of the contents of the Emergency Medication Kit shall be attached to the outside of the kit. If the seal is broken, the kit must be resealed the next business day after use.

*Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.23 FS. History—New 4-1-82, Amended 4-1-84, 7-1091, Formerly 10D-29.112, Amended 4-18-94.*

#### **59A-4.118 Medical Records.**

- (1) The facility shall designate a full-time employee as being responsible and accountable for the facility's medical records. If this employee is not a qualified Medical Record Practitioner, then the facility shall have the services of a qualified Medical Record Practitioner on a consultant basis. A qualified Medical Record Practitioner is one who is eligible for a certification as a Registered Record Administrator or an Accredited Record Technician by the American Health Information Management Association or a graduate of a School of Medical Record Science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Health Information Management Association.
- (2) Each medical record shall contain sufficient information to clearly identify the resident, his diagnosis and treatment, and results. Medical records shall be complete, accurate, accessible and systematically organized.
- (3) Medical records shall be retained for a period of five years from the date of discharge. In the case of a minor, the record shall be retained for 3 years after a resident reaches legal age under state law.

*Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.145, 400.23 FS. History—New 4-1-82, Amended 4-184, 3-2-88, Formerly 10D-29.118, Amended 4-18-94.*

#### **59A-4.122 Physical Environment.**

- (1) The facility shall provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible.
- (2) The facility shall provide:
  - (a) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;
  - (b) Clean bed and bath linens that are in good condition;
  - (c) Private closet space for each resident;
  - (d) Furniture, such as a bed-side cabinet, drawer space;
  - (e) Adequate and comfortable lighting levels in all areas;
  - (f) Comfortable and safe temperature levels; and
  - (g) The maintenance of comfortable sound levels. Individual radios, TVs and other such transmitters belonging to the resident will be tuned to stations of the resident's choice.

*Specific Authority 400.23 FS. Law Implemented 400.102, 400.141, 400.23 FS. History—New 4-1-82, Amended 4-1-84, Formerly 10D29.122, Amended 4-18-94.*

#### **59A-4.123 Risk Management and Quality Assurance.**

- (1) The facility shall maintain a risk management and quality assurance committee as required in Section 400.147,  
F.S.
- (2) The facility shall use AHCA Form 3110-0009, Revised, January, 2002, October, 2001, "Confidential Nursing Home Initial Adverse Incident Report – 1 Day," and AHCA Form 3110-0010, 3110-0010A, and 3110-0010B, Revised, January, 2002, "Confidential Nursing Home Complete Adverse Incident Report – 15 Day," which are incorporated by reference when reporting events as stated in Section 400.147, F.S. These forms may be obtained from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, MS 33, Tallahassee, FL 32308.
- (3) Each facility shall use AHCA Form 3110-0008, Revised, October 2008, "Nursing Home Monthly Liability

Claim Information”, which are incorporated by reference when reporting liability claims filed against it as required by Section 400.147(9), F.S. These forms may be obtained from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, MS 33, Tallahassee, FL 32308.

*Specific Authority 400.23 FS. Law Implemented 400.022, 400.102, 400.141, 400.147, 400.23 FS. History—New 4-1-82, Amended 9-582, 4-1-84, 8-1-85, 7-10-91, Formerly 10D-29.123, Amended 4-18-94, 5-5-02.*

**59A-4.126 Disaster Preparedness.**

- (1) Each nursing home facility shall have a written plan with procedures to be followed in the event of an internal or externally caused disaster. The initiation, development, and maintenance of this plan shall be the responsibility of the facility administrator, and shall be accomplished in consultation with the Department of Community Affairs, County Emergency Management Agency.
- (2) The plan shall include, at a minimum, the following:
  - (a) Criteria, as shown, in Section 400.23(2)(g), F.S.; and
  - (b) The Emergency Management Planning Criteria for Nursing Home Facilities, AHCA 3110-6006, March, 1994, which is incorporated herein by reference and available from the Agency for Health Care Administration.

*Specific Authority 400.23 FS. Law Implemented 400.102, 400.141, 400.23 FS. History—New 4-1-82, Amended 4-1-84, Formerly 10D29.126, Amended 8-15-94.*

**59A-4.128 Evaluation of Nursing Homes and Licensure Status.**

- (1) The agency shall, at least every 15 months, evaluate and assign a licensure status to every nursing home facility. The evaluation and licensure status shall be based on the facility's compliance with the requirements contained in this rule, and Chapter 400, Part II, F.S.
- (2) The evaluation shall be based on the most recent licensure survey report, investigations conducted by the AHCA and those persons authorized to inspect nursing homes under Chapter 400, Part II, F.S.
- (3) The licensure status assigned to the nursing home facility will be either conditional or standard. The licensure status is based on the compliance with the standards contained in this rule and Chapter 400, Part II, F.S. Noncompliance will be stated as deficiencies measured in terms of scope and severity.

*Specific Authority 400.23 FS. Law Implemented 400.102, 400.19, 400.23 FS. History—New 4-1-82, Amended 4-1-84, 9-26-85, 7-2187, Formerly 10D-29.128, Amended 8-15-94, 2-28-95, 10-13-96, 5-5-02.*

**59A-4.1288 Exception.** Nursing homes that participate in Title XVIII or XIX must follow certification rules and regulations found in 42 C.F.R. 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference. Non-certified facilities must follow the contents of this rule and the standards contained in the Conditions of Participation found in 42 C.F.R. 483, Requirements for Long Term Care Facilities, September 26, 1991, which is incorporated by reference with respect to social services, dental services, infection control, dietary and the therapies.

*Specific Authority 400.23 FS. Law Implemented 400.102, 400.141, 400.23 FS. History—New 4-18-94.*

**59A-4.1295 Additional Standards for Homes That Admit Children 0 Through 20 Years of Age.**

- (1) Nursing homes who accept children with a level of care of Intermediate I or II, skilled or fragile must meet the following standards as indicated. Intermediate I and II are defined in Chapter 59G-4, F.A.C. Children considered skilled have a chronic debilitating disease or condition of one or more physiological or organ systems that generally make the child dependent upon 24 hour per day medical, nursing, or health supervision or intervention. Fragile children are medically complex and the medical condition is such that they are technologically dependent through medical apparatus or procedure(s) to sustain life and who can expire, without warning unless continually under observation.

(2) Each child shall have an assessment upon admission by licensed physical, occupational, and speech therapists who are experienced in working with children. Therapies will be administered based upon the outcome of these

assessments and the orders of the child's physician.

(3) Admission criteria:

(a) The child must require intermediate, skilled or fragile nursing care, and be medically stable, as documented by the physician determining level of care.

(b) For nursing facility placement a recommendation shall be made in the form of a written order by the child's attending physician in consultation with the parent(s) or legal guardian(s). For Medicaid certified nursing facilities, the recommendations for placement of a Medicaid applicant or recipient in the nursing facility shall be made by the Multiple Handicap Assessment Team. Consideration must be given to relevant medical, emotional, psychosocial, and environmental factors.

(c) Each child admitted to the nursing home facility shall have a plan of care developed by the interdisciplinary care plan team. The plan of care shall consist of those items listed below.

- Physician's orders, diagnosis, medical history, physical examination and rehabilitative or restorative needs.
- A preliminary nursing evaluation with physician orders for immediate care, completed on admission.

3. A comprehensive, accurate, reproducible, and standardized assessment of each child's functional capability which is completed within 14 days of the child's admission to the facility and every twelve months thereafter. The assessment shall be:

- a. Reviewed no less than once every 120 days;
- b. Reviewed promptly after a significant change in the child's physical or mental condition;
- c. Revised as appropriate to assure the continued usefulness of the assessment.

- 1. The plan of care shall also include measurable objectives and timetables to meet the child's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the child's highest practicable physical, mental, social and educational wellbeing. The care plan must be completed within 7 days after completion of the child's assessments required in subsection (3) above.
- 2. In order to enhance the quality of life of each child ages 3 years through 15 years, the facility must notify by certified mail the school board in the county in which the facility is located that there is a school-age child residing in the facility. Children ages 16 through 20 years may be enrolled in an education program according to their ability to participate. Program participation for each child regardless of age is predicated on their intellectual function, physical limitations, and medical stability. Collaborative planning with the public school system and community at-large is necessary to produce integrated and inclusive settings which meet each child's needs. The failure or inability on the part of City, County, State, or Federal school system to provide an educational program according to the child's ability to participate shall not obligate the facility to supply or furnish an educational program or bring suit against any City, County, State, or Federal organizations for their failure or inability to provide an educational program. Nothing contained herein is intended to prohibit, restrict or prevent the parents or legal guardian of the child from providing a private educational program that meets applicable State laws.
- 3. At the child's guardian's option, every effort shall be made to include the child and his or her family or responsible party, including private duty nurse or nursing assistant, in the development, implementation, maintenance and evaluation of the child's plan of care.
- 4. All employees of the facility who provide hands on care, shall be knowledgeable of, and have access to, the child's plan of care.
- 5. A summary of the child's plan of care shall accompany each child discharged or transferred to another health care facility or shall be forwarded to the facility receiving the child as soon as possible consistent with good medical practice.

(4) The child's attending physician, licensed under Chapter 458 or 459, F.S., shall maintain responsibility for the overall medical management and therapeutic plan of care and will be available for face-to-face consultation and collaboration with the nursing facility medical and nursing director. At a minimum, the physician or his or her designee shall:

- (a) Evaluate and document the status of the child's condition at least monthly;
- (b) Review and update the plan of care every 60 days;
- (c) Prepare orders as needed and accompany them by a signed progress note in the child's medical record;



and

(d) Co-sign verbal orders no more than 72 hours after the order is given. Physician orders may be transmitted by facsimile machine. It is not necessary for a physician to re-sign a facsimile order when he or she visits a facility. Orders transmitted via computer mail are not acceptable. Verbal orders not co-signed within seventy-two (72) hours shall not be held against the facility if it has documented timely, good-faith efforts to obtain said co-signed orders.

(5) The following must be completed for each child. An RN shall be responsible for ensuring these tasks are accomplished:

(a) Informing the attending physician and medical director of beneficial and untoward effects of the therapeutic interventions;

(b) Maintaining the child's record in accordance with facility policies and procedures; and

(c) instructing or arranging for the instruction of the parent(s), legal guardian(s), or other caretakers(s) on how to provide the necessary interventions, how to interpret responses to therapies, and how to manage unexpected responses in order to facilitate a smooth transition from the nursing facility to the home or other placement. This instruction will cover care coordination and will gradually pass the role of care coordinator to the parent or legal guardian, as appropriate.

(6) The facility shall provide the following:

(a) A minimum of 100 square feet in a single bedroom and 80 square feet per child in multiple bedrooms;

(b) Bathroom and bathing facilities appropriate to the child's needs to allow for:

- Toileting functions with privacy (a door to the bathroom will be provided); and
- Stall showers and tubs.

(c) There shall be indoor activities area that:

1. Encourage exploration and maximize the child's capabilities;
2. Accommodate mobile and non-mobile children; and
3. Support a range of activities for children and adolescents of varying ages and abilities.

(d) There shall be an outdoor activity area that is:

1. Secure with areas of sun and shade;
2. Free of safety hazards; and

3. Equipped with age appropriate recreational equipment for developmental level of children and has storage space for same.

(e) All furniture and adaptive equipment must be physically appropriate to the developmental and medical needs of the children;

(f) Other equipment and supplies shall be made available to meet the needs of the children as prescribed or recommended by the attending physician or medical director and in accordance with professional standards of care.

(7) For those nursing facilities who admit children age 0 through 15 years of age the following standards apply in addition to those above and throughout Chapter 59A-4, F.A.C.

(a) Each child shall have an assessment upon admission by licensed physical, occupational, and speech therapists who are experienced in working with children. Therapies will be administered based upon the outcome of these assessments and the orders of the child's physician.

(b) The facility shall have a contract with a board certified pediatrician who serves as a consultant and liaison between the nursing facility and the medical community for quality and appropriateness of services to children.

(c) The facility must assure that pediatric physicians are available for routine and emergency consultation to meet the child's needs.

(d) The facility must ensure that children reside in distinct and separate units from adults.

(e) The facility shall be equipped and staffed to accommodate no more than sixty (60) children at any given time, of which there shall be no more than 40 children of ages 0 through 15 at any given time, nor more than 40 children of ages 16 through 20 at any given time.

(f) The facility must provide access to emergency and other forms of transportation for children.

(g) At least one licensed health care staff person with current Life Support certification for children shall be on the unit at all times where children are residing.

(h) The facility shall maintain an Emergency Medication Kit of pediatric medications, as well as adult dosages for those children who require adult doses. The contents in the Emergency Medication Kit shall be determined in consultation with the Medical Director, Director of Nursing, a registered nurse who has current experience working with children, and a Pharmacist who has pediatric expertise. The kit shall be readily available and shall be kept sealed. All items in the kit shall be properly labeled. The facility shall maintain an accurate log of receipt and disposition of each item in the Emergency Medication Kit. An inventory to include expiration dates of the contents of the Emergency Medication Kit shall be attached to the outside of the kit. If the seal is broken, the kit must be resealed the next business day after use.

(i) Each nursing home facility shall develop, implement, and maintain a written staff education plan which ensures a coordinated program for staff education for all facility employees who work with children. The plan shall:

1. Be reviewed at least annually by the quality assurance committee and revised as needed.
2. Include both pre-service and in-service programs. In-service for each department must include pediatric-specific requirements as relevant to its discipline.
3. Ensure that education is conducted annually for all facility employees who work with children, at a minimum, in the following areas:
  - a. Childhood diseases to include prevention and control of infection;
  - b. Childhood accident prevention and safety awareness programs;
4. Ensure that all non licensed employees of the nursing home complete an initial educational course on HIV and AIDS, preferably pediatric HIV and AIDS. If the employee does not have a certificate of completion at the time they are hired, they must have two hours within six months of employment. All employees shall have a minimum of one hour biennially.

(j) All facility staff shall receive in-service training in and demonstrate awareness of issues particular to pediatric residents annually.

(8) For the purposes of this rule, nursing care shall consist of the following:

(a) For residents who are skilled: registered nurses, licensed practical nurses, respiratory therapists, respiratory care practitioners, and certified nursing assistants (CNA's). The child's nursing care shall be as follows:

1. There shall be one registered nurse on duty, on-site 24 hours per day on the unit where children reside. There shall be an average of 3.5 hours of nursing care per patient day.
2. In determining the minimum hours of nursing care required above, there shall be no more than 1.5 hours per patient day of certified nursing assistant (CNA) care and no less than 1.0 hours per patient day of licensed nursing care.

(b) For residents who are fragile: registered nurses, licensed practical nurses, respiratory therapists, respiratory care practitioners, and certified nursing assistants. The child's nursing care shall be as follows:

1. One registered nurse on duty, on-site 24 hours per day on the unit where children reside. There shall be an average of 5.0 hours of nursing care per patient day.
2. In determining the minimum hours per patient day required above, there shall be no more than 1.5 hours per patient day of CNA care, and no less than 1.7 hours per patient day of licensed nursing care.

(c) In the event that there are more than forty-two (42) children in the facility, there shall be no fewer than two (2) registered nurses on duty, on-site, 24 hours per day on the unit where the children reside.

(9) A qualified dietitian with knowledge, expertise and experience in the nutritional management of medically involved children shall evaluate the needs and special diet of each child at least every 60 days.

(10) The pharmacist will have access to appropriate knowledge concerning pediatric pharmaceutical procedures, i.e., total parenteral nutrition (TPN) infusion regime and be familiar with pediatric medications and dosages.

(11) The nursing facility shall maintain or contract as needed for pediatric dental services.

(12) Safety equipment, such as, child proof safety latches on closets, cabinets, straps on all seating services, locks on specific storage cabinets, bumper pads on cribs and car seats for transporting must be used whenever appropriate to ensure the safety of the child.

(13) Pediatric equipment and supplies shall be available as follows:

- (a) Suction machines, one per child requiring suction, plus one suction machine for emergency use;
- (b) Oxygen, in portable tanks with age appropriate supplies;
- (c) Thermometers;
- (d) Sphygmomanometers, stethoscopes, otoscopes; and
- (e) Apnea monitor and pulse oximeter.

(14) Other equipment and supplies shall be made available to meet the needs of the children as prescribed or recommended by the attending physician or medical director and in accordance with professional standards of care.

*Specific Authority 400.23(2), (4) FS. Law Implemented 400.23(4) FS. History—New 11-5-96, Amended 9-7-97.*

**59A-4.130 Fire Prevention, Fire Protection, and Life Safety.**

- (1) A licensee shall comply with the life safety code requirements and building code standards applicable at the time of departmental approval of the facility's Third Stage – Construction Documents.
- (2) Fire prevention, fire protection, and life safety practices shall be the responsibility of the facility Administrator.
- (3) All fires or explosions shall be reported immediately to the local fire department. A written report of each fire or explosion shall be made to the AHCA, with a copy to the director of the local county health unit, within ten days of occurrence. Such report shall contain the following information:
  - (a) The name and complete address of the facility;
  - (b) The date of the report;
  - (c) The date, time, cause, and location of the fire or explosion;
  - (d) The extent of flame, smoke, and water damage;
  - (e) The extent of other damage;
  - (f) The estimated amount of loss;
  - (g) The number of residents with injuries and the number of resident deaths;
  - (h) The name and job title of the individual who reported the fire or explosion;
  - (i) The time that the fire or explosion was reported and identification of to whom it was reported;
  - (j) Information as to whether or not the in-house fire alarm was activated;
  - (k) Information as to whether or not the fire or explosion was reported to the local fire department, and if not, an explanation as to why it was not;
  - (l) A description of the method used to extinguish the fire;
  - (m) Information as to whether or not the facility is equipped with an automatic fire sprinkler system;
  - (n) The Administrator's narrative description of the incident and what action, if any, is to be taken to prevent further occurrences; and
  - (o) Attachments consisting of:
    - A copy of the fire report of the local fire department, if applicable, and
    - Photographs, if damage was extensive.
- (4) Within ten days of receipt, the facility shall forward to the appropriate Area Office of the AHCA a copy of all reports of fire safety inspections made by local fire authorities.

*Specific Authority 381.031(1)(g)7., 400.23, 400.191(2) FS. Law Implemented 381.031, 400.102, 400.141, 400.23, 633.05(8), 633.051 FS. History—New 4-1-82, Amended 4-1-84, 8-1-85, Formerly 10D-29.119, 59A-4.119.*

**59A-4.133 Plans Submission and Review and Construction Standards.**

- (1) When construction is contemplated for new buildings or for additions, conversions, renovations, or alterations to existing buildings, the plans and specifications for the contemplated construction shall be prepared by Florida-registered architects and engineers.
- (2) All contemplated additions, conversions, renovations, or alterations shall be submitted for approval or exemption from the plans review process.
- (3) Plans and specifications submitted for review shall be subject to a plan review fee. This fee is prescribed by statute and is as follows.
  - (a) The amount of the plan review fee for the portion of the review through the first revised construction document review shall not exceed 1 percent of the total estimated cost of the construction project. A cost estimate of the proposed construction shall be submitted by the Florida-registered architect or Florida-registered engineer who is the primary design professional for the project.
  - (b) An initial fee payment is due with the first submission of plans and specifications to the AHCA. This initial payment shall be 1 percent of the estimated construction cost or \$10,000, whichever is less, but shall in no case be less than \$2,000.00. A \$2,000.00 portion of the initial fee payment is non-refundable.

- (c) The AHCA shall also collect its actual cost on all subsequent portions of the plan reviews and construction inspections.
- (d) All fees shall be paid by check made payable to the Treasurer, State of Florida, with the check noted and identified that it is for the AHCA Plans and Review Trust Fund. Fees will be accepted only from the licensee or prospective licensee.
- (4) Plans and specifications for contemplated new buildings or additions, conversions, renovations, or alterations which affect the structural integrity, life or fire safety, or use of space of existing buildings shall be submitted in three stages as follows:

(a) First Stage – Schematic Plans, which shall, at a minimum, include the following:

1. A list of services to be provided in the proposed constructions;
1. A schedule showing total number of beds; types of bedrooms such as private, semi-private, etc.; and types of ancillary spaces;
2. Single line drawings of each floor which show the relationship of the various activities or services to each other and the room arrangement in each. The name of each room shall be noted;
3. The proposed roads, walks, service and entrance courts, parking, and orientation shall be shown on either a small plot plan or the first floor plan;

5. A simple cross section diagram of the building; and

6. If the proposed construction is an addition to or is otherwise related to existing buildings on the site, the plans shall show the facilities and general arrangement of those buildings.

(b) Second Stage – Preliminary Plans, Design Development Drawing, which shall, at a minimum, include the following:

1. Civil engineering plans – show existing grade structure and proposed improvements. Provide a vicinity map;
1. Architectural plans – provide floor plan, 1/8" scale preferred. Show door swings, windows, case work and millwork, fixed equipment, and plumbing fixtures. Indicate function of each space. Provide large plan of typical new bedroom. Provide typical large scale wall interior and exterior section and exterior wall elevations;
2. Life safety plans – provide single sheet floor plans of both contemplated and existing areas, showing fire and smoke compartmentation, all means of egress, all exit markings, and a description of exterior egress lighting. Dimension the compartments, calculate and tabulate exit units, and poché unsprinklered areas;
3. Mechanical engineering plans – provide one line diagram of the ventilating system with relative pressures of each space. Provide, at a minimum, in outline form, a description or drawing of the anticipated emergency smoke control, passive or active, and system operation, correlated with the life safety plans;
4. Electrical engineering drawings – provide one line diagram of essential electrical system showing both normal and alternate power supplies, service entrances, switchboards, transfer switches, distribution and panel boards, and description of loads. Show zoned fire alarm correlated with the life safety plans;
5. Outline specifications – provide a general description of the construction, including construction classification and rate of components, interior finishes, general types and locations of acoustical material, floor coverings, hardware groups, electrical equipment, ventilating equipment, and plumbing fixtures;
6. If conversion of an existing building to a nursing home is contemplated, the general layout of space of the existing structure shall be submitted; and
7. If addition, alteration, renovation, or remodeling to a new or existing facility is proposed, the plans for that existing building shall be submitted.

(c) Third Stage – Construction Documents.

1. The construction documents shall be an extension of the Second Stage-Preliminary Plans submittal and shall completely describe the construction contemplated.
2. In the case of additions to new or existing facilities, it is specifically required that mechanical and electrical conditions, including essential electrical systems, be a part of this submittal.

(5) The AHCA shall approve or disapprove Third Stage submittals within 60 days of receipt of those documents.

(a) Disapproval of Third Stage submittals because of noncompliance with required codes or the provisions of these rules will automatically terminate the run of the 60 day time period; subsequent resubmissions of the project will initiate another 60 day response period.

(b) A lack of response within 90 days from the date of disapproval of the Third Stage submittals will constitute abandonment of the project.

(6) Construction work shall not be started until written approval has been given by the AHCA and must be started within one year following written approval of the construction documents. If construction work is not started within this time period, reapproval must be obtained.

(7) All subsequent addenda, change orders, field orders, and contractor letters altering the approved Construction Documents shall be submitted to the AHCA for approval. Any deviation from approved submittals shall require written approval from the AHCA.

(8) Construction inspections.

(a) All construction projects shall be inspected and approved by the AHCA prior to occupancy.

(b) The prospective licensee shall notify the AHCA a minimum of 30 days prior to project completion for inspection scheduling.

(9) Construction standards.

(a) For the purposes of these rules, new facility shall be defined as:

1. All new facilities which are constructed for the purpose of operating a nursing home according to Second Stage – Preliminary Plans approved by the AHCA subsequent to April 3, 1995.
2. All conversions of existing buildings from other occupancies which are converted for the purpose of operating a nursing home according to Second Stage – Preliminary Plans approved by the AHCA subsequent to April 3, 1995.
3. All buildings previously licensed under the requirements of Chapter 400, Part I, F.S., but not licensed during the 12 calendar months prior to April 3, 1995.
4. All new construction additions to facilities according to Second Stage – Preliminary Plans approved by the AHCA subsequent to April 3, 1995.

(10) For the purposes of these rules, existing facility shall be defined as:

(a) All facilities in operation prior to April 3, 1995.

(b) All facilities with Second Stage – Preliminary Plans approved by the AHCA prior to April 3, 1995.

(11) A licensee for a new facility shall comply with all the following technical codes and standards which are adopted by reference:

(a) The fire codes described in Chapter 4A-3, F.A.C.;

(b) Building Construction Standards in accordance with the provisions of Chapter 553, F.S.;

(c) "Duct Construction," Chapter 1 of ASHRAE Guide and Data Book, 1986 Edition, Equipment, American Society of Heating, Refrigeration and Air Conditioning Engineers; and

(d) I.E.S. Lighting Handbook, Application Volume and Reference Volume, Illuminating Engineering Society of North America, Copyright 1981.

(e) The following Sheet Metal and Air Conditioning Contractors' National Association, Inc., Standards:

- Fire Damper and Health Stop for Air Handling Systems, Second Edition, 1981.
- Low Pressure Duct Construction Standards, Fifth Edition, 1976.
- High Pressure Duct Construction Standards, Third Edition, 1979.
- Rectangular Industrial Duct Construction Standards, 1980.
- Round Industrial Duct Construction Standards, 1977.
- Flexible Duct Performance and Installation Standards, First Edition, 1980.
- Duct Liner Application Standards, Second Edition, 1975.

- (12) A licensee of an existing facility shall comply with the requirements listed in Table I excluding those requirements identified by an asterisk.
- (a) A licensee shall complete required alterations within a time schedule approved by the AHCA.
- (b) Failure of a licensee to complete alterations within the approved time schedule shall constitute a violation of this subsection.
- (13) Local codes which set more stringent standards or add additional requirements shall take precedence over the standards and requirements set forth in this rule.
- (14) No currently licensed and operating facility, either previously conforming or nonconforming or as originally approved by the AHCA shall reduce its current degree of compliance with these standards.
- (15) Each facility shall comply, as appropriate, with the standards in Tables I, II, and III, hereby incorporated by reference. Tables I, II, and III may be obtained from the Agency for Health Care Administration, Long Term Care Section, 2727 Mahan Drive, Tallahassee, Florida 32308.
- (16) All facilities shall comply with the following standards:
  - (a) All operable windows shall be equipped with well fitted insect screens not less than 16 mesh per inch.
  - (b) Throw rugs or scatter rugs shall not be used in the facility. Floor mats are allowed in the facility.
  - (c) Interior corridor doors, except for those small closets and janitors' closets, shall not swing into corridors.
  - (d) The temperature of hot water supplied to resident use lavatories, showers, and baths shall be between 105 degrees Fahrenheit and 115 degrees Fahrenheit.
  - (e) Forced fresh air ventilation shall be provided to all rooms and spaces as required in Table I.
  - (f) Laundry facilities, if provided, shall be separated from resident and food service areas, shall be self-contained and shall not be accessible through any other room. The layout of the laundry shall provide a soiled holding room and shall provide for the separation of clean and soiled functions with partitions and doors. Plumbing fixtures and trim shall be in accordance with Table III.
  - (g) All spaces occupied by people, machinery, and equipment within buildings, approaches to buildings, and parking lots shall be provided with artificial lighting commensurate with the tasks to be performed in, and the function intended for, the space.
  - (h) Ceiling mounted racks and cubicle curtains shall be provided for privacy at each bed in multiple occupancy resident bedrooms. In instances where the use of cubicle curtains is contraindicated by the resident's condition or the attending physician's orders, the facility shall make provision for an alternate, effective method for ensuring resident privacy, approved by the AHCA. In facilities where portable screens have been accepted by the AHCA in lieu of ceiling mounted tacks and cubicle curtains, such screens may continue to be used.
  - (i) All facilities shall be supplied with potable water which is in compliance with the provisions of Chapter 62-550 or 64E-8, F.A.C., whichever is applicable. Whenever a municipal or community water supply is available to the property, such water supply shall be used in lieu of installing a privately owned water system.
  - (j) A safe method of sewage collection, treatment, and disposal shall be provided for each nursing home and shall be in compliance with the provisions of Chapter 62-600 or 64E-6, F.A.C., whichever is applicable. Whenever a municipal or public sewer system is available to the property, such system shall be used.
  - (k) All windows in resident bedrooms shall be provided with light control devices appropriate to the needs of the residents occupying the room.
  - (l) All ice making equipment installed in resident access areas subsequent to April 1, 1982, shall be the self-dispensing type.
  - (m) All wiring for power and light feeders, subfeeders and branch circuits in the normal, emergency, essential, and equipment systems including nurse call, emergency communication, alarm, and alerting systems, shall be installed in metal raceways except: Schedule 40 PVC minimum conduit may be used:
    - In underground or in concrete slabs.
    - For ungrounded, isolated power branch.
    - Above non-fire rated ceilings and where ceiling cavity is not used for a return air plenum.
- (17) Alterations:
  - (a) If, within a period of 12 months, alterations, conversions, renovations, or repairs, costing in excess of 50 percent



of the then physical value of the nonconforming building as determined by the sponsor, architect, or engineer and approved by the AHCA are made, such buildings shall be made to conform to each and every standard for a new facility.

(b) If a nonconforming building is damaged by fire or otherwise, in excess of 50 percent of its then physical value before such damage is repaired, it shall be made to conform to each and every standard for a new facility.

(c) If the cost of such alterations, conversions, renovations, or repairs, or the amount of such damage is more than 25 percent but not more than 50 percent of the then physical value of the nonconforming building, the degree of compliance with new facility standards shall be determined by the AHCA.

(d) Alterations, renovations, or repairs not covered by the three preceding paragraphs to restore a nonconforming building to its condition previous to damage or deterioration shall minimally meet standards for new facilities.

(18) Physical Plant Requirements for Disaster Preparedness of New Nursing Home Construction.

(a) Definitions. The following definitions shall apply specifically to all new facilities as used in subsection 59A-4.133(18), F.A.C.:

1. "New facility" means a nursing home, or an addition of a wing or floor to an existing nursing home, which has not received a Stage II Preliminary Plan approval pursuant to Chapter 59A-4, F.A.C., prior to the effective date of this rule. Interior renovation, refurbishing, modifications or conversions inside of an existing structure licensed as a nursing home, shall not have to meet the standards contained in this paragraph;
2. "Net square footage" means the clear floor space of an area excluding cabinetry and other fixed furniture or equipment;
3. "During and immediately following" means a period of 72 hours following the loss of normal support utilities to the facility;
4. "Occupied resident area(s)" means the location of residents inside of the new facility or in the addition of a wing or floor to an existing facility during and immediately following a disaster;

5. "Building code" means the building codes as described in Section 553.73, F.S.

6. "Resident support area(s)" means the area(s) required to ensure the health, safety and well-being of residents during and immediately following a disaster, such as a nursing station, clean and soiled utility areas, food preparation area, and other areas as determined by the facility.

(b) New Facility Construction Standards. The following construction standards are in addition to the physical plant requirements described in subsections (1) through (11) of Rule 59A-4.133, F.A.C. These minimum standards are intended to increase the ability of the new facility to be structurally capable of serving as a shelter for residents, staff and the family of residents and staff and equipped to be self-supporting during and immediately following a disaster:

1. Space Standards.

- a. For planning purposes, as estimated by the facility, each new facility shall provide a minimum of 30 net square feet per resident served in the occupied resident area(s).
- b. As determined by the facility, space for administrative and support activities shall be provided for use by facility staff to allow for care of residents in the occupied resident area(s).
- c. As determined by the facility, space shall be provided for all staff and family members of residents and staff.

2. Site standards.

- a. All new facilities and additions to existing facilities shall be located above the 100-year flood plain or hurricane Category 3 (Saffir-Simpson scale) hurricane surge inundation elevation, whichever requires the highest elevation, or;
- b. The floor elevation of all new occupied resident area(s) and all resident support area(s) and resident support utilities, including mechanical, electrical, and food services shall be located above the 100-year flood plain or hurricane Category 3 (Saffir-Simpson scale) hurricane surge inundation elevations, whichever requires the highest elevation, or
- c. New additions or floors added to existing facilities, as determined by their site locations, shall be so designed and constructed as to be in compliance with the current standards of the National Flood Insurance Program of the Federal Emergency Management Agency, incorporated by reference and available from Federal Emergency Management Agency, Federal Insurance Administration, Attn. Publications, P. O. Box 70274, Washington, D.C. 20024.
- d. Where an off-site public access route is available to the new facility at or above the 100-year flood plain, a

minimum of one on-site emergency access route shall be provided that is located at the same elevation as the public access route;

e. New landscaping elements shall be located so if damaged they will not block the on-site emergency access route to the facility. Outdoor signs and their foundations shall be designed to meet the wind load criteria of the applicable building code;

f. New light standards and their foundations used for lighting the on-site emergency access route shall be designed to meet the wind load criteria of the American Society of Civil Engineers (ASCE 7-95), fifty-year recurrence interval of wind velocity with appropriate exposure category dependent on site location, incorporated by reference and available from the American Society of Civil Engineers, United Engineering Center, 345 East 47th Street, New York, NY 100172398.

3. Structural Standards. Wind load design of the building structure and exterior envelope including exterior wall systems shall be designed in accordance with the building code.

4. Roofing Standards.

a. Roofing membrane material shall resist the uplift forces specified in the building code. Roof coverings shall be installed according to the specifications provided by the manufacturer.

b. Loose-laid ballasted roofs shall not be permitted;

c. All new roof appendages such as ducts, tanks, ventilators, receivers, dx condensing units and decorative mansard roofs and their attachment systems shall be structurally engineered to meet the wind load requirements of the applicable building code. All of these attachment systems shall be connected directly to the underlying roof structure or roof support structure.

5. Exterior Unit Standards.

a. All exterior window units, skylights, exterior louvers and exterior door units including vision panels and their anchoring systems shall be designed to resist the wind load requirements of the building code and the debris impact requirements as specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130.

b. Permanently attached protective systems such as shutters and baffling shall be designed to meet the wind load requirements and the debris impact requirements as specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130;

c. Removable protective systems designed to intricately fit with the wall/window system of the facility and stored on-site at the facility and that meet the wind load requirements of the building code, and the debris impact requirements specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130 may be utilized to protect the exterior units;

d. All anchoring and attachment to the building of both the permanently attached and removable protective systems shall be designed to meet wind load requirements of the building code, and the impact requirements specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130. These designs shall be signed, sealed and dated by a registered structural engineer;

e. The glazed openings inside or outside of the protective systems shall meet the cyclical loading requirements specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130;

f. All of the exterior impact protective systems shall be designed and installed so that they do not come in contact with the glazing under uniform, impact or cyclic pressure loading;

g. When not being utilized to protect the windows, the protective system shall not restrict the operability of the windows in the occupied resident bedrooms.

h. When not being utilized to protect the windows, the protective systems shall not reduce the clear window opening below 8% of the gross square footage of the resident room.

6. Heating, Ventilation and Air Conditioning (HVAC) Standards.

a. Air moving equipment, dx condensing units, through-wall units and other HVAC equipment located outside of or on the roof of the facility shall be permitted only when either of the following are met:

(I) They are located inside a penthouse designed to meet the wind load requirements of the building code, or;

(II) Their fastening systems are designed to meet the wind load requirements of the building code and they are protected from impact as specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130.

b. All occupied resident areas and resident support areas shall be supplied with sufficient HVAC as determined by the facility to ensure the health, safety and well being of all residents and staff during and immediately following a disaster.

c. As determined by the facility these selected HVAC systems and their associated support equipment such as a control air compressor essential to the maintenance of the occupied resident and resident support area(s) shall receive their power from the emergency power supply system(s).

d. Ventilation air change rates in occupied resident areas shall be maintained as specified in Chapter 59A-4, F.A.C., during and immediately following a disaster.

e. Auxiliary equipment and specialties such as hydronic supply piping and pneumatic control piping shall be located, routed and protected in such a manner as determined by the facility to ensure the equipment receiving the services will not be interrupted.

#### 7. Plumbing Standards.

a. There shall be an independent on-site supply (i.e., water well) or on-site storage capability of potable water at a minimum quantity of 3 gallons per resident served per day during and immediately following a disaster.

b. There shall be an independent on-site supply or storage capability of potable water at a minimum quantity of 1 gallon per facility staff, and other personnel in the facility per day during and immediately following a disaster. For planning purposes, the number of these personnel shall be estimated by the facility.

c. The facility shall determine what amount of water will be sufficient to provide for resident services, and shall maintain an on-site supply or on-site storage of the determined amount.

d. When utilized to meet the minimum requirements of this rule, selected system appurtenances such as water pressure maintenance house pumps, and emergency water supply well pumps shall take power from the emergency power supply system(s).

8. Medical Gas Systems Standards. The storage, distribution piping system and appurtenances shall be contained within a protected area(s) designed and constructed to meet the structural and debris impact requirements as specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130.

#### 9. Emergency Electrical Generator and Essential Electrical System Standards.

a. There shall be an on-site Level I emergency electrical generator system designed to support the occupied resident area (s) and resident support area (s) with at least the following support services:

(I) Ice making equipment to produce ice for the residents served, or freezer storage equipment for the storage of ice for the residents served;

(II) Refrigerator unit(s) and food service equipment if required by the emergency food plan;

(III) Life safety and critical branch lighting and systems as required by Chapter 59A-4, F.A.C.;

(IV) Selected HVAC systems as determined by the facility and other systems required by this rule;

b. The emergency generator system shall be fueled by a fuel supply stored on-site sized to fuel the generator for 100 percent load for 64 hours or 72 hours for actual demand load of the occupied resident area (s) and resident support area(s) and resident support utilities during and immediately following a disaster, whichever is greater.

(I) The fuel supply shall either be located below ground or contained within a protected area that is designed and constructed to meet the structural and debris impact requirements as specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130. If an underground system is utilized, it shall be designed so as to exclude the entrance of any foreign solids or liquids;

(II) All fuel lines supporting the generator system(s) shall be protected also with a method designed and constructed to meet the structural and debris impact requirements as specified by Section 2315 of the South

Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130.

(III) All panel boards, transfer switches, disconnect switches, enclosed circuit breakers or emergency system raceway systems required to support the occupied resident area(s), resident support area(s) or support utilities shall be contained within a protected area(s) designed and constructed to meet the structural and debris impact requirements as specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130, and shall not rely on systems or devices outside of this protected area(s) for their reliability or continuation of service.

(IV) The emergency generator(s) shall be air or self-contained liquid cooled and it and other essential electrical equipment shall be installed in a protected area(s) designed and constructed to meet the structural and debris impact requirements as specified by Section 2315 of the South Florida Building Code, Dade edition 1994, incorporated by reference and available from the Metropolitan Dade County Building Code Compliance Department, 140 West Flagler Street, Suite 1603, Miami, FL 33130.

#### 10. Fire Protection Standards.

a. If the facility requires fire sprinklers as part of its fire protection, either of the following shall be met:

(I) On site water storage capacity to continue sprinkler coverage, in accordance with the requirements of NFPA 13, 1996 edition, incorporated by reference and available from NFPA, 1 Batterymarch Park, P. O. Box 9101, Quincy, MA 02269-9101 or

(II) If the facility plans to provide a Fire Watch, it shall use the following procedure as approved by the Office of Plans and Construction for all areas of the facility that are without sprinkler coverage due to interrupted water flow.

(A) Notify the local fire department and document instructions.

(B) Notify the Agency through the Area Office.

(C) Assess the extent of the condition and effect correction action, with a documented time frame. If the corrective action will take more than four (4) hours, do the following items:

I. Implement a contingency plan to the facility fire plan containing: a description of the problem, specifically what the system is not doing that it normally does, and the projected correction time frame. All staff on shifts involved shall have documented in-servicing and drilling for the contingency.

II. Begin a documented firewatch, until the system is restored. Persons used for firewatch must be trained in what to look for, what to do, and be able to expeditiously contact the fire department. For a firewatch, a facility can use only: public safety persons (i.e., fire service), a guard service, or staff (e.g., a nurse, maintenance, drill or safety coordinator); if the persons are:

A. Off duty from their regular position; in compliance with current state staffing ratios and personnel policies (i.e., not in a condition that would impair performance);

B. Trained and competent in what to look for and what to do;

C. Have a provision for priority communication (i.e., a radio or special telephone).

D. Notify Agency and local authorities, if the time-frame changes or system is restored.

b. If the facility provides a Fire Watch in lieu of sprinkler on-site water or water storage, then one 4-A type fire extinguisher or equivalent shall be provided for every 3 or less 2-A fire extinguishers required by NFPA 10, 1998 edition, incorporated by reference and available from NFPA, 1 Batterymarch Park, P. O. Box 9101, Quincy, MA 02269-9101, for the area served. These additional extinguishers shall be equally distributed throughout the area they are protecting.

11. External Emergency Communications Standards. Each new facility shall provide for external electronic communication not dependent on terrestrial telephone lines, cellular, radio or microwave towers, such as on-site radio transmitter, satellite communication systems or a written agreement with an amateur radio operator volunteer group(s). This agreement shall provide for a volunteer operator and communication equipment to be re-located into the facility in the event of a disaster until communications are restored. Other methods which can be shown to maintain uninterrupted electronic communications not dependent on land-based transmission shall be pre-approved by the Office of Plans and Construction.

*Specific Authority 381.031(1)(g)7., 400.23 FS. Law Implemented 381.031, 400.011(2), 400.021(1)-(17), 400.022(1)-(4), 400.102, 400.141, 400.23 FS. History–New 4-1-82, Amended 4-1-84, 4-29-92, Formerly 10D-29.120, 59A-4.120, Amended 2-6-97, 10-21-99.*

#### **59A-4.150 Geriatric Outpatient Nurse Clinic.**

##### (1) Definitions:

- (a) Advanced Registered Nurse Practitioner – a person who holds a current active license to practice professional nursing and a current Advanced Registered Nurse Practitioner certificate issued by the Florida State Board of Nursing.
  - (b) Appropriate Resources – those service providers who provide most effectively and efficiently the specific services needed by the geriatric patient.
  - (c) Agency for Health Care Administration – AHCA.
  - (d) Geriatric Outpatient Nurse Clinic – a site in a nursing home treatment room for the provision of health care to geriatric patients on an outpatient basis which is staffed by a registered nurse or by a physician's assistant.
  - (e) Geriatric Patient – any patient who is 60 years of age or older.
  - (f) Nursing Facility – a facility licensed under Part I of Chapter 400, F.S.
  - (g) Physician's Assistant – a person who holds a current certificate issued by the Florida State Board of Medical Examiners of Florida State Board of Osteopathic Medical Examiners, to serve as a physician's assistant to function in the dependent relationship with the supervising physician. (Sections 458.135(2)(d); 459.151(2)(d), F.S.)
  - (h) Pre-established Protocols – a statement prepared by or with the responsible or attending physician defining the extent and limits of the medical services provided by the nurse. Such protocols are to be reviewed at periods not to exceed one year, to be dated and signed by the physician, and to be kept readily available.
  - (i) Professional Standards of Practice – those measurements or guides for practice developed and/or endorsed by the respective professional disciplines.
  - (j) Registered Dietitian – one who meets the standards and qualifications established by the Committee on Professional Registration of the American Dietetic Association and is currently registered with the American Dietetic Association.
  - (k) Registered Nurse – a person who holds a current active license to practice professional nursing issued by the Florida State Board of Nursing. (Section 464.071, F.S.)
  - (l) Responsible Physician – the licensed physician delegated by the supervising physician as responsible for the services rendered by the physician's assistant in the absence of the supervising physician.
  - (m) Routine Health Care – the provision of preventive care, detection of health problems, referral for medical care, and management of chronic illness within medical prescriptions.
  - (n) Substantive Change – when the patient's condition changes to such an extent that a change in treatment and/or medication orders is indicated or when pre-established protocols are not applicable.
  - (o) Supervising Physician – the licensed physician assuming responsibility and legal liability for the services rendered by the physician's assistant. (Sections 458.135(2)(e); 459.151(2), (3), F.S.)
  - (p) Treatment Room – the room or suite of rooms set aside for the examination and care of patients.
- (2) Applications.
- (a) A letter shall be sent through the local county Health unit to the AHCA by the operator of a currently licensed nursing home stating intent to establish a geriatric outpatient nurse clinic in compliance with Chapter 400, F.S., Chapter 77-401, Laws of Florida, and the rules pertaining to these chapters. A copy of said letter shall be sent to the Health Program Office of the Department of Health and Rehabilitative Services by the local county health unit. This letter shall be sent at least sixty (60) days prior to the anticipated date of establishment of the clinic. The Director, County Health Unit shall provide specific recommendations for operation of the clinic when transmitting the letter.
  - (b) The AHCA shall ascertain compliance with all applicable laws, rules, regulations, and codes and by letter notify the operator of compliance or non-compliance.

(c) Receipt of the letter of notification stating compliance shall constitute authority to operate a geriatric outpatient nurse clinic within the facility.



(d) Application for renewal of authority to operate a geriatric outpatient nurse clinic shall be submitted in the manner described above at the same time the application for the nursing home relicensure is submitted.

(e) Suspension or revocation of the nursing home license automatically suspends or revokes authority to operate the geriatric outpatient nurse clinic.

(f) A Certificate of Need issued by the AHCA required by Sections 381.493 through 381.497, F.S., is a pre-requisite to establish a geriatric outpatient nurse clinic.

(3) Treatment Rooms and Access Areas.

(a) Plant maintenance and housekeeping shall be in accordance with Rule 59A-4.049, F.A.C.

(b) Every facility conducting a geriatric outpatient nurse clinic shall:

- Use an existing treatment room exclusively for the examination and treatment of patients.
- Store supplies and equipment in such a manner that safeguards patients and staff from hazards.
- Have a waiting area which does not interfere with regular in-patient functions.
- Provide clinic patients with the most direct route to and from the treatment room.
- (4) Administration.

— (a) The business and administrative management of the geriatric outpatient nurse clinic shall be under the management control of the facility administrator. This shall include, but not be limited to maintenance of the following written records.

1. Clinic financial records which identify all income by source and describe all expenditures by category in such a manner as to be suitable by community recognized procedure.
2. An accident and incident record, containing a clear description of each accident and any other incident hazardous or deviant behavior of a patient or staff member with names of individuals involved, description of medical and other services provided, by whom such services were provided and the steps taken to prevent recurrence.
3. Personnel records for each clinic employee and/or contractual provider. These records will be kept updated and include current Florida license and certificate numbers. Original application for the position, references furnished and an annual performance evaluation shall be included.
4. A record of personnel policies, including statement of policies affecting personnel and a job description for each person providing clinic services.
  - Clinic Schedule.
  - Compliance with requirements of Title VI of the Civil Rights Act of 1964.

(b) The provision of health services through geriatric outpatient nurse clinics shall be under the direct management control of the registered nurse or physician's assistant providing those services. Management control of the provision of health services shall contain the following:

1. Assurance that all health services are provided according to legal, ethical and professional practice standards to protect the health, safety and well-being of the patients.
2. Maintenance and confidentiality of clinical records for each patient as required in this chapter.
3. Responsibility for development and periodic review of written policies and protocols governing patient care, including emergency procedures.
  - Responsibility for development and periodic review of patient referral system.
  - Responsibility for the administration and handling of drugs and biological as required in these rules.
  - Maintenance of an individual and cumulative clinic census record.

7. Coordination of patient care with the attending physician and other community health and social agencies and/or facilities.

8. Maintenance of a safe, sanitary clinic environment.

(5) Fiscal Management.

(a) There shall be a recognized system of accounting used to accurately reflect business details of the clinic operation and services kept separate from the facility fiscal records.

(b) A reasonable fee, based on cost of operation and services, may be charged for clinic services rendered.

(c) Personnel involved in operating and/or providing clinic services shall not:

1. Pay any commission, bonus, rebate or gratuity to any organization, agency, physician, employee or other person for referral of any patients to the clinic.
2. Request or accept any remuneration, rebate, gift, benefit, or advantage of any form from any vendor or other supplier because of the purchase, rental, or loan, of equipment, supplies or services for the client and/or patient.

(6) Personnel Policies.

- (a) Staff in the geriatric outpatient nurse clinic will be governed by their Personnel Standards in rules and Regulations governing Nursing Homes and Related Health Care Facilities, Rule 59A-4.157, F.A.C.
  - (b) Staff in the geriatric outpatient nurse clinic shall be qualified and sufficient in numbers to perform the necessary services.
  - (c) Services of this clinic will in no way reduce the minimum staffing standards for in-patient care.
  - (d) Staff in the geriatric outpatient clinic may be regularly employed or serve on a contractual basis.
- (7) Personnel Functions and Responsibilities.
- (a) Registered Nurse (Sections 464.021(2)(a)1., 2., F.S.)

1. The nurse shall have the responsibility for eliciting and recording a health history, observation and assessment nursing diagnosis, counseling and health teaching of patients and the maintenance of health and prevention of illness. The nurse shall provide treatment for the medical aspects of care according to pre-established protocols or physician's orders.
2. The nurse shall note findings and activities on the clinical record.
3. The nurse shall provide progress reports to the attending physicians about patients under the physician's care when there is a substantive change in the patient's condition, there are deviations from the plan of care, or at least every sixty (60) days.

(b) The Advanced Registered Nurse Practitioner (Section 464.003(3)(c), F.S.)

1. The Advanced Registered Nurse Practitioner shall perform the functions outlined for the Registered Nurse, and in addition: Provide additional services dependent upon the certification authority of the Advanced Registered Nurse Practitioner by the Florida State Board of Nursing.

2. The Advanced Registered Nurse Practitioner shall note findings and activities on the clinical record.

(c) The Physician's Assistant (Sections 458.347(3); 459.022, F.S.)

1. The Physician's assistant shall perform health care tasks delegated by the supervising or responsible physician.
2. The Physician's Assistant shall note findings and activities on the clinical record.

(8) Patient Eligibility Criteria.

(a) Acceptance of patients and discharge policies shall include but not be limited to the following:

(b) Patients shall be accepted for clinic services on self-referral for nursing care, or upon a plan treatment established by the patient's attending physician.

(c) The patients with an attending physician will be held responsible for providing the clinic with a written medical plan of treatment reviewed and signed by their physician at least sixty (60) days.

(d) When services are to be terminated, the patient is to be notified of the date of termination and the reason for termination which shall be documented in the patient's clinical record. A plan shall be developed for a referral made for any continuing care indicated.

(9) Patient's Rights.

(a) The facility shall adopt and make public a statement of the rights and responsibilities of the clinic patients and shall treat such patients in accordance with the provisions of said statement. This statement shall be conspicuously posted and available to clinic patients in pamphlet form. The statement shall insure each patient the following:

(b) The right to have private communication with any person of his or her choice.

(c) The right to present grievances on behalf of himself, herself, or others to the facility's staff or administrator, to government officials, or to any person without fear of reprisal, and to join with other patients or individuals to work for improvements in patient care.

(d) The right to be fully informed in writing, prior to at the time of admission and during his or her attendance, of fees and services not covered under Title XVIII or Title XIX of the Social Security Act or other third party reimbursement agents.

(e) The right to be adequately informed of his or her medical condition and proposed treatment unless otherwise indicated in the written medical plan of treatment by the physician, and to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated in the written medical plan of treatment by the physician, and to know the consequences of such actions.

(f) The right to receive adequate and appropriate health care consistent with established and recognized practice standards within the community and with rules as promulgated by the AHCA.

(g) The right to have privacy in treatment and in caring for personal needs, confidentiality in the treatment of personal and medical records.

(h) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement of the services provided by the facility.

(i) The right to freedom of choice in selecting a nursing home.

1. Each nursing home shall post a copy of the statement required by subsection (1) so that it is clearly evident.

2. Any violation of the patient's rights set forth in this section shall constitute grounds for action by the AHCA under the provisions of Section 400.102, F.S.

(10) Scope of Services of the Geriatric Outpatient Nurse Clinic.

(a) Observation of signs and symptoms.

(b) Assessment of health status/progress.

(c) Nursing diagnosis and plan of care.

(d) Nursing care of patients and counseling to maintain health and prevent disease, including diet counseling.

(e) Health instruction to control progression of disease and/or disability and self care measures.

(f) Administration of medication and treatment as prescribed by a person licensed in this state to prescribe such medications and treatment.

(g) Provision of progress reports to the attending physician.

(h) Referral for additional services as needed.

(i) Follow-up on a regular basis by communication with the patient, the patient's physician, and other agencies or persons to which referrals were made.

(j) When staffed by an Advanced Registered Nurse Practitioner or Physician's Assistant, additional services may be provided dependent upon their respective certification authority. (Sections 458.347, 459.022, 464.003(3)(c), F.S.)

(11) Clinical Records.

(a) The clinic shall maintain a clinical record for every patient receiving health services that contain the following:

1. Identification data including name, address, telephone number, date of birth, sex, social security number, clinic case number if used, next of kin or guardian and telephone number, name and telephone number of patient's attending physician.

2. Assessment of problems.

3. Health Care Plan including diagnose, type, and frequency of services and when receiving medications and medical treatments, the medical treatment plan and dated signature of the health professional licensed in this state to prescribe such medications and treatments.

4. Clinical notes, signed and dated by staff providing service.

a. Progress notes with changes in the patient's condition.

b. Services rendered with progress reports.

c. Observations.

d. Instructions to the patient and family.

e. Referrals made.

f. Consultation reports.

g. Case conferences.

h. Reports to physicians.

i. Termination summary.

(I) Date of first and last visit.

(II) Total number of visits by discipline.

- (III) Reason for termination of service.
- (IV) Evaluation of achievements of previously established goals at time of termination.
- (V) Condition of patient on discharge.

j. Clinical records shall be confidential. Information may be released by the nurse or physician's assistant responsible for clinical services only:

- (I) When permission is granted in writing by the patient or guardian.
- (II) To those persons or agencies with a legitimate professional need or regulatory authority pursuant to Section 455.241, F.S.
- (III) When so ordered by the courts.

(12) Medications. The clinic shall have policies and procedures for the administration of medications by health care professionals acting within the scope of practice defined by laws and rules of the Department and the Department of Professional Regulation which shall include, for example, the following:

- (a) All prescriptions for medications shall be noted on the patient record, and include the date, drug, dosage, frequency, method or site of administration, and the authorized health care professional's signature.
- (b) All verbal orders for medication or medication changes shall be taken by the clinic registered nurse or physician's assistant. Such must be in writing and signed by the authorized health care professional within eight (8) days and added to the patient's record.
- (c) The clinic registered nurse or physician's assistant shall record and sign for each medication administered, by drug, dosage, method, time and site on patient's record.
- (d) An emergency plan for reversal of drug reaction to include the facility's PRN standing orders for medications available in the emergency medication kit.
- (e) If there is not a separate emergency medication kit in the clinic, the facility's emergency medication kit shall be immediately accessible for use in the outpatient clinic.

(f) A drug storage system which includes:

1. Prescribed medications for individual outpatients may be retained in the clinic. These medications shall be stored separately from those of the nursing home in-patients for preventive measures and treatment of minor illnesses.
2. Multi-dose containers shall be limited to medications or biologicals commonly prescribed for preventive measures and treatment of minor illnesses.

3. A list shall be kept of patients receiving medication from multi-dose medication containers.

*Specific Authority 381.493-381.497, 400.141(3), 400.23(2) FS. Law Implemented 400.33, 400.141, 400.333 FS. History—New 4-2778, Formerly 10D-29.71, 10D-29.071, 59A-4.071, Amended 2-6-97.*

#### **59A-4.165 Nursing Home Guide.**

- (1) Pursuant to Section 400.191 F.S., the Agency shall provide information to the public in consumer-friendly printed and electronic formats (hereafter collectively the "Guide") to assist consumers and their families in comparing and evaluating nursing home facilities.
- (2) The format of the printed Guide is shown in the "Nursing Home Guide 2000" document, dated July 2000, incorporated by reference herein.
- (3) The format of the electronic Guide will be the same as the printed Guide, but with the addition of the following:
  - (a) The ability to search for a facility electronically.
  - (b) Details of which deficiencies the facility has been cited for over the past 45 months.
- (4) The data provided in the Guide shall include the following:
  - (a) General guidance about when a nursing home is the appropriate choice of care.
  - (b) General guidance about selecting a nursing home.
  - (c) Contact information such as phone numbers and web sites where questions can be answered, and further information obtained.
  - (d) A listing of all nursing home facilities in the state of Florida, including hospital based skilled nursing units.

This listing shall include for each facility the following:

- Name;
- Address;
- Voice and fax phone numbers;
- Web address of facility;
- A recognition if the facility has been awarded a Gold Seal;
- The current licensee;
- Which calendar year the current licensee became the licensee;

8. Whether the licensee is a for-profit, or non-profit entity, and whether or not the facility is part of a retirement community;
- Any corporate or religious affiliations;
  - The number of private, semi-private, and total beds at the facility;
  - The lowest daily charge for a semi-private room;
  - The payment forms accepted;
  - Any special services or amenities, or recreational programs provided;
  - Any non-English languages spoken by the administrator or staff of the facility; and
  - 15. A summary of the deficiencies found at the facility over a 45 month period prior to the publication of the Guide. The summarization procedure is discussed in detail below.

(5) The Guide will employ a procedure for summarizing the deficiencies as follows:

- (a) All deficiencies cited over the most recently available 45 month period prior to the publication of the Guide will be collected.
- (b) Each citation will be assigned points based on the type of deficiency and its assigned severity and scope. For those facilities that are not federally certified, each citation will be assigned points based on the type of deficiency and its assigned class. Facilities that are federally certified have their deficiencies recorded as F-Tags and K-Tags. Facilities that are not federally certified receive N-Tags instead of F-Tags and K-Tags. For the non-federally certified facilities the findings supporting each N-Tag shall be read by the Agency to determine which F-Tag or K-Tag each of the cited N-Tags is equivalent to. The points assigned to an N-Tag shall be those that would be assigned to the equivalent F-Tag or K-Tag, if the facility were federally certified.
- (c) A score for a facility will be computed by summing the points of all of its citations, and then dividing this sum by the number of annual recertification surveys conducted at the facility in the same 45 month period as in paragraph (a) above. For those facilities that are not federally certified, the number of annual licensure surveys will be used in place of the number of annual recertification surveys.
- (d) For federally certified facilities, the above computations will reflect any changes resulting from the Informal Dispute Resolution process, or administrative or appellate proceedings; inasmuch as the federal Health Care Financing Administration concurs with such changes.
- (e) The scores for the freestanding nursing facilities will be ranked within each region. The regions are defined in the "Nursing Home Guide Performance Measures Algorithm" document, dated July 2000, incorporated by reference herein.
- (f) Ranks for the hospital based skilled nursing units will be assigned the same rank as the freestanding nursing facility in the same region with an equal or next lower score.
- (g) These ranks shall be presented numerically and/or symbolically in the Guide.
- (h) (b) through (g) shall be repeated for subsets of the citations. These subsets are discussed in the "Nursing Home Guide Performance Measures Algorithm" document, dated July 2000, incorporated by reference herein.
- (i) Facilities that are federally certified have their deficiencies recorded as F-Tags and K-Tags. Facilities that are not federally certified receive N-Tags instead of F-Tags and K-Tags. For the non-federally certified facilities the findings supporting each N-Tag shall be read by the Agency to determine which F-Tag or K-Tag each of the cited N-Tags is equivalent to. The subsetting of the tags in (h) for non-certified facilities shall be accomplished by using these equivalent F-Tags and K-Tags.
- (j) The documents incorporated by reference may be obtained from the Agency for Health Care Administration, Managed Care and Health Quality Division, 2727 Mahan Dr., Tallahassee, FL 32308.

(6) The internet version of the guide will be available at [www.fdhc.state.fl.us](http://www.fdhc.state.fl.us) and [www.floridahealthstat.com](http://www.floridahealthstat.com).

*Specific Authority 400.191(6) FS. Law Implemented 400.191 FS. History—New 2-15-01.*

**59A-4.166 Nursing Home Consumer Satisfaction Survey.**

- (1) Pursuant to Section 400.0225, F.S., the Agency or its contractor shall conduct consumer satisfaction surveys of all nursing homes and skilled nursing units of hospitals in the state. These nursing homes and skilled nursing units shall hereafter be referred to as “nursing facilities”.
- (2) The Agency or its contractor will survey family members and guardians of residents of these nursing facilities by way of mail surveys. This will require each nursing facility to provide to the Agency or its contractor, upon request, the names and addresses of at least one family member or guardian for each resident.
- (3) The Agency or its contractor will interview residents of these facilities in person. This will require each nursing facility to provide to the Agency or its contractor, upon request, a list of all residents, along with each resident's room number, and each resident's birth date.
- (4) The Agency or its contractor shall conduct these surveys and interviews at each nursing facility at least annually.
- (5) The specific protocol for conducting these surveys and interviews is shown in the “Nursing Home and Skilled Nursing Unit Resident and Family Member Survey Project” document, dated July 2000, incorporated by reference herein.
- (6) Only data summarized to the level of the facility may be released.
- (7) The documents incorporated by reference may be obtained from the Agency for Health Care Administration, Managed Care and Health Quality Division, 2727 Mahan Dr., Tallahassee, FL 32308.

*Specific Authority 400.0225 FS. Law Implemented 400.0225 FS. History—New 2-15-01.*

**59A-4.200 Definitions.**

- (1) Agency means the Agency for Health Care Administration.
- (2) Panel means the Panel on Excellence in Long Term Care.
- (3) Parent company means an entity that owns, leases, or through any other device controls a group of two or more health care facilities or at least one health care facility and any other business. A related party management company is considered to be a parent company.
- (4) Region means a geographical area of the state of Florida defined by a list of counties reflected by the agency's 11 inspection regions. The regions are defined, as part of the Nursing Home Guide Performance Measures Algorithm, July 2000 which is incorporated by reference. Copies of this form may be obtained from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, MS 33, Tallahassee, FL 32308 or from the Agency website at <http://ahcaxnet.fdhc.state.fl.us/nhcguid/>.
- (5) Quality of Care score means all of the parameters included in the Nursing Home Guide that reflect the results of the overall inspection. These parameters are defined in the Nursing Home Guide Performance Measures Algorithm, July 2000, as specified in Rule 59A-4.165, F.A.C.

*Specific Authority 400.235(9) FS. Law Implemented 400.235 FS. History—New 8-21-01, Amended 5-15-07.*

**59A-4.201 Gold Seal Award.**

- (1) To be considered for recommendation for a Gold Seal Award, a nursing home licensee must submit to the Agency's Long Term Care Unit:
  - (a) A letter of recommendation;
  - (b) A completed application for Gold Seal Award (AHCA Form 3110-0007 (Rev. March 07)) which is incorporated by reference. Copies of this form may be obtained from the Agency for Health Care Administration, Long Term Care Unit, 2727 Mahan Drive, MS 33, Tallahassee, FL 32308 or from the Agency



website at [http://ahca.myflorida.com/MCHQ/ Long\\_Term\\_Care/LTC/index.shtml](http://ahca.myflorida.com/MCHQ/Long_Term_Care/LTC/index.shtml);

(c) The financial documentation required by Rule 59A-4.203, F.A.C.; and

(d) The stable workforce documentation required by Rule 59A-4.204, F.A.C.

(2) During the effective dates of the award, a nursing home licensee may use the Gold Seal designation in facility advertising and marketing. All advertising and marketing of the Gold Seal designation must include the range of dates for which the Gold Seal was awarded and shall only represent the facility to which it has been designated. Within 90 days after termination or expiration of the Gold Seal award, the Gold Seal designation must be removed from all advertising and marketing materials.

*Specific Authority 400.235(9) FS. Law Implemented 400.235 FS. History-New 8-21-01, Amended 5-15-07.*

**59A-4.2015 Review Process.**

(1) A review process is established which provides submission deadlines for applications, and Panel meeting timeframes to review applications. Facilities may submit applications at any time for review as follows.

(2) Review Period 1 requires applications be submitted by March 15 each year to be eligible for review during this period. The quality of care score for this review period will be obtained from the preceding quarter ending December 31, and will be available by February 15 to ensure facilities qualify for this criterion prior to submitting an application. Application reviews will be complete by April 15. Site visits will be conducted after April 15 and a meeting will be held to determine those licensees to be recommended for the Gold Seal. This meeting must be held prior to June 15.

(3) Review Period 2 requires applications be submitted by September 15 each year to be eligible for review during this period. The quality of care score for this review period will be obtained from the preceding quarter ending June 30 and will be available by August 15 to ensure facilities qualify under this criterion prior to submitting an application. Application reviews will be complete by October 15. Site visits will be conducted after October 15 and a meeting will be held to determine those licensees to be recommended for the Gold Seal. This meeting must be held prior to December

15.

(4) Quality of care scoring information may be obtained by contacting the Bureau of Long Term Care Services at (850)488-5861 or from the Agency website at [http://ahca.myflorida.com/MCHQ/Long\\_Term\\_Care/index.shtml](http://ahca.myflorida.com/MCHQ/Long_Term_Care/index.shtml) under the heading Nursing Home Gold Seal Award/ Governor's Panel on Excellence in Long-Term Care.

(5) Any nursing home licensee not meeting all requirements or having omissions in financial information will be notified to allow a licensee to submit additional information or withdraw the application. Licensees have 10 business days after the Agency's request to provide required documentation to continue to be eligible for consideration.

(6) If the panel determines that an applicant has failed to meet all Gold Seal criteria and the application is not withdrawn, a recommendation to deny the Gold Seal award will be made to the Governor.

*Specific Authority 400.235(9) FS. Law Implemented 400.235 FS. History--New 5-15-07.*

#### **59A-4.202 Quality of Care.**

(1) The Agency shall determine how a Gold Seal recommended licensee ranks relative to other licensees in the same region.

(2) The agency shall compute a quality of care score and rank nursing home licensees, in accordance with the Nursing Home Guide Performance Measures Algorithm, July 2000.

(3) To be considered further for a Gold Seal Award, the facility's quality of care rank must be in the top 15% of facilities in the applicant's region or top 10% statewide. The facility must also be ranked in the Nursing Home Guide as a five-star facility overall.

*Specific Authority 400.235(9) FS. Law Implemented 400.235 FS. History-New 8-21-01, Amended 5-15-07.*

#### **59A-4.203 Financial Requirements.**

(1) To be eligible for a Gold Seal designation, a facility must have been in operation for a minimum of 30 months prior to the date of application and must provide evidence of financial soundness and stability. This subsection provides the criteria for use of financial statements. To demonstrate 30 months of financial soundness and stability prior to the date of the application:

(a) The licensee of the facility shall submit financial statements prepared in accordance with Generally Accepted Accounting Principles (GAAP) for the three consecutive fiscal years immediately preceding the date of application, including: a balance sheet, income statement and statement of cash flows and all relevant notes. The licensee concurrently shall submit a report from a certified public accountant (CPA) who has audited or reviewed these financial statements. A report of audited financial statements must specify an unqualified opinion. A report on reviewed financial statements must be a standard report and must not contain

any departure from GAAP. Financial statements that have been reviewed by a CPA may not be substituted for audited financial statements when the audit was conducted for the same financial accounting period. Each licensee shall also submit a one-year set of pro-forma financial statements, including balance sheet, income statement and statement of cash flows. For a licensee whose audited or reviewed financial statements are prepared as part of a consolidated entity, the licensee can satisfy the requirements for submitting financial statements by submitting the three most recent consecutive years of CPA audited or reviewed consolidated financial statements if the statements break out the balance sheet, income statement and statement of cash flows of the individual licensee or submit accreditation documents in accordance with Section 400.235(5)(b) Florida Statutes. In the event a continuing care retirement center has its designation as a CCRC revoked by the Department of Financial Services, the CCRC is required to submit financial statements as described in this rule.

(b) Each licensee must meet at least two of the three following financial soundness and stability thresholds listed below for at least two of three years of the statements, to include the most recent year submitted and the pro-forma statements. Otherwise, its facilities cannot be recommended for the Gold Seal Award except as described in subsection (2) below.

1. A positive current ratio of at least one (1). The current ratio is determined by dividing current liabilities into current assets. Current assets are those held for conversion within a year or less, such as cash, temporary investments, receivables, inventory, and prepaid expenses. Board designated assets of cash or near cash instruments, where the board of directors has the option to change the authorized use of the assets and the assets are otherwise unencumbered as disclosed by the auditor, can be considered current assets for this calculation. Current liabilities are short-term debts and unearned revenues to be paid out of current assets within a year or less.
2. A positive tangible net worth as determined by the balance sheet. This shall be determined as equity (total assets less total liabilities) net of intangible assets. An intangible asset is a capital asset having no physical existence, its value being dependent on the rights that possession confers upon the owner. Examples include goodwill and trademarks.
3. A times interest earned ratio of at least 1.15 or 115 percent. This shall be determined by dividing interest expense into net income before deducting such interest and income tax. Net income is defined as revenues (receipts or earnings) less expenses (costs). Not-for-profit providers may include non-operating income, such as public or governmental support and foundation transfers in determining net income.

(2) If the licensee can meet only one of the three financial ratios in paragraph (1)(b) above for one of the two required years, the licensee may be recommended for a Gold Seal Award only if the most recent CPA prepared financial statements provided are for a period ending within six months of the date of the application and these financial statements meet all three of the financial criteria set forth in paragraph (1)(b) above.

(3) Neither the licensee nor its parent company shall have been the subject of bankruptcy proceedings during the period beginning 30 months prior to the date of the application and ending on the date of the award of the Gold Seal.

*Specific Authority 400.235 FS. Law Implemented 400.235(9) FS. History-New 8-21-01, Amended 5-19-02, 3-21-04.*

#### **59A-4.204 Turnover Ratio.**

(1) An applicant for Gold Seal Award must meet at least one of the following to demonstrate a stable workforce:

(a) Have a turnover rate no greater than 50 percent for the most recent 12 month period ending on the last workday of the most recent calendar quarter prior to submission of an application. The turnover rate will be computed in accordance with Section 400.141(15)(b), F.S., or

(b) Have a stability rate indicating that at least 50 percent of its staff have been employed at the facility for at least one year. The stability rate will be computed in accordance with Section 400.141(15)(c), F.S.

- (2) Each applicant for Gold Seal Award must submit evidence of an effective recruitment and retention program.

*Specific Authority 400.235(9) FS. Law Implemented 400.235 FS. History-New 8-21-01, Amended 5-15-07.*

**59A-4.205 The State Long Term Care Ombudsman Council Review.** The State Long Term Care Ombudsman Council shall provide a profile of substantiated ombudsman program complaints against licensees applying for the Gold Seal Award. Upon request, the State Long Term Care Ombudsman Council shall provide the findings of ombudsman program administrative inspections of facilities applying for the Gold Seal Award. The Panel on Excellence in Long Term Care shall make the final determination regarding whether the licensee demonstrated an outstanding history in regard to substantiated ombudsman complaints.

*Specific Authority 400.235(9) FS. Law Implemented 400.235 FS. History-New 8-21-01, Amended 5-15-07.*

**59A-4.206 Termination and Frequency of Review.**

- (1) The occurrence of any one of the following events shall disqualify the licensee from continuing as a Gold Seal facility:
  - (a) The filing of a petition by or against the owner or its parent company under the Bankruptcy Code;
  - (b) The issuance of a Class I or Class II deficiency or the assignment of a conditional license.
- (2) For federally certified facilities, if the disqualifying event is the issuance of a citation for a Class I or Class II deficiency or the assignment of a conditional license status, the Gold Seal Award shall be withdrawn only after the results of the federal Informal Dispute Resolution (IDR) process are considered, if an IDR is requested.
- (3) The termination or correction of a disqualifying event does not cause the Gold Seal to be reinstated. The licensee shall resubmit a complete application package and must meet all the conditions necessary to be awarded a Gold Seal.
- (4) If a licensee receives a Class I or Class II deficiency or is assigned a conditional license status while it is being considered for a Gold Seal Award by the panel, the application will be denied.
- (5) Frequency of Review. A Gold Seal licensee shall submit a complete renewal application every two years. The renewal application must be received by the agency during the appropriate review period as provided in Rule 59A4.2015, F.A.C., to ensure the licensee will not have a lapse in the Gold Seal designation.

*Specific Authority 400.235(9) FS. Law Implemented 400.235 FS. History-New 8-21-01, Amended 5-15-07.*

**STATUTES: 2010 Florida Code TITLE XXIX PUBLIC HEALTH Chapter 400  
NURSING HOMES AND RELATED HEALTH CARE FACILITIES PART X NURSING  
HOMES(ss. 400.011-400.334)**

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. 83181; 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) "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.
- (6) "Department" means the Department of Children and Family Services.
- (7) "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.
- (8) "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.
- (9) "Geriatric patient" means any patient who is 60 years of age or older.
- (10) "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.
- (11) "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.
- (12) "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.
- (13) "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.
- (14) "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.
- (15) "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.
- (16) "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.

(17) "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.

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



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. 76168; 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; s. 55, ch. 2007-230.

#### 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, s. 400.121, or part II of chapter 408. In order to determine whether the licensee is adequately protecting residents' rights, the licensure 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; s. 56, ch. 2007-230.

#### 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:

— Rejecting the claim; or

— 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 429.298, 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; s. 24, ch. 2006-197.

#### 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, 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. 83181; 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; s. 57, ch. 2007-230.

400.062 License required; fee; disposition.

(1) The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to this part and part II of chapter 408 and to entities licensed by or applying for such licensure from the Agency for Health Care Administration pursuant to this part. A license issued by the agency is required for the operation of a nursing home in this state.

(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) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. The license fee 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 biennially and shall be \$100 per bed unless modified by rule. Part II of the license fee shall be the resident protection fee, which shall be at the rate of not less than 50 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 Health Care Trust Fund for resident protection is less than \$1 million, the agency may adopt rules to establish a rate which may not exceed \$20 per bed. The rate per bed shall revert back to the minimum rate per bed when the amount on deposit in the Health Care Trust Fund for resident protection 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 may not be expended without prior approval of the Legislature. The agency may prorate the biennial license fee for those licenses which it issues under this part for less than 2 years. The resident protection fee collected shall be deposited in the Health Care 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.

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; s. 58, ch. 2007-230; s. 11, ch. 2008-9.

#### 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.

(1) The Health Care Trust Fund shall be used for the purpose of collecting and disbursing funds generated from the license fees and administrative fines as provided for in ss. 393.0673(4), 400.062(3), 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 Health Care 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 Health Care 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 1s. 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 Health Care 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 Health Care 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; s. 59, ch. 2007-230; s. 101, ch. 2008-4; s. 12, ch. 2008-9; s. 12, ch. 2008-244.

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

#### 400.071 Application for license.

(1) In addition to the requirements of part II of chapter 408, the application for a license shall be under oath and must contain the following:

(a) 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.

(b) A signed affidavit disclosing any financial or ownership interest that a controlling interest as defined in part II of chapter 408 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.

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

(d) Information relating to the applicant and employees which the agency requires by rule. 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.

(e) 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.

(2) 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.

(3) 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.

(4) 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.

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

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; s. 60, ch. 2007-230.

#### 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 inactivity before receiving approval from the agency; and a licensee that violates this provision may not be issued an inactive license.

(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 the current licensure expiration date but may be renewed by the agency at the time of licensure renewal.

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

History. s. 1, ch. 2004-298; s. 61, ch. 2007-230; s. 102, ch. 2008-4; s. 37, ch. 2009-223.

#### 400.102 Action by agency against licensee; grounds.

In addition to the grounds listed in part II of chapter 408, any of the following conditions shall be grounds for action by the agency against a licensee:

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

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

(3) 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; or

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

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; s. 62, ch. 2007-230.

#### 400.111 Disclosure of controlling interest.

In addition to the requirements of part II of chapter 408, the licensee shall submit a signed affidavit disclosing any financial or ownership interest that a controlling interest 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; s. 63, ch. 2007-230.

#### 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) 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; s. 38, ch. 2009-223.

#### 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 to the agency at the time of relicensure the total number of grievances handled during the prior licensure period, 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.

History. s. 19, ch. 2001-45; s. 64, ch. 2007-230.

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

(1) Incident reports filed with the risk manager and administrator of a long-term care facility licensed under this part or part I of chapter 429, 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. (2)(a) The meetings of an internal risk management and quality assurance committee of a long-term care facility licensed under this part or part I of chapter 429 are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Records of those meetings are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3)(a) 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 records made confidential and exempt pursuant to this section to the appropriate law enforcement agency or regulatory board.

(b) Records disclosed to a law enforcement agency remain confidential and exempt until criminal charges are filed.

(4) Records made confidential and exempt under this section 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.

History. s. 1, ch. 2001-44; s. 59, ch. 2002-1; s. 1, ch. 2006-110; s. 25, ch. 2006-197.

400.121 Denial, suspension, revocation of license; administrative fines; procedure; order to increase staffing.

(1) The agency may deny an application, revoke or suspend a license, and impose an administrative fine, not to exceed \$500 per violation per day for the violation of any provision of this part, part II of chapter 408, or applicable rules, against any applicant or licensee for the following violations by the applicant, licensee, or other controlling interest:

(a) A violation of any provision of this part, part II of chapter 408, or applicable rules; or

(b) 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 or part II of chapter 408 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 Health Care 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 issued pursuant to this part or part II of chapter 408 which are 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) If the agency has placed a moratorium pursuant to this part or part II of chapter 408 on any facility two times within a 7-year period, the agency may suspend the nursing home license.

(5) An action taken by the agency to deny, suspend, or revoke a facility's license under this part or part II of chapter 408 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.

(6) 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.

(7) 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.

(8) In addition to any other sanction imposed under this part or part II of chapter 408, 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; s. 65, ch. 2007-230; s. 13, ch. 2008-9.

#### 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 Health Care 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; s. 14, ch. 2008-9.

400.141 Administration and management of nursing home facilities.

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

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

(b) 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.

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

(d) 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 or chapter 429, 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 this paragraph may 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 in this paragraph. A pharmacist who repackages and relabels prescription medications, as authorized under this paragraph, may charge a reasonable fee for costs resulting from the implementation of this provision.

(e) 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.

(f) 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 paragraph, 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.

(g) 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 of this chapter or part I or part III of chapter 429 on a single campus, be allowed to share programming and staff. At the time of inspection and in the semiannual report required pursuant to paragraph (o), 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 paragraph 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.

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

(i) 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 paragraph, the agency shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics.

(j) 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.

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

(l) 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.

(m) 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.

(n) Submit to the agency the information specified in s. 400.071(1)(b) for a management company within 30 days after the effective date of the management agreement.

(o)1. 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 sub-subparagraph, 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)1.b. and c. 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.

2. This paragraph does not 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.

(p) 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.

(q) 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.

(r) 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.

(s) 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)(g).

(t) 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.

(u) 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 paragraph. This paragraph 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 paragraph.

(v) 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 paragraph. This paragraph 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 paragraph.

(w) 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 paragraph.

(2) 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. 77401; 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; s. 1, ch. 2005-136; s. 2, ch. 2006-28; s. 26, ch. 2006-197; s. 67, ch. 2007-230; s. 39, ch. 2009-223; s. 82, ch. 2010-5; s. 1, ch. 2010-156; s. 2, ch. 2010-197.

#### 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.

(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.

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

#### 400.1415 Patient records; penalties for alteration.



(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:

- Death;
- Brain or spinal damage;
- Permanent disfigurement;
- Fracture or dislocation of bones or joints;
- A limitation of neurological, physical, or sensory function;

1. Any condition that required medical attention to which the resident has not given his or her informed consent, including failure to honor advanced directives;
  2. 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; or
8. An event that is reported to law enforcement or its personnel for investigation; or
- (b) Resident elopement, if the elopement places the resident at risk of harm or injury.
  - (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) Abuse, neglect, or exploitation must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415.
  - (10) 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.
  - (11) 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.
  - (12) 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.
  - (13) 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.
  - (14) The agency may adopt rules to administer this section.
  - (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; s. 40, ch. 2009-223.

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 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.

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

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

(5) 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; s. 107, ch. 2010-102.

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 and the resident's representative if appropriate at admission and when revised. 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.

(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.

1. 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.
2. 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 Health Care 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; s. 15, ch. 2008-9; s. 41, ch. 2009-223.

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.

History. s. 26, ch. 2001-45; s. 62, ch. 2005-2.

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 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) 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:

- Medicaid rate changes or adjustments;
- Any depreciation recapture;
- Any recapture of fair rental value system indexing; or
- 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 annually thereafter, in the amount of 1 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 Grants and Donations 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. 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. By March 31 of each year, the agency shall assess the cumulative fees collected under this subparagraph, minus any amounts used to repay nursing home Medicaid overpayments and amounts transferred to contribute to the General Revenue Fund pursuant to s.

215.20. If the net cumulative collections, minus amounts utilized to repay nursing home Medicaid overpayments, exceed \$25 million, the provisions of this subparagraph shall not apply for the subsequent fiscal year.

1. 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.
2. 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.
3. It shall be the responsibility of all nursing facility operators, operating the facility as a leasehold, to renew the 30month bond and to provide proof of such renewal to the agency annually.
4. 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, revoke, and 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 pursuant to part II of chapter 408, 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.

(e) For the 2009-2010 fiscal year only, the provisions of paragraph (d) shall not apply. This paragraph expires July 1, 2010.

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; s. 63, ch. 2005-2; s. 3, ch. 2006-28; s. 68, ch. 2007-230; s. 1, ch. 2008-143; s. 3, ch. 2009-47; s. 13, ch. 2009-82; s. 2, ch. 2010-156.

#### 400.18 Closing of nursing facility.

(1) In addition to the requirements of part II of chapter 408, the licensee also shall inform each resident or the next of kin, legal representative, or agency acting on behalf of the resident of the fact, and the proposed time, of discontinuance of operation 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.

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; s. 69, ch. 2007-230.

400.19 Right of entry and inspection.

(1) In accordance with part II of chapter 408, 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, part II of chapter 408, and applicable rules in force pursuant thereto. 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.

(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 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. 2001-145; s. 70, ch. 2007-230.

#### 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 a licensure 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. The agency may provide electronic access to inspection reports as a substitute for sending copies.

(2) The agency shall publish the Nursing Home Guide quarterly in electronic form 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 section entitled "Have you considered programs that provide alternatives to nursing home care?" which shall be the first section of the Nursing Home Guide and which shall prominently display information about available alternatives to nursing homes and how to obtain additional information regarding these alternatives. The Nursing Home Guide shall explain that this state offers alternative programs that permit qualified elderly persons to stay in their homes instead of being placed in nursing homes and shall encourage interested persons to call the Comprehensive Assessment Review and Evaluation for Long-Term Care Services (CARES) Program to inquire if they qualify. The Nursing Home Guide shall list available home and community-based programs which shall clearly state the services that are provided and indicate whether nursing home services are included if needed.
2. A list by name and address of all nursing home facilities in this state, including any prior name by which a facility was known during the previous 24-month period.
  - Whether such nursing home facilities are proprietary or nonproprietary.
  - The current owner of the facility's license and the year that that entity became the owner of the license.
5. 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.
  - The total number of beds in each facility and the most recently available occupancy levels.
  - The number of private and semiprivate rooms in each facility.
  - The religious affiliation, if any, of each facility.
  - The languages spoken by the administrator and staff of each facility.
  - 10. Whether or not each facility accepts Medicare or Medicaid recipients or insurance, health maintenance organization, Veterans Administration, CHAMPUS program, or workers' compensation coverage.
  - Recreational and other programs available at each facility.
  - Special care units or programs offered at each facility.
1. Whether the facility is a part of a retirement community that offers other services pursuant to part III of this chapter or part I or part III of chapter 429.
2. Survey and deficiency information, including all federal and state recertification, licensure, revisit, and complaint survey information, for each facility for the past 30 months. For noncertified nursing homes, state survey and deficiency information, including licensure, revisit, and complaint survey information for the past 30 months shall be provided.



(b) 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.
1. Whether the facility currently possesses the Gold Seal designation awarded pursuant to s. 400.235.
2. 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 the reports shall be retained in the records for not less than 5 years following the date the reports are filed or issued.

(a) The agency shall publish in the Nursing Home Guide 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 and each facility that is operating under bankruptcy protection. 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 days and percentage of days the facility had a conditional license in the past 30 months. 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 health quality assurance field offices.

(b) Upon publication of each Nursing Home Guide, the agency must post a copy on its website by the 15th calendar day of the second month following the end of the calendar quarter. Each nursing home licensee must retrieve the most recent version of the Nursing Home Guide from the agency's 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 must be made available to the agency on the premises of the facility and submitted to the agency. Each facility must submit this information to the agency by electronic transmission when available.

(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 the deficiencies and indicating in the summaries where the full reports may be inspected in the nursing home.
2. A copy of all of the pages that list the facility in the most recent version of the Nursing Home Guide.

(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, a nursing home, or to any relative, spouse, or guardian of the 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; s. 1, ch. 2006-49; s. 27, ch. 2006-197; s. 71, ch. 2007-230; s. 42, ch. 2009-223.

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:

— Techniques for assisting with eating and proper feeding;

— Principles of adequate nutrition and hydration;

— Techniques for assisting and responding to the cognitively impaired resident or the resident with difficult behaviors;

— Techniques for caring for the resident at the end-of-life; and

— 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 level 2 background screening for personnel as required in s. 408.809(1)(e) pursuant to chapter 435 and s. 408.809.

(2) The agency shall, as allowable, reimburse nursing facilities for the cost of conducting background screening as required by this section. This reimbursement is not subject to any rate ceilings or payment targets in the Medicaid Reimbursement plan.

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; s. 28, ch. 2006-197; s. 6, ch. 2010-114.

Note. Section 58, ch. 2010-114, provides that “[t]he changes made by this act are intended to be prospective in nature. It is not intended that persons who are employed or licensed on the effective date of this act be rescreened until such time as they are otherwise required to be rescreened pursuant to law, at which time they must meet the requirements for screening as set forth in this act.”

## 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 and part II of chapter 408 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 and part II of chapter 408, which shall include reasonable and fair criteria in relation to:

(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 or part II of chapter 408, the agency may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code which apply to nursing homes. Residents or their representatives shall be able to request a change in the placement of the bed in their room, provided that at admission they are presented with a room that meets requirements of the Florida Building Code. The location of a bed may be changed if the requested placement does not infringe on the resident's roommate or interfere with the resident's care or safety as determined by the care planning team in accordance with facility policies and procedures. In addition, the bed placement may not be used as a restraint. Each facility shall maintain a log of resident rooms with beds that are not in strict compliance with the Florida Building Code in order for such log to be used by surveyors and nurse monitors during inspections and visits. A resident or resident representative who requests that a bed be moved shall sign a statement indicating that he or she understands the room will not be in compliance with the Florida Building Code, but they would prefer to exercise their right to self-determination. The statement must be retained as part of the resident's care plan. Any facility that offers this option must submit a letter signed by the nursing home administrator of record to the agency notifying it of this practice with a copy of the policies and procedures of the facility. 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)(a)1. The agency shall adopt rules providing minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility:

a. A minimum weekly average of certified nursing assistant and licensed nursing staffing combined of 3.9 hours of direct care per resident per day. As used in this sub-subparagraph, a week is defined as Sunday through Saturday.

b. A minimum certified nursing assistant staffing of 2.7 hours of direct care per resident per day. A facility may not staff below one certified nursing assistant per 20 residents.

c. A minimum licensed nursing staffing of 1.0 hour of direct care per resident per day. A facility may not staff below one licensed nurse per 40 residents.

1. Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if their job responsibilities include only nursing-assistant-related duties.
2. 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.
3. 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 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 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) Nonnursing staff providing eating assistance to residents 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. In addition to license categories authorized under part II of chapter 408, 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) The agency shall adopt rules that:

- Establish uniform procedures for the evaluation of facilities.
- Provide criteria in the areas referenced in paragraph (c).
- Address other areas necessary for carrying out the intent of this section.

(8) The agency shall adopt rules pursuant to this part and part II of chapter 408 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 licensure inspection or any inspection or complaint investigation since the last licensure 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 licensure inspection or any inspection or complaint investigation since the last licensure 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 licensure inspection or any inspection or complaint investigation since the last licensure 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, a civil penalty may not 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; s. 2, ch. 2005-60; s. 2, ch. 2005-147; s. 1, ch. 2005-234; s. 4, ch. 2006-28; s. 72, ch. 2007-230; s. 44, ch. 2009-223; s. 3, ch. 2010-156.

#### 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. 91282; 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 State Surgeon General; 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.

(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.

(8)(a) Facilities awarded the Gold Seal may use the designation in their advertising and marketing.

(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; s. 49, ch. 2008-6.

400.241 Prohibited acts; penalties for violations.

(1) 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) or part II of chapter 408. Alerting or advising a facility of the actual or approximate date of such inspection shall be a per se violation of this subsection.

(2) 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 is 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; s. 73, ch. 2007-230.

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.

## **2010 Florida Code TITLE XXIX PUBLIC HEALTH Chapter 400 NURSING HOMES AND RELATED HEALTH CARE FACILITIES PART X LONG-TERM CARE FACILITIES: OMBUDSMAN PROGRAM(ss. 400.0060400.0091)**

### 400.0060 Definitions.

When used in this part, unless the context clearly dictates otherwise, the term:

- (1) "Administrative assessment" means a review of conditions in a long-term care facility which impact the rights, health, safety, and welfare of residents with the purpose of noting needed improvement and making recommendations to enhance the quality of life for residents.
- (2) "Agency" means the Agency for Health Care Administration.
- (3) "Department" means the Department of Elderly Affairs.
- (4) "Local council" means a local long-term care ombudsman council designated by the ombudsman pursuant to s. 400.0069. Local councils are also known as district long-term care ombudsman councils or district councils.
- (5) "Long-term care facility" means a nursing home facility, assisted living facility, adult family-care home, board and care facility, or any other similar residential adult care facility.
- (6) "Office" means the Office of State Long-Term Care Ombudsman created by s. 400.0063.
- (7) "Ombudsman" means the individual appointed by the Secretary of Elderly Affairs to head the Office of State Long-Term Care Ombudsman.
- (8) "Resident" means an individual 60 years of age or older who resides in a long-term care facility.
- (9) "Secretary" means the Secretary of Elderly Affairs.
- (10) "State council" means the State Long-Term Care Ombudsman Council created by s. 400.0067.

History. ss. 1, 30, ch. 93-177; s. 4, ch. 95-210; s. 1, ch. 2006-121.

### 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 fully 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, a representative of a long-term care facility resident, or any other concerned citizen 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 a long-term care facility resident. The Legislature finds that concerned citizens are often more effective advocates for 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 investigations or onsite administrative assessments of long-term care facilities. It is the further intent of the Legislature that the environment in long-term care facilities 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; s. 2, ch. 2006-121.

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 serve on a full-time basis and shall personally, or through representatives of the office, carry out the purposes and functions of the office in accordance with state and federal law.

(b) The ombudsman shall be appointed by and shall serve at the pleasure of the Secretary of Elderly Affairs. The secretary shall appoint a person who has expertise and experience in the fields of long-term care and advocacy to serve as ombudsman.

(3)(a) There is created in the office the position of legal advocate, who shall be selected by and serve at the pleasure of the ombudsman and 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.

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

— Pursuing administrative, legal, and other appropriate remedies on behalf of residents.

— 4. Serving as legal counsel to the state and local 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; s. 3, ch. 2006-121; s. 20, ch. 2006-197.

400.0065 State Long-Term Care Ombudsman; duties and responsibilities.

(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 that assist in protecting the health, safety, welfare, and rights of residents.

(c) Inform residents, their representatives, and other citizens about obtaining the services of the State Long-Term Care Ombudsman Program 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) Administer the state and local 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 and necessary.

(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) Establish and coordinate local councils throughout the state.

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

(c) Within the limits of appropriated federal and state funding, employ such personnel as are necessary to perform adequately the functions of the office and provide or contract for legal services to assist the state and local councils in the performance of their duties. Staff positions established for the purpose of coordinating the activities of each local council and assisting its members may be filled by the ombudsman after approval by the secretary. Notwithstanding any other provision of this part, upon certification by the ombudsman that the staff member hired to fill any such position has completed the initial training required under s. 400.0091, such person shall be considered a representative of the State Long-Term Care Ombudsman Program for purposes of this part.

(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 Advocacy Council for the purpose of coordinating and avoiding duplication of advocacy services provided to residents.

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

(i) Prepare an annual report describing the activities carried out by the office, the state council, and the local councils in the year for which the report is prepared. The ombudsman shall submit the report to the secretary at least 30 days before the convening of the regular session of the Legislature. The secretary shall in turn submit the report to the United States Assistant Secretary for Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the Secretary of Children and Family Services, and the Secretary of Health Care Administration. The report shall, at a minimum:



1. Contain and analyze data collected concerning complaints about and conditions in long-term care facilities and the disposition of such complaints.
2. Evaluate the problems experienced by residents.
3. Analyze the successes of the ombudsman program during the preceding year, including an assessment of how successfully the program has carried out its responsibilities under the Older Americans Act.
4. Provide recommendations for policy, regulatory, and statutory changes designed to solve identified problems; resolve residents' complaints; improve residents' lives and quality of care; protect residents' rights, health, safety, and welfare; and remove any barriers to the optimal operation of the State Long-Term Care Ombudsman Program.
5. Contain recommendations from the State Long-Term Care Ombudsman Council regarding program functions and activities and recommendations for policy, regulatory, and statutory changes designed to protect residents' rights, health, safety, and welfare.

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

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; s. 4, ch. 2006-121.

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) Serve as an advisory body to assist the ombudsman in reaching a consensus among local councils on issues affecting residents and impacting the optimal operation of the program.

(b) Serve as an appellate body in receiving from the local councils complaints not resolved at the local level. Any individual member or members of the state council may enter any long-term care facility involved in an appeal, pursuant to the conditions specified in s. 400.0074(2).

(c) Assist the ombudsman to discover, investigate, and determine the existence of abuse or neglect in any long-term care facility, and work with the adult protective services program as required in ss. 415.101-415.113.

(d) Assist the ombudsman in eliciting, receiving, responding to, and resolving complaints made by or on behalf of residents.

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

(f) Assist the ombudsman in preparing the annual report described in s. 400.0065.

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

(a) Each local council shall elect by majority vote a representative from among the council members to represent the interests of the local council on the state council. A local council chair may not serve as the representative of the local council on the state council.

(b)1. The secretary, after consulting with the ombudsman, shall submit to the Governor a list of persons recommended for appointment to the at-large positions on the state council. The list shall not include the name of any person who is currently serving on a local council.

2. The Governor shall appoint three at-large members chosen from the list.

3. If the Governor does not appoint an at-large member to fill a vacant position within 60 days after the list is submitted, the secretary, after consulting with the ombudsman, shall appoint an at-large member to fill that vacant position.

(c)1. All state council members shall serve 3-year terms.

2. A member of the state council may not serve more than two consecutive terms.

1. A local council may recommend removal of its elected representative from the state council by a majority vote. If the council votes to remove its representative, the local council chair shall immediately notify the ombudsman. The secretary shall advise the Governor of the local council's vote upon receiving notice from the ombudsman.

2. The position of any member missing three state council meetings within a 1-year period without cause may be declared vacant by the ombudsman. The findings of the ombudsman regarding cause shall be final and binding.

5. Any vacancy on the state council shall be filled in the same manner as the original appointment.

(d)1. The state council shall elect a chair to serve for a term of 1 year. A chair may not serve more than two consecutive terms.

1. The chair shall select a vice chair from among the members. The vice chair shall preside over the state council in the absence of the chair.
2. The chair may create additional executive positions as necessary to carry out the duties of the state council. Any person appointed to an executive position shall serve at the pleasure of the chair, and his or her term shall expire on the same day as the term of the chair.
3. A chair may be immediately removed from office prior to the expiration of his or her term by a vote of two-thirds of all state council members present at any meeting at which a quorum is present. If a chair is removed from office prior to the expiration of his or her term, a replacement chair shall be chosen during the same meeting in the same manner as described in this paragraph, and the term of the replacement chair shall begin immediately. The replacement chair shall serve for the remainder of the term and is eligible to serve two subsequent consecutive terms.

(e)1. The state council shall meet upon the call of the chair or upon the call of the ombudsman. The council shall meet at least quarterly but may meet more frequently as needed.

1. A quorum shall be considered present if more than 50 percent of all active state council members are in attendance at the same meeting.
2. The state council may not vote on or otherwise make any decisions resulting in a recommendation that will directly impact the state council or any local council, outside of a publicly noticed meeting at which a quorum is present.

(f) Members shall receive no compensation but shall, with approval from the ombudsman, be reimbursed for per diem and travel expenses as provided in s. 112.061.

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; s. 6, ch. 2006-121.

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

(1)(a) The ombudsman shall designate local long-term care ombudsman councils to carry out the duties of the State Long-Term Care Ombudsman Program within local communities. Each local council shall function under the direction of the ombudsman.

(b) The ombudsman shall ensure that there is at least one local council operating in each of the department's planning and service areas. The ombudsman may create additional local councils as necessary to ensure that residents throughout the state have adequate access to State Long-Term Care Ombudsman Program services. The ombudsman, after approval from the secretary, shall designate the jurisdictional boundaries of each local council.

(2) The duties of the local councils are to:

(a) Serve as a third-party mechanism for protecting the health, safety, welfare, and civil and human rights of residents.

(b) 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.

(c) Elicit, receive, investigate, respond to, and resolve complaints made by or on behalf of residents.

(d) Review and, if necessary, comment on all existing or proposed rules, regulations, and other governmental policies and actions relating to long-term care facilities that may potentially have an effect on the rights, health, safety, and welfare of residents.

(e) Review personal property and money accounts of residents who are receiving assistance under the Medicaid program pursuant to an investigation to obtain information regarding a specific complaint or problem.

(f) Recommend that the ombudsman and the legal advocate seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.

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

(3) In order to carry out the duties specified in subsection (2), a member of a local council is authorized to enter any long-term care facility without notice or first obtaining a warrant, subject to the provisions of s. 400.0074(2).

(4) Each local council shall be composed of members whose primary residence is located within the boundaries of the local council's jurisdiction.

(a) The ombudsman shall strive to ensure that each local council include the following persons as members:

1. At least one medical or osteopathic physician whose practice includes or has included a substantial number of geriatric patients and who may practice in a long-term care facility;
- At least one registered nurse who has geriatric experience;
- At least one licensed pharmacist;
- At least one registered dietitian;
- At least six nursing home residents or representative consumer advocates for nursing home residents;
- 6. At least three residents of assisted living facilities or adult family-care homes or three representative consumer advocates for alternative long-term care facility residents;
- At least one attorney; and
- At least one professional social worker.

(b) In no case shall the medical director of a long-term care facility or an employee of the agency, the department, the Department of Children and Family Services, or the Agency for Persons with Disabilities serve as a member or as an ex officio member of a council. (5)(a) Individuals wishing to join a local council shall submit an application to the ombudsman. The ombudsman shall review the individual's application and advise the secretary of his or her recommendation for approval or disapproval of the candidate's membership on the local council. If the secretary approves of the individual's membership, the individual shall be appointed as a member of the local council.

(b) The secretary may rescind the ombudsman's approval of a member on a local council at any time. If the secretary rescinds the approval of a member on a local council, the ombudsman shall ensure that the individual is immediately removed from the local council on which he or she serves and the individual may no longer represent the State Long-Term Care Ombudsman Program until the secretary provides his or her approval.

(c) A local council may recommend the removal of one or more of its members by submitting to the ombudsman a resolution adopted by a two-thirds vote of the members of the council stating the name of the member or members recommended for removal and the reasons for the recommendation. If such a recommendation is adopted by a local council, the local council chair or district coordinator shall immediately report the council's recommendation to the ombudsman. The ombudsman shall review the recommendation of the local council and advise the secretary of his or her recommendation regarding removal of the council member or members. (6)(a) Each local council shall elect a chair for a term of 1 year. There shall be no limitation on the number of terms that an approved member of a local council may serve as chair.

(b) 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.

(c) The chair may create additional executive positions as necessary to carry out the duties of the local council. Any person appointed to an executive position shall serve at the pleasure of the chair, and his or her term shall expire on the same day as the term of the chair.

(d) A chair may be immediately removed from office prior to the expiration of his or her term by a vote of two-thirds of the members of the local council. If any chair is removed from office prior to the expiration of his or her term, a replacement chair shall be elected during the same meeting, and the term of the replacement chair shall begin immediately. The replacement chair shall serve for the remainder of the term of the person he or she replaced.

(7) Each local council shall meet upon the call of its chair or upon the call of the ombudsman. Each local council shall meet at least once a month but may meet more frequently if necessary.

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

(9) The local 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 councils in providing requested information and agency representation at council meetings.

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; s. 7, ch. 2006-121; s. 21, ch. 2006-197.

Note. Former s. 400.307.

#### 400.0070 Conflicts of interest.

(1) The 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.

(2) Each employee of the office, each state council member, and each local council member shall certify that he or she has no conflict of interest.

(3) The department shall define by rule:

(a) Situations that constitute a person having a conflict of interest that could materially affect the objectivity or capacity of a person to serve on an ombudsman council, or as an employee of the office, while carrying out the purposes of the State Long-Term Care Ombudsman Program as specified in this part.

(b) The procedure by which a person listed in subsection (2) shall certify that he or she has no conflict of interest. History. s. 8, ch. 2006-121.

#### 400.0071 State Long-Term Care Ombudsman Program complaint procedures.

The department shall adopt rules implementing state and local complaint procedures. The rules must include procedures for:

(1) Receiving complaints against a long-term care facility or an employee of a long-term care facility.

(2) Conducting investigations of a long-term care facility or an employee of a long-term care facility subsequent to receiving a complaint.

(3) Conducting onsite administrative assessments of long-term care facilities.

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; s. 9, ch. 2006-121.

Note. Former s. 400.311.

#### 400.0073 State and local ombudsman council investigations.

(1) A local council shall investigate, within a reasonable time after a complaint is made, any complaint of a resident, a representative of a resident, or any other credible source based on an action or omission by an administrator, an employee, or a representative of a 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; or
- (g) Otherwise adversely affecting the health, safety, welfare, or rights of a resident.

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

(3) Subsequent to an appeal from a local council, the state council may investigate any complaint received by the local council involving a long-term care facility or a resident.

(4) If the ombudsman or any state or local council member is not allowed to enter a long-term care facility, the administrator of the facility shall be considered to have interfered with a representative of the office, the state council, or the local council in the performance of official duties as described in s. 400.0083(1) and to have committed a violation of this part. The ombudsman shall report a facility's refusal to allow entry to the agency, and the agency shall record the report and take it into consideration when determining actions allowable under s. 400.102, s. 400.121, s. 429.14, s. 429.19, s. 429.69, or s. 429.71.

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; s. 10, ch. 2006-121; s. 22, ch. 2006-197; s. 76, ch. 2007-5; s. 53, ch. 2007-230.

Note. Former s. 400.314.

#### 400.0074 Local ombudsman council onsite administrative assessments.

(1) In addition to any specific investigation conducted pursuant to a complaint, the local council shall conduct, at least annually, an onsite administrative assessment of each nursing home, assisted living facility, and adult family-care home within its jurisdiction. This administrative assessment shall focus on factors affecting the rights, health, safety, and welfare of the residents. Each local council is encouraged to conduct a similar onsite administrative assessment of each additional long-term care facility within its jurisdiction.

(2) An onsite administrative assessment conducted by a local council shall be subject to the following conditions:

- (a) To the extent possible and reasonable, the administrative assessments shall not duplicate the efforts of the agency surveys and inspections conducted under part II of this chapter and parts I and II of chapter 429.
- (b) An administrative assessment shall be conducted at a time and for a duration necessary to produce the information required to carry out the duties of the local council.
- (c) Advance notice of an administrative assessment may not be provided to a long-term care facility, except that notice of followup assessments on specific problems may be provided.
- (d) A local council member physically present for the administrative assessment shall identify himself or herself and cite the specific statutory authority for his or her assessment of the facility.
- (e) An administrative assessment may not unreasonably interfere with the programs and activities of residents.
- (f) A local council member may not enter a single-family residential unit within a long-term care facility during an administrative assessment without the permission of the resident or the representative of the resident.
- (g) An administrative assessment must be conducted in a manner that will impose no unreasonable burden on a long-term care facility.

(3) Regardless of jurisdiction, the ombudsman may authorize a state or local council member to assist another local council to perform the administrative assessments described in this section.

(4) An onsite administrative assessment may not be accomplished by forcible entry. However, if the ombudsman or a state or local council member is not allowed to enter a long-term care facility, the administrator of the facility shall be considered to have interfered with a representative of the office, the state council, or the local council in the performance of official duties as described in s. 400.0083(1) and to have committed a violation of this part. The ombudsman shall report the refusal by a facility to allow entry to the agency, and the agency shall record the report and take it into consideration when determining actions allowable under s. 400.102, s. 400.121, s. 429.14, s. 429.19, s. 429.69, or s.

429.71.

History. s. 11, ch. 2006-121; s. 77, ch. 2007-5; s. 54, ch. 2007-230.

400.0075 Complaint notification and resolution procedures.

(1)(a) Any complaint or problem verified by an ombudsman council as a result of an investigation or onsite administrative assessment, which complaint or problem is determined to require remedial action by the local 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, with the concurrence of the local 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 council chair may, after obtaining approval from the ombudsman and a majority of the members of the local council:

1. Extend the target date if the chair has reason to believe such action would facilitate the resolution of the complaint.
2. In accordance with s. 400.0077, publicize the complaint, the recommendations of the council, and the response of the long-term care facility.
3. Refer the complaint to the state council.



(b) If the local council chair believes that the health, safety, welfare, or rights of the resident are in imminent danger, the chair shall notify the ombudsman or legal advocate, who, after verifying that such imminent danger exists, shall seek immediate legal or administrative remedies to protect the resident.

(c) If the ombudsman has reason to believe that the long-term care facility or an employee of the facility has committed a criminal act, the ombudsman shall provide the local law enforcement agency with the relevant information to initiate an investigation of the case.

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

1. In accordance with s. 400.0077, publicize the complaint, the recommendations of the local or state council, and the response of the long-term care facility.

2. Recommend to the department and the agency a series of facility reviews pursuant to s. 400.19, s. 429.34, or s. 429.67 to ensure correction and nonrecurrence of conditions that give rise to complaints against a long-term care facility.

1. Recommend to the department and the agency that the long-term care facility no longer receive payments under any state assistance program, including Medicaid.
2. Recommend to the department and the agency that procedures be initiated for revocation of the long-term care facility's license in accordance with chapter 120.

(b) If the state council chair believes that the health, safety, welfare, or rights of the resident are in imminent danger, the chair shall notify the ombudsman or legal advocate, who, after verifying that such imminent danger exists, shall seek immediate legal or administrative remedies to protect the resident.

(c) If the ombudsman has reason to believe that the long-term care facility or an employee of the facility has committed a criminal act, the ombudsman shall provide local law enforcement with the relevant information to initiate an investigation of the case.

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; s. 12, ch. 2006-121; s. 78, ch. 2007-5.

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 1s. 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. 429.14 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(10)(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; s. 23, ch. 2006-197; s. 33, ch. 2009-223.

Note. Repealed by s. 1, ch. 95-217.

Note. Former s. 400.321.

#### 400.0078 Citizen access to State Long-Term Care Ombudsman Program services.

(1) The office shall establish a statewide toll-free telephone number for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents.

(2) Every resident or representative of a resident shall receive, upon admission to a long-term care facility, information regarding the purpose of the State Long-Term Care Ombudsman Program, the statewide toll-free telephone number for receiving complaints, and other relevant information regarding how to contact the program. Residents or their representatives must be furnished additional copies of this information upon request.

History. s. 4, ch. 99-394; s. 13, ch. 2006-121.

#### 400.0079 Immunity.

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

(2) The ombudsman or any person authorized by the ombudsman to act on behalf of the office, as well as all members of the state and local councils, 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; s. 14, ch. 2006-121.

Note. Former s. 400.324.

#### 400.0081 Access to facilities, residents, and records.

(1) A long-term care facility shall provide the office, the state council and its members, and the local councils and their members access to:

(a) Any portion of the long-term care facility and any resident as necessary to investigate or resolve a complaint.

(b) Medical and social records of a resident for review as necessary to investigate or resolve a complaint, 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 or resolve a complaint, if:

1. A legal representative or guardian of the resident refuses to give permission;
2. The office has reasonable cause to believe that the representative or guardian is not acting in the best interests of the resident; and
3. The state or local council member obtains the approval of the ombudsman.

(d) The administrative records, policies, and documents to which 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) The department, in consultation with the ombudsman and the state council, may adopt rules to establish procedures to ensure access to facilities, residents, and records as described in this section.

History. ss. 11, 30, ch. 93-177; s. 131, ch. 2000-349; s. 51, ch. 2000-367; s. 15, ch. 2006-121.

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, the state council, or a local council in the performance of official duties.

(2) It shall be unlawful for any person, long-term care facility, or other entity to knowingly or willfully take action or 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, the state council, or a local council.

(3) Any person, long-term care facility, or other entity that violates this section:

(a) Shall be liable for damages and equitable relief as determined by law.

(b) 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; s. 16, ch. 2006-121. 400.0087 Department oversight; funding.

(1) The department shall meet the costs associated with the State Long-Term Care Ombudsman Program from funds appropriated to it.

(a) The department shall include the costs associated with support of the State Long-Term Care Ombudsman Program when developing its budget requests for consideration by the Governor and submittal to the Legislature.

(b) The department may divert from the federal ombudsman appropriation an amount equal to the department's administrative cost ratio to cover the costs associated with administering the program. The remaining allotment from the Older Americans Act program shall be expended on direct ombudsman activities.

(2) The department shall monitor the office, the state council, and the local councils to ensure that each is carrying out the duties delegated to it by state and federal law.

(3) The department is responsible for ensuring that the office:

(a) Has the objectivity and independence required to qualify it for funding under the federal Older Americans Act.

(b) Provides information to public and private agencies, legislators, and others.

(c) Provides appropriate training to representatives of the office or of the state or local councils.

(d) 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.

(4) The department shall also:

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

(b) Whenever necessary, act as liaison between agencies and branches of the federal and state governments and the State Long-Term Care Ombudsman Program.

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; s. 18, ch. 2006-121.

#### 400.0089 Complaint data reports.

The office 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 office shall publish quarterly and make readily available information pertaining to the number and types of complaints received by the State Long-Term Care Ombudsman Program and shall include such information in the annual report required under s. 400.0065.

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; s. 19, ch. 2006-121.

#### 400.0091 Training.

The ombudsman shall ensure that appropriate training is provided to all employees of the office and to the members of the state and local councils.

(1) All state and local council members and employees of the office shall be given a minimum of 20 hours of training upon employment with the office or approval as a state or local council member and 10 hours of continuing education annually thereafter.

(2) The ombudsman shall approve the curriculum for the initial and continuing education training, which must, at a minimum, address:

- (a) Resident confidentiality.
- (b) Guardianships and powers of attorney.
- (c) Medication administration.
- (d) Care and medication of residents with dementia and Alzheimer's disease.
- (e) Accounting for residents' funds.
- (f) Discharge rights and responsibilities.
- (g) Cultural sensitivity.
- (h) Any other topic recommended by the secretary.

(3) No employee, officer, or representative of the office or of the state or local councils, other than the ombudsman, may hold himself or herself out as a representative of the State Long-Term Care Ombudsman Program or conduct any authorized program duty described in this part unless the person has received the training required by this section and has been certified by the ombudsman as qualified to carry out ombudsman activities on behalf of the office or the state or local 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; s. 20, ch. 2006-121.

## CHAPTER 64B10-11 LICENSURE

64B10-11.001 Application for Examination 64B10-11.0011 Mandatory HIV/AIDS and Prevention of Medical Errors Education 64B10-11.002 Examination for Licensure 64B10-11.003 Reexamination 64B10-11.0061 Definitions 64B10-11.007 College Training in Health Administration 64B10-11.011 Provisional License (Repealed) 64B10-11.012 Notification of Change of Address or Employing Facility 64B10-11.013 Temporary License

### **64B10-11.001 Application for Licensure Fee.**

Any person desiring to be licensed as a nursing home administrator shall apply to the Board of Nursing Home Administrators. The application shall be made on the Application for Nursing Home Administrators Examination and Endorsement/Temporary form DHMQA-NHA002 (revised 07/10), hereby adopted and incorporated by reference, and can be obtained from the Board of Nursing Home Administrators' website at <http://www.doh.state.fl.us/mqa/nurshome/index.html>.

*Rulemaking Authority 456.033, 468.1685(1), (2), 468.1695(1) FS. Law Implemented 456.033, 468.1685(2), 468.1695(1), 468.1075 FS. History— New 12-26-79, Formerly 21Z-11.01, Amended 1-18-87, 10-2-88, 3-5-89, 3-15-90, 12-3-90, 11-3-92, Formerly 21Z-11.001, 61G12-11.001, Amended 12-4-95, 9-4-96, 7-21-97, Formerly 59T-11.001, Amended 5-15-00, 1-7-04, 2-15-06, 11-9-08, 10-24-10.*

### **64B10-11.0011 Mandatory HIV/AIDS and Prevention of Medical Errors Education.**

(1) Each licensee shall be required to complete no later than upon first renewal a Board-approved course on human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS). To receive Board-approval, courses on HIV/AIDS shall consist of one hour of instruction, which shall be approved by any board within the Department of Health's Medical Quality Assurance.

(2) Each applicant as a condition of initial licensure and each licensee as part of the renewal process shall complete a Board-approved two-hour course on the prevention of medical errors, which must contain the following components: root cause analysis; error reduction; prevention and patient safety.

*Rulemaking Authority 456.013(7), 456.033, 468.1685(1) FS. Law Implemented 456.013(7), 456.033(1) FS. History—New 8-30-05, Amended 3-18 09.*

### **64B10-11.002 Eligibility for Licensure.**

(1) Required Examinations.

(a) The Board approves the Nursing Home Administrators Examination developed and administered by the National Association of Boards of Examiners of Nursing Home Administrators.

(b) In addition to the national examination referenced in paragraph (1)(a) above, each applicant for licensure shall also be required to take an examination on the laws and regulations of the State of Florida which governs the practice of nursing home administrators.

(2) To establish eligibility for licensure as a nursing home administrator by examination under Section 468.1695, F.S., the applicant must successfully pass the required examinations in subsection (1), and must provide that the applicant holds:

(a) A baccalaureate degree from an accredited college or university with a major in health care administration or has credit for at least 60 semester hours in subjects as defined under Rule 64B10-11.007, F.A.C.; and

- Completed a college-affiliated or university-affiliated internship; or
- Completed a 1,000-hour nursing home administrator-in-training program approved by the Board; or

(b) A baccalaureate degree from an accredited college or university; and

1. Completed a 2,000-hour nursing home administrator-in-training program approved by the Board; or
2. Has one year of management experience by performing executive duties and skills, including the staffing, budgeting, and directing of resident care, dietary, and bookkeeping departments within a skilled nursing facility, hospital, hospice, assisted living facility with a minimum of 60 licensed beds, or geriatric residential treatment program. If, however, such experience is not in a skilled nursing facility, the applicant must complete the requirements of a 1,000-hour nursing home administrator-in-training program approved by the Board.

(3) To establish eligibility for licensure as a nursing home administrator by endorsement under Section 468.1705, F.S., the applicant must successfully pass the required examinations in subsection (1); and

(a) Hold a valid active license to practice nursing home administration in another state, provided that the current requirements for licensure in that state are substantially equivalent to, or more stringent than, the current requirements in the state of Florida; and

(b) Have practiced as a nursing home administrator for 2 years within the 5-year period immediately preceding the application by endorsement.

*Rulemaking Authority 456.017, 468.1685(1), 468.1695(1), (2) FS. Law Implemented 456.017, 468.1695(1), (2), 468.1705 FS. History—New 12-2679, Amended 3-1-82, 7-29-82, Formerly 21Z-11.02, Amended 1-18-87, 6-2-87, 12-3-90, Formerly 21Z-11.002, 61G12-11.002, Amended 7-16-95, Formerly 59T-11.002, Amended 5-15-00, 11-6-02, 8-30-05, 11-8-07.*

#### **64B10-11.003 Reexamination.**

(1) An applicant must pass both parts of the Nursing Home Administrators Examination (NAB) within one year of the date of application for licensure. If the applicant fails to pass both parts within the stated one-year period, the applicant must reapply and meet current licensing requirements.

(2) An applicant must pass both parts of the examination within one year from first failure; otherwise, the applicant must retake both parts of the examination and pay the full fees. The application shall be made on the Application for Nursing Home Administrators Re-Examination form DH-MQA 1129 (revised 7/10), hereby adopted and incorporated by reference and can be obtained from the Board of Nursing Home Administrators' website at <http://www.doh.state.fl.us/mqa/nurshome/index.html>.

*Rulemaking Authority 456.017(2), 468.1685(1) FS. Law Implemented 456.017(2) FS. History—New 12-26-79, Amended 3-1-82, 6-14-82, Formerly 21Z-11.03, Amended 3-5-89, 8-19-92, Formerly 21Z-11.003, 61G12-11.003, Amended 6-2-96, Formerly 59T-11.003, Amended 5-15-00, 11-6-02, 2-15-06, 4-22-09, 10-11-10.*

#### **64B10-11.0061 Definitions.**

(1) "Accredited College or University," for purposes of Section 468.1695, Florida Statutes, means an academic institution of higher learning which includes general education courses as requisite to such institution's principal educational programs and which institution has received institutional accreditation from an accrediting body approved by the United States Department of Education, the Council on Recognition of Postsecondary Accreditation, or the Council on Postsecondary Education.

(2) "Administrator-in-Training Program" means an internship which satisfies Rule Chapter 64B10-16, F.A.C.

*Rulemaking Authority 468.1685(1), 468.1695 FS. Law Implemented 468.1695 FS. History—New 10-2-88, Formerly 21Z-11.0061, 61G12-11.0061, Amended 2-22-96, 7-21-97, Formerly 59T-11.0061.*

#### **64B10-11.007 College Training in Health Administration.**

(1) Courses from the following subject areas are required to fulfill the 60 semester hour requirement pursuant to Section 468.1695(2)(a)1., F.S.:

(a) General administration and management of health care facilities (minimum 6 hours).

(b) Accounting and financial management (minimum 6 hours).

(c) Personnel management and labor relations (minimum 3 hours).

(d) Computer applications (minimum 3 hours).

(e) Long-term health care administration (minimum 3 hours).

(f) Health care planning and delivery systems (minimum 3 hours).

(g) Aging (minimum 3 hours).

(h) Governmental standards and regulation of long-term health care (minimum 3 hours).

(i) Legal aspects of health care administration (minimum 3 hours).

(j) Patient care management (minimum 3 hours).

(2) Persons seeking to qualify pursuant to subsection (1) shall provide official transcripts.

*Rulemaking Authority 468.1685(1), 468.1695(2) FS. Law Implemented 468.1695(2) FS. History--New 12-26-79, Amended 3-24-81, 7-31-83, Formerly 21Z-11.07, Amended 4-22-87, 10-2-88, Formerly 21Z-11.007, 61G12-11.007, Amended 10-17-94, 7-21-97, Formerly 59T-11.007, Amended 8-30-05.*

**64B10-11.011 Provisional License.**

*Rulemaking Authority 468.1685(1), 468.1735 FS. Law Implemented 468.1735 FS. History--New 12-6-79, Amended 8-17-81, Formerly 21Z-11.11, Amended 4-22-87, Formerly 21Z-11.011, 61G12-11.011, Amended 7-21-97, Formerly 59T-11.011, Amended 10-30-00, 8-30-05, 11-9-06, 8-13-08, 4-22-09, Repealed 5-23-10.*

**64B10-11.012 Notification of Change of Address or Employing Facility.** Within 48 hours of assuming or leaving a position as a nursing home administrator, assistant nursing home administrator or any change in the identity of the employing facility within the State of Florida, each licensee must inform the Department of Health, Board of Nursing Home Administrators, 4052 Bald Cypress Way, Bin C07, Tallahassee, Florida 32399-3257, in writing of the exact date of assuming or leaving the position, or change in the identity of the facility. The notification shall be made on the Change of Address of Employing Facility, Form DH-MQA 1130 (revised 06/09 hereby adopted and incorporated by reference) and can be obtained from the Board of Nursing Home Administrators' website at <http://www.doh.state.fl.us/mqa/nurshome/index.html>.

*Rulemaking Authority 456.035, 468.1685(1), (5), (7), (8) FS. Law Implemented 456.035, 468.1685(5), (7), (8) FS. History--New 6-14-82, Formerly 21Z-11.12, 21Z-11.012, Amended 10-26-93, Formerly 61G12-11.012, Amended 10-17-94, 7-27-97, Formerly 59T-11.012, Amended 11-6-02, 12-306, 10-24-10.*

**64B10-11.013 Temporary License.** The determination of eligibility for temporary licensure shall be made by a committee appointed by the Chairman, and shall be ratified by the Board at its next meeting. This temporary license shall expire upon notification to the applicant of the applicant's certified laws and rules examination results.

*Rulemaking Authority 468.1685(1), (2) FS. Law Implemented 468.1705(4) FS. History--New 4-22-87, Amended 12-3-90, Formerly 21Z-11.013, 61G12-11.013, 59T-11.013, Amended 10-12-97, 2-14-06, 4-22-09.*