CHAPTER 2001-45

Committee Substitute for Committee Substitute for Committee Substitute for Senate Bill No. 1202

An act relating to long-term care; amending s. 400.0073, F.S.; clarifying duties of the local ombudsman councils with respect to inspections of nursing homes and long-term care facilities; amending s. 400.021, F.S.; defining the terms "controlling interest" and "voluntary board member" and revising the definition of "resident care plan" for purposes of part II of ch. 400, F.S., relating to the regulation of nursing homes; requiring the Agency for Health Care Administration and the Office of the Attorney General to study the use of electronic monitoring devices in nursing homes; requiring a report; amending s. 400.023, F.S.; providing for election of survival damages, wrongful death damages, or recovery for negligence; providing for attorney's fees for injunctive relief or administrative remedy; providing that ch. 766, F.S., does not apply to actions under this section; providing burden of proof; providing that a violation of a right is not negligence per se; prescribing the duty of care; prescribing a nurse's duty of care; eliminating presuit provisions; eliminating the requirement for presuit mediation; creating s. 400.0233, F.S; providing for presuit notice; prohibiting the filing of suit for a specified time; requiring a response to the notice; tolling the statute of limitations; limiting discovery of presuit investigation documents; limiting liability of presuit investigation participants; authorizing the obtaining of opinions from a nurse or doctor; authorizing the obtaining of unsworn statements; authorizing discovery of relevant documents; prescribing the time for acceptance of settlement offers; requiring mediation; prescribing the time to file suit; creating s. 400.0234, F.S.; requiring the availability of facility records for presuit investigation; specifying the records to be made available; specifying what constitutes evidence of failure to make records available in good faith; specifying the consequences of such failure; creating s. 400.0235, F.S.; providing that the provisions of s. 768.21(8), F.S., do not apply to actions under part II of ch. 400, F.S.; creating s. 400.0236, F.S.; providing a statute of limitations; providing a statute of limitations when there is fraudulent concealment or intentional misrepresentation of fact; providing for application of the statute of limitation to accrued actions; creating s. 400.0237, F.S.; requiring evidence of the basis for punitive damages; prohibiting discovery relating to financial worth; providing for proof of punitive damages; defining the terms "intentional misconduct" and "gross negligence"; prescribing criteria governing employers' liability for punitive damages; providing for the remedial nature of provisions; creating s. 400.0238, F.S.; prescribing limits on the amount of punitive damages; providing for a criminal investigation with a finding of liability for punitive damages under certain circumstances; providing for the admissibility of findings in subsequent civil and criminal actions; providing for the calculation of attorney's fees; providing for a division of punitive damages; amending s. 768.735, F.S.; providing that

the section is inapplicable to actions brought under ch. 400, F.S.; amending s. 415.1111, F.S.; limiting actions against nursing homes and assisted living facilities; amending s. 400.0255, F.S.; providing for applicability of provisions relating to transfer or discharge of nursing home residents; amending s. 400.062, F.S.; increasing the bed license fee for nursing home facilities; amending s. 400.071, F.S.; revising license application requirements; requiring certain disclosures; authorizing the Agency for Health Care Administration to issue an inactive license; requiring quality assurance and risk-management plans; amending s. 400.102, F.S.; providing additional grounds for action by the agency against a licensee; amending s. 400.111, F.S.; prohibiting renewal of a license if an applicant has failed to pay certain fines; requiring licensees to disclose financial or ownership interests in certain entities; authorizing placing fines in escrow; amending s. 400.118, F.S.; revising duties of quality-of-care monitors in nursing facilities; creating s. 400.1183, F.S.; providing for resident grievance procedures; amending s. 400.121, F.S.; specifying additional circumstances under which the agency may deny, revoke, or suspend a facility's license or impose a fine; authorizing placing fines in escrow; requiring that the agency revoke or deny a nursing home license under specified circumstances; providing standards for administrative proceedings; providing for the agency to assess the costs of an investigation and prosecution; specifying facts and conditions upon which administrative actions that are challenged must be reviewed; amending s. 400.126, F.S.; requiring an assessment of residents in nursing homes under receivership; providing for alternative care for qualified residents; amending s. 400.141, F.S.; providing additional administrative and management requirements for licensed nursing home facilities; requiring a facility to submit information on staff-to-resident ratios, staff turnover, and staff stability; requiring that certain residents be examined by a licensed physician; providing requirements for dining and hospitality attendants; requiring additional reports to the agency; requiring liability insurance coverage; requiring daily charting of specified certified nursing assistant services; creating s. 400.1413, F.S.; authorizing nursing homes to impose certain requirements on volunteers; creating s. 400.147, F.S.; requiring each licensed nursing home facility to establish an internal risk management and quality assurance program; providing requirements of the program; requiring the use of incident reports; defining the term “adverse incident”; requiring that the agency be notified of adverse incidents; requiring reporting of liability claims; specifying duties of the internal risk manager; requiring the reporting of sexual abuse; limiting the liability of a risk manager; requiring that the agency report certain conduct to the appropriate regulatory board; requiring that the agency annually report to the Legislature on the internal risk management of nursing homes; creating s. 400.148, F.S.; providing for a pilot project to coordinate resident quality of care through the use of medical personnel to monitor patients; providing purpose; providing for appointment of guardians; creating s. 400.1755, F.S.; prescribing training standards for employees of nursing homes that provide care

for persons with Alzheimer's disease or related disorders; amending s. 400.19, F.S.; requiring the agency to conduct surveys of certain facilities cited for deficiencies; providing for a survey fine; providing for inspections; amending s. 400.191, F.S.; requiring the agency to publish a Nursing Home Guide Watch List; specifying contents of the watch list; specifying distribution of the watch list; requiring that nursing homes post certain additional information; amending s. 400.211, F.S.; revising employment requirements for nursing assistants; requiring inservice training; amending s. 400.23, F.S.; revising minimum staffing requirements for nursing homes; requiring the documentation and posting of compliance with such standards; requiring correction of deficiencies prior to change in conditional status; providing definitions of deficiencies; adjusting the fines imposed for certain deficiencies; amending s. 400.235, F.S.; revising requirements for the Gold Seal Program; creating s. 400.275, F.S.; providing for training of nursing home survey teams; amending s. 400.407, F.S.; revising certain licensing requirements; providing for the biennial license fee to be based on number of beds; amending s. 400.414, F.S.; specifying additional circumstances under which the Agency for Health Care Administration may deny, revoke, or suspend a license; providing for issuance of a temporary license; amending s. 400.419, F.S.; increasing the fines imposed for certain violations; creating s. 400.423, F.S.; requiring certain assisted living facilities to establish an internal risk management and quality assurance program; providing requirements of the program; requiring the use of incident reports; defining the term "adverse incident"; requiring that the agency be notified of adverse incidents and of liability claims; requiring reporting of liability claims; requiring that the agency report certain conduct to the appropriate regulatory board; requiring that the agency annually report to the Legislature on the internal risk management of assisted living facilities; amending s. 400.426, F.S.; requiring that certain residents be examined by a licensed physician; amending s. 400.428, F.S.; revising requirement for notice of a resident's relocation or termination from a facility; providing a penalty; amending s. 400.429, F.S.; providing for election of survival damages, wrongful death damages, or recovery for negligence; providing for attorney's fees for injunctive relief or administrative remedy; providing that ch. 766, F.S., does not apply to actions under this section; prescribing the burden of proof; providing that a violation of a right is not negligence per se; prescribing the duty of care; prescribing a nurse's duty of care; eliminating presuit provisions; eliminating the requirement for presuit mediation; requiring copies of complaints filed in court to be provided to the agency; creating s. 400.4293, F.S; providing for presuit notice; prohibiting the filing of suit for a specified time; requiring a response to the notice; tolling the statute of limitations; limiting the discovery of presuit investigation documents; limiting liability of presuit investigation participants; authorizing the obtaining of opinions from a nurse or doctor; authorizing the obtaining of unsworn statements; authorizing discovery of relevant documents; prescribing a time for acceptance of settlement offers; requiring mediation; prescribing the

time to file suit; creating s. 400.4294, F.S.; requiring the availability of facility records for presuit investigation; specifying the records to be made available; specifying what constitutes evidence of failure to make records available in good faith; specifying the consequences of such failure; creating s. 400.4295, F.S.; providing that the provisions of s. 768.21(8), F.S., do not apply to actions under part III of ch. 400, F.S.; creating s. 400.4296, F.S.; providing a statute of limitations; providing a statute of limitations when there is fraudulent concealment or intentional misrepresentation of fact; providing for application of the statute of limitation to accrued actions; creating s. 400.4297, F.S.; requiring evidence of the basis for punitive damages; prohibiting discovery relating to financial worth; providing for proof of punitive damages; defining the terms "intentional misconduct" and "gross negligence"; prescribing criteria governing employers' liability for punitive damages; providing for the remedial nature of provisions; creating s. 400.4298, F.S.; providing limits on the amount of punitive damages; providing for a criminal investigation with a finding of liability for punitive damages under certain circumstances; providing for the admissibility of findings in subsequent civil and criminal actions; providing for the calculation of attorney's fees; providing for a division of punitive damages; amending s. 400.434, F.S.; authorizing the Agency for Health Care Administration to use information obtained by certain councils; amending s. 400.441, F.S.; clarifying facility inspection requirements; creating s. 400.449, F.S.; prohibiting the alteration or falsification of medical or other records of an assisted living facility; providing penalties; amending s. 409.908, F.S.; prohibiting nursing home reimbursement rate increases associated with changes in ownership; modifying requirements for nursing home cost reporting; requiring a report; authorizing waivers to treat a portion of the Medicaid nursing home per diem as capital for a risk-retention group; amending s. 464.203, F.S.; revising certification requirements for nursing assistants; authorizing employment of certain nursing assistants pending certification; requiring continuing education; amending s. 397.405, F.S., relating to service providers; conforming provisions to changes made by the act; prohibiting the issuance of a certificate of need for additional community nursing home beds; providing intent for such prohibition; providing an exemption; reenacting s. 400.0255(3) and (8), F.S., relating to discharge or transfer of residents; reenacting s. 400.23(5), F.S., relating to rules for standards of care for persons under a specified age residing in nursing home facilities; reenacting s. 400.191(2) and (6), F.S., relating to requirements for providing information to consumers; reenacting s. 400.0225, F.S., relating to consumer satisfaction surveys for nursing homes; reenacting s. 400.141(4) and (5), F.S., relating to the repackaging of residents' medication and access to other health-related services; reenacting s. 400.235(3)(a), (4), and (9), F.S., relating to designation under the nursing home Gold Seal Program; reenacting s. 400.962(1), F.S., relating to the requirement for licensure under pt. XI of ch. 400, F.S.; reenacting s. 10 of ch. 2000-350, Laws of Florida, relating to requirements for a study of the use of automated medication-dispensing

machines in nursing facilities and for demonstration projects and a report; amending s. 400.562, F.S.; revising requirements for standards to be included in rules implementing part V of ch. 400, F.S.; providing for applicability of specified provisions of the act; requiring the Auditor General to develop a standard chart of accounts for Medicaid long-term care provider cost reporting; requiring implementation by the agency by a specified date; requiring the agency to amend the Medicaid Title XIX Long-Term Care Reimbursement Plan to include specified provisions; providing for office space for the Office of State Long-Term Care Ombudsman; prohibiting enforcement of provisions relating to a requirements for liability insurance until a specified date; providing appropriations; providing for severability; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) of section 400.0073, Florida Statutes, is amended to read:

400.0073 State and local ombudsman council investigations.—

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

Section 2. Section 400.021, Florida Statutes, is amended to read:

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

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

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

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

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

(5) "Controlling interest" means:

(a) The applicant for licensure or a licensee;

(b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5 percent or greater ownership interest in the manage-

ment company or other entity, related or unrelated, which the applicant or licensee may contract with to operate the facility; or

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

The term does not include a voluntary board member.

(6)~~(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.

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

(8)~~(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.

(9)~~(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.

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

(11)~~(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.

(12)~~(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.

(13)~~(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.

(14)~~(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.

(15)~~(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.

(16)~~(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.

(17)~~(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 and the resident, the resident's designee, or the resident's legal representative.

(18)~~(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.

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

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

Section 3. The Agency for Health Care Administration and the Office of the Attorney General shall jointly study the potential use of electronic monitoring devices in nursing home facilities licensed under part II of chapter 400, Florida Statutes. The study shall include, but not be limited to, a review of the current use of electronic monitoring devices by nursing home facilities and their residents and other health care facilities; an analysis of other state laws and proposed legislation related to the mandated use of electronic monitoring devices in nursing home facilities; an analysis of the potential ramifications of requiring facilities to install such devices when requested by or on behalf of a resident; the impact of the devices on the privacy and dignity of the resident on whose behalf the device is installed and other residents who may be affected by the device; the potential impact on improving the care of residents; the potential impact on the care environment and

on staff recruitment and retention; appropriate uses of any tapes if mandated by law, including methods and timeframes for reporting any questionable incidents to the facility and appropriate regulatory agencies; appropriate security needed to protect the integrity of tapes for the protection of the resident and direct-care staff; and the potential ramifications on the care environment of allowing the use of recorded tapes in legal proceedings, including any exceptions that should apply if prohibited. The Agency for Health Care Administration shall lead the study and shall submit the findings and recommendations of the study to the Governor, the President of the Senate, and Speaker of the House of Representatives by January 1, 2002.

Section 4. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.023, Florida Statutes, is amended to read:

400.023 Civil enforcement.—

(1) Any resident whose rights as specified in this part are violated ~~deprived or infringed upon~~ shall have a cause of action ~~against any licensee responsible for the violation~~. 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 ~~when the cause of death resulted from the deprivation or infringement of the decedent's rights~~. 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 ~~deprivation or infringement on~~ 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. ~~Any plaintiff who prevails in any such action may be entitled to recover reasonable attorney's fees, costs of the action, and damages, unless the court finds that the plaintiff has acted in bad faith, with malicious purpose, and that there was a complete absence of a justiciable issue of either law or fact. A prevailing defendant may be entitled to recover~~

~~reasonable attorney's fees pursuant to s. 57.105. The remedies provided in this section are in addition to and cumulative with other legal and administrative remedies available to a resident and to the agency.~~

(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.

~~(2) Attorneys' fees shall be based on the following criteria:~~

~~(a) The time and labor required;~~

~~(b) The novelty and difficulty of the questions;~~

~~(c) The skill requisite to perform the legal service properly;~~

~~(d) The preclusion of other employment by the attorney due to the acceptance of the case;~~

~~(e) The customary fee;~~

~~(f) Whether the fee is fixed or contingent;~~

~~(g) The amount involved or the results obtained;~~

~~(h) The experience, reputation, and ability of the attorneys;~~

~~(i) The costs expended to prosecute the claim;~~

~~(j) The type of fee arrangement between the attorney and the client;~~

~~(k) Whether the relevant market requires a contingency fee multiplier to obtain competent counsel;~~

~~(l) Whether the attorney was able to mitigate the risk of nonpayment in any way.~~

(3) In any claim brought pursuant to s. 400.023, 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)~~(3)~~ 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 provision of s. 768.21(8) do not apply to a claim alleging death of the resident.

~~(4) Claimants alleging a deprivation or infringement of adequate and appropriate health care pursuant to s. 400.022(1)(k) which resulted in personal injury to or the death of a resident shall conduct an investigation which shall include a review by a licensed physician or registered nurse familiar with the standard of nursing care for nursing home residents pursuant to this part. Any complaint alleging such a deprivation or infringement shall be accompanied by a verified statement from the reviewer that there exists reason to believe that a deprivation or infringement occurred during the resident's stay at the nursing home. Such opinion shall be based on records or other information available at the time that suit is filed. Failure to provide records in accordance with the requirements of this chapter shall waive the requirement of the verified statement.~~

~~(5) For the purpose of this section, punitive damages may be awarded for conduct which is willful, wanton, gross or flagrant, reckless, or consciously indifferent to the rights of the resident.~~

~~(6) To recover attorney's fees under this section, the following conditions precedent must be met:~~

~~(a) Within 120 days after the filing of a responsive pleading or defensive motion to a complaint brought under this section and before trial, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with this paragraph for the purpose of an early resolution of the matter.~~

~~1. Within 60 days after the filing of the responsive pleading or defensive motion, the parties shall:~~

~~a. Agree on a mediator. If the parties cannot agree on a mediator, the defendant shall immediately notify the court, which shall appoint a mediator within 10 days after such notice.~~

~~b. Set a date for mediation.~~

~~c. Prepare an order for the court that identifies the mediator, the scheduled date of the mediation, and other terms of the mediation. Absent any disagreement between the parties, the court may issue the order for the mediation submitted by the parties without a hearing.~~

~~2. The mediation must be concluded within 120 days after the filing of a responsive pleading or defensive motion. The date may be extended only by agreement of all parties subject to mediation under this subsection.~~

~~3. The mediation shall be conducted in the following manner:~~

~~a. Each party shall ensure that all persons necessary for complete settlement authority are present at the mediation.~~

~~b. Each party shall mediate in good faith.~~

~~4. All aspects of the mediation which are not specifically established by this subsection must be conducted according to the rules of practice and procedure adopted by the Supreme Court of this state.~~

~~(b) If the parties do not settle the case pursuant to mediation, the last offer of the defendant made at mediation shall be recorded by the mediator in a written report that states the amount of the offer, the date the offer was made in writing, and the date the offer was rejected. If the matter subsequently proceeds to trial under this section and the plaintiff prevails but is awarded an amount in damages, exclusive of attorney's fees, which is equal to or less than the last offer made by the defendant at mediation, the plaintiff is not entitled to recover any attorney's fees.~~

~~(c) This subsection applies only to claims for liability and damages and does not apply to actions for injunctive relief.~~

~~(d) This subsection applies to all causes of action that accrue on or after October 1, 1999.~~

~~(7) Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.~~

~~(8) In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.~~

Section 5. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.0233, Florida Statutes, is created to read:

400.0233 Presuit notice; investigation; notification of violation of resident's rights or alleged negligence; claims evaluation procedure; informal discovery; review.—

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

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

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

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

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

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

2. Internal review by counsel for each prospective defendant;

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

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

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

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

1. Rejecting the claim; or

2. Making a settlement offer.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer of the defendant to reply to the notice within 75 days after receipt shall be deemed a rejection of the claim for purposes of this section.

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

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

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

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

(a) Unsworn statements.—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of claims evaluation and are not discoverable or admissible in any civil action for any purpose by any party. A party seeking to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at

the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

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

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

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

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

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

Section 6. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.0234, Florida Statutes, is created to read:

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.

Section 7. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.0235, Florida Statutes, is created to read:

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.

Section 8. Effective May 15, 2001, section 400.0236, Florida Statutes, is created to read:

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.

Section 9. Section 400.0237, Florida Statutes, is created to read:

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.

Section 10. Section 400.0238, Florida Statutes, is created to read:

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 State Treasurer 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 Banking and Finance shall collect or cause to be collected all payments due the state under this section. Such payments are made to the Comptroller 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.

Section 11. Subsection (1) and paragraph (a) of subsection (2) of section 768.735, Florida Statutes, are amended and subsection (3) is added to that section to read:

768.735 Punitive damages; exceptions; limitation.—

(1) Sections 768.72(2)-(4), 768.725, and 768.73 do not apply to any civil action based upon child abuse, abuse of the elderly under chapter 415, or abuse of the developmentally disabled ~~or any civil action arising under chapter 400~~. Such actions are governed by applicable statutes and controlling judicial precedent. This section does not apply to claims brought pursuant to s. 400.023 or s. 400.429.

(2)(a) In any civil action based upon child abuse, abuse of the elderly under chapter 415, or abuse of the developmentally disabled, ~~or actions arising under chapter 400~~ and involving the award of punitive damages, the judgment for the total amount of punitive damages awarded to a claimant may not exceed three times the amount of compensatory damages awarded to each person entitled thereto by the trier of fact, except as provided in paragraph (b). This subsection does not apply to any class action.

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

Section 12. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 415.1111, Florida Statutes, is amended to read:

415.1111 Civil actions.—A vulnerable adult who has been abused, neglected, or exploited as specified in this chapter has a cause of action against any perpetrator and may recover actual and punitive damages for such abuse, neglect, or exploitation. The action may be brought by the vulnerable adult, or that person's guardian, by a person or organization acting on behalf of the vulnerable adult with the consent of that person or that person's guardian, or by the personal representative of the estate of a deceased victim

without regard to whether the cause of death resulted from the abuse, neglect, or exploitation. The action may be brought in any court of competent jurisdiction to enforce such action and to recover actual and punitive damages for any deprivation of or infringement on the rights of a vulnerable adult. A party who prevails in any such action may be entitled to recover reasonable attorney's fees, costs of the action, and damages. The remedies provided in this section are in addition to and cumulative with other legal and administrative remedies available to a vulnerable adult. Notwithstanding the foregoing, any civil action for damages against any licensee or entity who establishes, controls, conducts, manages, or operates a facility licensed under part II of chapter 400 relating to its operation of the licensed facility shall be brought pursuant to s. 400.023, or against any licensee or entity who establishes, controls, conducts, manages, or operates a facility licensed under part III of chapter 400 relating to its operation of the licensed facility shall be brought pursuant to s. 400.429. Such licensee or entity shall not be vicariously liable for the acts or omissions of its employees or agents or any other third party in an action brought under this section.

Section 13. Subsection (17) is added to section 400.0255, Florida Statutes, to read:

400.0255 Resident transfer or discharge; requirements and procedures; hearings.—

(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.

Section 14. Subsection (3) of section 400.062, Florida Statutes, is amended to read:

400.062 License required; fee; disposition; display; transfer.—

(3) The annual license fee required for each license issued under this part shall be comprised of two parts. Part I of the license fee shall be the basic license fee. The rate per bed for the basic license fee shall be established annually and shall be $50 per bed. The agency may adjust the per bed licensure fees by the Consumer Price Index based on the 12 months immediately preceding the increase ~~must be reasonably calculated~~ to cover the cost of regulation under this part~~, but may not exceed $35 per bed~~. Part II of the license fee shall be the resident protection fee, which shall be at the rate of not less than 25 cents per bed. The rate per bed shall be the minimum rate per bed, and such rate shall remain in effect until the effective date of a rate per bed adopted by rule by the agency pursuant to this part. At such time as the amount on deposit in the Resident Protection Trust Fund is less than $1 million ~~$500,000~~, the agency may adopt rules to establish a rate which may not exceed $10 per bed. The rate per bed shall revert back to the minimum rate per bed when the amount on deposit in the Resident Protection Trust Fund reaches $1 million ~~$500,000~~, 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 ~~$800,000~~ shall revert to the Health Care Trust Fund and may not be expended without prior approval of the Legislature.

The agency may prorate the annual license fee for those licenses which it issues under this part for less than 1 year. Funds generated by license fees collected in accordance with this section shall be deposited in the following manner:

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

(b) The resident protection fee collected shall be deposited in the Resident Protection Trust Fund for the sole purpose of paying, in accordance with the provisions of s. 400.063, for the appropriate alternate placement, care, and treatment of a resident removed from a nursing home facility on a temporary, emergency basis or for the maintenance and care of residents in a nursing home facility pending removal and alternate placement.

Section 15. Subsections (2) and (5) of section 400.071, Florida Statutes, are amended, and subsections (11) and (12) are added to that section, to read:

400.071 Application for license.—

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

(a) The name, address, and social security number of the applicant if an individual; if the applicant is a firm, partnership, or association, its name, address, and employer identification number (EIN), and the name and address of <u>any controlling interest</u> ~~every member; if the applicant is a corporation, its name, address, and employer identification number (EIN), and the name and address of its director and officers and of each person having at least a 5 percent interest in the corporation~~; and the name by which the facility is to be known.

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

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

(d) The name of the person or persons under whose management or supervision the facility will be conducted and the name of <u>the</u> ~~its licensed~~ administrator.

<u>(e) A signed affidavit disclosing any financial or ownership interest that a person or entity described in paragraph (a) or paragraph (d) has held in</u>

the last 5 years in any entity licensed by this state or any other state to provide health or residential care which has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. The affidavit must disclose the reason any such entity was closed, whether voluntarily or involuntarily.

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

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

(h)~~(g)~~ 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.

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

(11) The agency may issue an inactive license to a nursing home that will be temporarily unable to provide services but that is reasonably expected to resume services. Such designation may be made for a period not to exceed 12 months but may be renewed by the agency for up to 6 additional months. Any request by a licensee that a nursing home become inactive must be submitted to the agency and approved by the agency prior to initiating any suspension of service or notifying residents. Upon agency approval, the nursing home shall notify residents of any necessary discharge or transfer as provided in s. 400.0255.

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

Section 16. Subsection (1) of section 400.102, Florida Statutes, is amended to read:

400.102 Action by agency against licensee; grounds.—

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

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

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

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

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

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

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

Section 17. Subsections (3) and (4) are added to section 400.111, Florida Statutes, to read:

400.111 Expiration of license; renewal.—

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

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

Section 18. Subsection (2) of section 400.118, Florida Statutes, is amended to read:

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

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

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

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

shall not apply when the quality-of-care monitor makes a report to the appropriate authorities regarding a threat to the health or safety of a resident.

Section 19. Section 400.1183, Florida Statutes, is created to read:

400.1183 Resident grievance procedures.—

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

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

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

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

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

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

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

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

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

Section 20. Section 400.121, Florida Statutes, is amended to read:

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

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

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

(b) A demonstrated pattern of deficient practice;

(c) Failure to pay any outstanding fines assessed by final order of the agency or final order of the Health Care Financing Administration pursuant to requirements for federal certification. The agency may renew or approve

the license of an applicant following the assessment of a fine by final order if such fine has been paid into an escrow account pending an appeal of a final order;

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

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

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

(2) Except as provided in s. 400.23(8), a $500 fine shall be imposed ~~The agency, as a part of any final order issued by it under this part, may impose such fine as it deems proper, except that such fine may not exceed $500~~ for each violation. Each day a violation of this part occurs constitutes a separate violation and is subject to a separate fine, but in no event may any fine aggregate more than $5,000. A fine may be levied pursuant to this section in lieu of and notwithstanding the provisions of s. 400.23. Fines paid ~~by any nursing home facility licensee under this subsection~~ shall be deposited in the Resident Protection Trust Fund and expended as provided in s. 400.063.

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

(a) Has had two moratoria imposed by final order for substandard quality of care, as defined by Title 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)~~(3)~~ The agency may issue an order immediately suspending or revoking a license when it determines that any condition in the facility presents a danger to the health, safety, or welfare of the residents in the facility.

(5)~~(4)~~(a) The agency may impose an immediate moratorium on admissions to any facility when the agency determines that any condition in the

facility presents a threat to the health, safety, or welfare of the residents in the facility.

(b) Where the agency has placed a moratorium on admissions on any facility two times within a 7-year period, the agency may suspend the license of the nursing home and the facility's management company, if any. ~~The licensee shall be afforded an administrative hearing within 90 days after the suspension to determine whether the license should be revoked.~~ During the suspension, the agency shall take the facility into receivership and shall operate the facility.

(6)~~(5)~~ An action taken by the agency to deny, suspend, or revoke a facility's license under this part~~, in which the agency claims that the facility owner or an employee of the facility has threatened the health, safety, or welfare of a resident of the facility,~~ shall be heard by the Division of Administrative Hearings of the Department of Management Services within 60 ~~120~~ days after the assignment of an administrative law judge ~~receipt of the facility's request for a hearing~~, 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. ~~This subsection does not modify the requirement that an administrative hearing be held within 90 days after a license is suspended under paragraph (4)(b).~~

(7)~~(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.

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

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

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

Section 21. Subsection (12) is added to section 400.126, Florida Statutes, to read:

400.126 Receivership proceedings.—

(12) Concurrently with the appointment of a receiver, the agency and the Department of Elderly Affairs shall coordinate an assessment of each resi-

dent 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.

Section 22. Subsections (14), (15), (16), (17), (18), (19), and (20) are added to section 400.141, Florida Statutes, to read:

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

(14) Submit to the agency the information specified in s. 400.071(2)(e) for a management company within 30 days after the effective date of the management agreement.

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

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

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

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

(d) A nursing facility that has failed to comply with state minimum-staffing requirements for 2 consecutive days is prohibited from accepting new admissions until the facility has achieved the minimum-staffing requirements for a period of 6 consecutive days. For the purposes of this paragraph, any person who was a resident of the facility and was absent

from the facility for the purpose of receiving medical care at a separate location or was on a leave of absence is not considered a new admission. Failure to impose such an admissions moratorium constitutes a class II deficiency.

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

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

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

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

(20) Maintain liability insurance coverage that is in force at all times.

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

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 its program.

Section 23. Section 400.1413, Florida Statutes, is created to read:

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.

Section 24. Section 400.147, Florida Statutes, is created to read:

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 work papers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management and quality assurance program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

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

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

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

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

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

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

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

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

(d) Resident elopement; or

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

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

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

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

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

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

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

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

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

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

(9) Each facility subject to this section shall report monthly any liability claim filed against it. The report must include the name of the resident, the date or dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is confidential as provided by law and is not discoverable or admissible in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.

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

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

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

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

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

(a) The total number of adverse incidents.

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

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

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

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

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

Section 25. Section 400.148, Florida Statutes, is created to read:

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

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

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

(3) The pilot project must ensure:

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

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

(c) Frequent onsite visits to the resident;

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

(e) Close communication with regulatory staff;

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

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

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

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

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

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

Section 26. Section 400.1755, Florida Statutes, is created to read:

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, promot-

ing the resident's independence in activities of daily living, and skills in working with families and caregivers.

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

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

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

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

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

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

Section 27. Subsections (3) and (4) of section 400.19, Florida Statutes, are amended to read:

400.19 Right of entry and inspection.—

(3) The agency shall every 15 months conduct at least one unannounced inspection to determine compliance by the licensee with statutes, and with rules promulgated under the provisions of those statutes, governing minimum standards of construction, quality and adequacy of care, and rights of residents. The survey shall be conducted every 6 months for the next 2-year period if the facility has been cited for a class I deficiency, has been cited for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period, or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency. In addition to any other fees or fines in this part, the agency

shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period shall be $6,000, one-half to be paid at the completion of each survey. The agency may adjust this fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during the annual inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility, which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person shall constitute cause for suspension of not fewer than 5 working days according to the provisions of chapter 110.

(4) The agency shall conduct unannounced onsite facility reviews following written verification of licensee noncompliance in instances in which a long-term care ombudsman council, pursuant to ss. 400.0071 and 400.0075, has received a complaint and has documented deficiencies in resident care or in the physical plant of the facility that threaten the health, safety, or security of residents, or when the agency documents through inspection that conditions in a facility present a direct or indirect threat to the health, safety, or security of residents. However, the agency shall conduct ~~four or more~~ unannounced onsite reviews every 3 months ~~within a 12-month period~~ of each facility while the facility ~~which~~ has a conditional license ~~licensure status~~. 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.

Section 28. Subsection (3) and paragraph (a) of subsection (5) of section 400.191, Florida Statutes, are amended to read:

400.191 Availability, distribution, and posting of reports and records.—

(3) Each nursing home facility licensee shall maintain as public information, available upon request, records of all cost and inspection reports pertaining to that facility that have been filed with, or issued by, any governmental agency. Copies of such reports shall be retained in such records for not less than 5 years from the date the reports are filed or issued.

(a) The agency shall quarterly publish a "Nursing Home Guide Watch List" to assist consumers in evaluating the quality of nursing home care in Florida. The watch list must identify each facility that met the criteria for a conditional licensure status on any day within the quarter covered by the list and each facility that was operating under bankruptcy protection on any day within the quarter. The watch list must include, but is not limited to, the facility's name, address, and ownership; the county in which the facility operates; the license expiration date; the number of licensed beds; a description of the deficiency causing the facility to be placed on the list; any corrective action taken; and the cumulative number of times the facility has been on a watch list. The watch list must include a brief description regarding

how to choose a nursing home, the categories of licensure, the agency's inspection process, an explanation of terms used in the watch list, and the addresses and phone numbers of the agency's managed care and health quality area offices.

(b) Upon publication of each quarterly watch list, the agency must transmit a copy of the watch list to each nursing home facility by mail and must make the watch list available on the agency's Internet web site.

(5) Every nursing home facility licensee shall:

(a) Post, in a sufficient number of prominent positions in the nursing home so as to be accessible to all residents and to the general public:~~,~~

1. A concise summary of the last inspection report pertaining to the nursing home and issued by the agency, with references to the page numbers of the full reports, noting any deficiencies found by the agency and the actions taken by the licensee to rectify such deficiencies and indicating in such summaries where the full reports may be inspected in the nursing home.

2. A copy of the most recent version of the Florida Nursing Home Guide Watch List.

Section 29. Subsection (2) of section 400.211, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

400.211 Persons employed as nursing assistants; certification requirement.—

(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; ~~or~~

(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.

(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, must be at least 18 hours per year, and may include hours accrued under s. 464.203(8);

(b) Include, at a minimum:

1. Techniques for assisting with eating and proper feeding;

2. Principles of adequate nutrition and hydration;

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

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

5. Recognizing changes that place a resident at risk for pressure ulcers and falls; and

(c) Address areas of weakness as determined in nursing assistant performance reviews and may address the special needs of residents as determined by the nursing home facility staff.

Costs associated with this training may not be reimbursed from additional Medicaid funding through interim rate adjustments.

Section 30. Subsections (2), (3), (7), and (8) of section 400.23, Florida Statutes, are amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(2) Pursuant to the intention of the Legislature, the agency, in consultation with the Department of Health and the Department of Elderly Affairs, shall adopt and enforce rules to implement this part, which shall include reasonable and fair criteria in relation to:

(a) The location and construction of the facility; including fire and life safety, plumbing, heating, cooling, lighting, ventilation, and other housing conditions which will ensure the health, safety, and comfort of residents, including an adequate call system. The agency shall establish standards for facilities and equipment to increase the extent to which new facilities and a new wing or floor added to an existing facility after July 1, 1999, are structurally capable of serving as shelters only for residents, staff, and families of residents and staff, and equipped to be self-supporting during and immediately following disasters. ~~The agency shall work with facilities licensed under this part and report to the Governor and Legislature by April 1, 1999, its recommendations for cost-effective renovation standards to be applied to existing facilities.~~ In making such rules, the agency shall be guided by criteria recommended by nationally recognized reputable professional groups and associations with knowledge of such subject matters. The agency shall update or revise such criteria as the need arises. All nursing homes must comply with those lifesafety code requirements and building code standards applicable at the time of approval of their construction plans. The agency may require alterations to a building if it determines that an existing condition constitutes a distinct hazard to life, health, or safety. The agency shall adopt fair and reasonable rules setting forth conditions under which existing facilities undergoing additions, alterations, conversions, ren-

ovations, or repairs shall be required to comply with the most recent updated or revised standards.

(b) The number and qualifications of all personnel, including management, medical, nursing, and other 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 implementation of the consumer satisfaction survey pursuant to s. 400.0225; 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) The agency shall adopt rules providing for the minimum staffing requirements for nursing homes. These requirements shall include, for each nursing home facility, a minimum certified nursing assistant staffing of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours of direct care per resident per day beginning January 1, 2003, and increasing to 2.9 hours of direct care per resident per day beginning January 1, 2004. Beginning January 1, 2002 no facility shall staff below one certified nursing assistant per 20 residents, and a minimum licensed

nursing staffing of 1.0 hour of direct resident care per resident per day but never below one licensed nurse per 40 residents., ~~including evening and night shifts and weekends.~~ Nursing assistants employed under s. 400.211(2) may be included in computing the staffing ratio for certified nursing assistants only if they provide nursing assistance services to residents on a full-time basis. Each nursing home must document compliance with staffing standards as required under this paragraph and post daily ~~Agency rules shall specify requirements for documentation of compliance with staffing standards, sanctions for violation of such standards, and requirements for daily posting of~~ the names of staff on duty for the benefit of facility residents and the public. The agency shall recognize the use of licensed nurses for compliance with minimum staffing requirements for certified nursing assistants, provided that the facility otherwise meets the minimum staffing requirements for licensed nurses and that the licensed nurses so recognized are performing the duties of a certified nursing assistant. Unless otherwise approved by the agency, licensed nurses counted towards the minimum staffing requirements for certified nursing assistants must exclusively perform the duties of a certified nursing assistant for the entire shift and shall not also be counted towards the minimum staffing requirements for licensed nurses. If the agency approved a facility's request to use a licensed nurse to perform both licensed nursing and certified nursing assistant duties, the facility must allocate the amount of staff time specifically spent on certified nursing assistant duties for the purpose of documenting compliance with minimum staffing requirements for certified and licensed nursing staff. In no event may the hours of a licensed nurse with dual job responsibilities be counted twice.

(b) The agency shall adopt rules to allow properly trained staff of a nursing facility, in addition to certified nursing assistants and licensed nurses, to assist residents with eating. The rules shall specify the minimum training requirements and shall specify the physiological conditions or disorders of residents which would necessitate that the eating assistance be provided by nursing personnel of the facility. Nonnursing staff providing eating assistance to residents under the provisions of this subsection shall not count towards 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.

(7) The agency shall, at least every 15 months, evaluate all nursing home facilities and make a determination as to the degree of compliance by each licensee with the established rules adopted under this part as a basis for assigning a licensure status to that facility. The agency shall base its evaluation on the most recent inspection report, taking into consideration findings from other official reports, surveys, interviews, investigations, and inspections. The agency shall assign a licensure status of standard or conditional to each nursing home.

(a) A standard licensure status means that a facility has no class I or class II deficiencies, has corrected all class III deficiencies within the time

established by the agency~~, and is in substantial compliance at the time of the survey with criteria established under this part, with rules adopted by the agency, and, if applicable, with rules adopted under 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~~.

(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~~, or, if applicable, with rules adopted under 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~~. If the facility has no class I, class II, or class III deficiencies ~~comes into substantial compliance~~ 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. ~~Correction of all deficiencies, within the period approved by the agency, shall result in termination of the conditional licensure status. Failure to correct the deficiencies within a reasonable period approved by the agency shall be grounds for the imposition of sanctions pursuant to this part.~~

(e) Each licensee shall post its license in a prominent place that is in clear and unobstructed public view at or near the place where residents are being admitted to the facility.

(f) ~~Not later than January 1, 1994,~~ The agency shall adopt rules that:

1. Establish uniform procedures for the evaluation of facilities.

2. Provide criteria in the areas referenced in paragraph (c).

3. Address other areas necessary for carrying out the intent of this section.

(8) The agency shall adopt rules to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified

according to the nature and the scope of the deficiency. The scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency where more than a very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents. The agency shall indicate the classification on the face of the notice of deficiencies as follows:

(a) A class I deficiency is a deficiency that ~~deficiencies are those which~~ 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 ~~present an imminent danger to the residents or guests of the nursing home facility or a substantial probability that death or serious physical harm would result therefrom~~. 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. ~~Notwithstanding s. 400.121(2),~~ 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 ~~in an amount not less than $5,000 and not exceeding $25,000 for each and every~~ deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A fine must ~~may~~ be levied notwithstanding the correction of the deficiency.

(b) A class II deficiency is a deficiency that ~~deficiencies are those which~~ 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 ~~have a direct or immediate relationship to the health, safety, or security of the nursing home facility residents, other than class I deficiencies~~. 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 ~~in an amount not less than $1,000 and not exceeding $10,000 for each and every~~ deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A fine shall be levied notwithstanding the correction of the deficiency. ~~A citation for a class II deficiency shall specify the time within which the deficiency is required to be corrected. If a class II deficiency is corrected within the time specified, no civil penalty shall be imposed, unless it is a repeated offense.~~

(c) A class III deficiency is a deficiency that ~~deficiencies are those which~~ 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 ~~to have an indirect or potential relationship to the health, safety, or security of the nursing home facility residents, other than class I or class II deficiencies~~. A class III deficiency is ~~shall be~~ subject to a civil penalty of $1,000 for an isolated deficiency, $2,000 for a patterned deficiency, and $3,000 for a widespread ~~not less than $500 and not exceeding $2,500 for each and every~~ deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last annual inspection or any inspection or complaint investigation since the last annual inspection. A citation for a class III deficiency must ~~shall~~ specify the time within which the deficiency is required to be corrected. If a class III deficiency is corrected within the time specified, no civil penalty shall be imposed~~, unless it is a repeated offense~~.

(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.

Section 31. Subsection (5) of section 400.235, Florida Statutes, is amended to read:

400.235 Nursing home quality and licensure status; Gold Seal Program.—

(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.

(c) Participate consistently in the required consumer satisfaction process as prescribed by the agency, 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 resident's 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.

Section 32. Section 400.275, Florida Statutes, is created to read:

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.

Section 33. Subsections (3) and (4) of section 400.407, Florida Statutes, are amended to read:

400.407 License required; fee, display.—

(3) Any license granted by the agency must state the maximum resident capacity of the facility, the type of care for which the license is granted, the date the license is issued, the expiration date of the license, and any other information deemed necessary by the agency. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(a) A standard license shall be issued to facilities providing one or more of the personal services identified in s. 400.402. Such facilities may also employ or contract with a person licensed under part I of chapter 464 to administer medications and perform other tasks as specified in s. 400.4255.

(b) An extended congregate care license shall be issued to facilities providing, directly or through contract, services beyond those authorized in paragraph (a), including acts performed pursuant to part I of chapter 464 by persons licensed thereunder, and supportive services defined by rule to persons who otherwise would be disqualified from continued residence in a facility licensed under this part.

1. In order for extended congregate care services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of a facility. Such designation may be made at the time of initial licensure or ~~biennial~~ relicensure, or upon request in writing by a licensee under this part. Notification of approval or denial of such request shall be made within 90 days after receipt of such request and all necessary documentation. Existing facilities qualifying to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards as specified in rule from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards resulting in a requirement to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium on admissions or initiation of injunctive proceedings.

2. Facilities that are licensed to provide extended congregate care services shall maintain a written progress report on each person who receives

such services, which report describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit such facilities at least quarterly ~~two times a year~~ to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part and with rules that relate to extended congregate care. One of these visits may be in conjunction with the regular ~~biennial~~ survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that ~~biennially~~ inspects such facility. The agency may waive one of the required yearly monitoring visits for a facility that has been licensed for at least 24 months to provide extended congregate care services, if, during the ~~biennial~~ inspection, the registered nurse determines that extended congregate care services are being provided appropriately, and if the facility has no class I or class II violations and no uncorrected class III violations. Before such decision is made, the agency shall consult with the long-term care ombudsman council for the area in which the facility is located to determine if any complaints have been made and substantiated about the quality of services or care. The agency may not waive one of the required yearly monitoring visits if complaints have been made and substantiated.

3. Facilities that are licensed to provide extended congregate care services shall:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency, as necessary.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place to the extent possible, so that moves due to changes in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, either directly or through contract, the services of a person licensed pursuant to part I of chapter 464.

h. In addition to the training mandated in s. 400.452, provide specialized training as defined by rule for facility staff.

4. Facilities licensed to provide extended congregate care services are exempt from the criteria for continued residency as set forth in rules adopted under s. 400.441. Facilities so licensed shall adopt their own requirements within guidelines for continued residency set forth by the department in rule. However, such facilities may not serve residents who require 24-hour nursing supervision. Facilities licensed to provide extended congregate care services shall provide each resident with a written copy of facility policies governing admission and retention.

5. The primary purpose of extended congregate care services is to allow residents, as they become more impaired, the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency. A facility licensed to provide extended congregate care services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the extended congregate care facility.

6. Before admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 400.426(4) and the facility must develop a preliminary service plan for the individual.

7. When a facility can no longer provide or arrange for services in accordance with the resident's service plan and needs and the facility's policy, the facility shall make arrangements for relocating the person in accordance with s. 400.428(1)(k).

8. Failure to provide extended congregate care services may result in denial of extended congregate care license renewal.

9. No later than January 1 of each year, the department, in consultation with the agency, shall prepare and submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the chairs of appropriate legislative committees, a report on the status of, and recommendations related to, extended congregate care services. The status report must include, but need not be limited to, the following information:

a. A description of the facilities licensed to provide such services, including total number of beds licensed under this part.

b. The number and characteristics of residents receiving such services.

c. The types of services rendered that could not be provided through a standard license.

d. An analysis of deficiencies cited during <u>licensure</u> ~~biennial~~ inspections.

e. The number of residents who required extended congregate care services at admission and the source of admission.

f. Recommendations for statutory or regulatory changes.

g. The availability of extended congregate care to state clients residing in facilities licensed under this part and in need of additional services, and

recommendations for appropriations to subsidize extended congregate care services for such persons.

h. Such other information as the department considers appropriate.

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. Such designation may be made at the time of initial licensure or ~~biennial~~ relicensure, or upon request in writing by a licensee under this part. Notification of approval or denial of such request shall be made within 90 days after receipt of such request and all necessary documentation. Existing facilities qualifying to provide limited nursing services shall have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. Facilities that are licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services, which report describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit such facilities at least twice ~~once~~ a year to monitor residents who are receiving limited nursing services and to determine if the facility is in compliance with applicable provisions of this part and with related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that ~~biennially~~ inspects such facility.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 400.428(1)(k), unless the facility is licensed to provide extended congregate care services.

(4)(a) The biennial license fee required of a facility is $300 ~~$240~~ per license, with an additional fee of $50 ~~$30~~ per resident based on the total licensed resident capacity of the facility, except that no additional fee will be assessed for beds designated for recipients of optional state supplementation payments provided for in s. 409.212. The total fee may not exceed $10,000, no part of which shall be returned to the facility. The agency shall adjust the per bed license fee and the total licensure fee annually by not more than the change in the consumer price index based on the 12 months immediately preceding the increase.

(b) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide extended congregate care

services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $400 per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility. No part of this fee ~~which~~ shall be returned to the facility. The agency may adjust the per-bed license fee and the annual license fee once each year by not more than the average rate of inflation for the 12 months immediately preceding the increase.

(c) In addition to the total fee assessed under paragraph (a), the agency shall require facilities that are licensed to provide limited nursing services under this part to pay an additional fee per licensed facility. The amount of the biennial fee shall be $250 ~~$200~~ per license, with an additional fee of $10 per resident based on the total licensed resident capacity of the facility. ~~The total biennial fee may not exceed $2,000,~~ No part of this fee ~~which~~ shall be returned to the facility. The agency may adjust the per-bed license fee and the $200 biennial license fee ~~and the maximum total license fee~~ once each year by not more than the average rate of inflation for the 12 months immediately preceding the increase.

Section 34. Paragraph (n) is added to subsection (1) of section 400.414, Florida Statutes, and subsection (8) is added to that section, to read:

400.414 Denial, revocation, or suspension of license; imposition of administrative fine; grounds.—

(1) The agency may deny, revoke, or suspend any license issued under this part, or impose an administrative fine in the manner provided in chapter 120, for any of the following actions by an assisted living facility, any person subject to level 2 background screening under s. 400.4174, or any facility employee:

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

Administrative proceedings challenging agency action under this subsection shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

(8) The agency may issue a temporary license pending final disposition of a proceeding involving the suspension or revocation of an assisted living facility license.

Section 35. Section 400.419, Florida Statutes, is amended to read:

400.419 Violations; administrative fines.—

(1) Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:

(a) Class “I” violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents

which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. A class I violation is subject to an administrative fine in an amount not less than $5,000 ~~$1,000~~ and not exceeding $10,000 for each violation. A fine may be levied notwithstanding the correction of the violation.

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the facility residents, other than class I violations. A class II violation is subject to an administrative fine in an amount not less than $1,000 ~~$500~~ and not exceeding $5,000 for each violation. A citation for a class II violation must ~~shall~~ specify the time within which the violation is required to be corrected. ~~If a class II violation is corrected within the time specified, no fine may be imposed, unless it is a repeated offense.~~

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of facility residents, other than class I or class II violations. A class III violation is subject to an administrative fine of not less than $500 ~~$100~~ and not exceeding $1,000 for each violation. A citation for a class III violation must ~~shall~~ specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, no fine may be imposed, unless it is a repeated offense.

(d) Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a building or to required reports, forms, or documents that do not have the potential of negatively affecting residents. These violations are of a type that the agency determines do not threaten the health, safety, or security of residents of the facility. A facility that does not correct a class IV violation within the time specified in the agency-approved corrective action plan is subject to an administrative fine of not less than $100 ~~$50~~ nor more than $200 for each violation. Any class IV violation that is corrected during the time an agency survey is being conducted will be identified as an agency finding and not as a violation.

~~(2) The agency may set and levy a fine not to exceed $1,000 for each violation which cannot be classified according to subsection (1). Such fines in the aggregate may not exceed $10,000 per survey.~~

(2)~~(3)~~ In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.

(b) Actions taken by the owner or administrator to correct violations.

(c) Any previous violations.

(d) The financial benefit to the facility of committing or continuing the violation.

(e) The licensed capacity of the facility.

(3)~~(4)~~ Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(4)~~(5)~~ Any action taken to correct a violation shall be documented in writing by the owner or administrator of the facility and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated facility, revoke or deny a facility's license when a facility administrator fraudulently misrepresents action taken to correct a violation.

(5)~~(6)~~ For fines that are upheld following administrative or judicial review, the violator shall pay the fine, plus interest at the rate as specified in s. 55.03, for each day beyond the date set by the agency for payment of the fine.

(6)~~(7)~~ Any unlicensed facility that continues to operate after agency notification is subject to a $1,000 fine per day. ~~Each day beyond 5 working days after agency notification constitutes a separate violation, and the facility is subject to a fine of $500 per day.~~

(7)~~(8)~~ Any licensed facility whose owner or administrator concurrently operates an unlicensed facility shall be subject to an administrative fine of $5,000 per day. ~~Each day that the unlicensed facility continues to operate beyond 5 working days after agency notification constitutes a separate violation, and the licensed facility shall be subject to a fine of $500 per day retroactive to the date of agency notification.~~

(8)~~(9)~~ Any facility whose owner fails to apply for a change-of-ownership license in accordance with s. 400.412 and operates the facility under the new ownership is subject to a fine of ~~not to exceed~~ $5,000.

(9)~~(10)~~ In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject of the complaint or monitoring visits conducted under s. 400.428(3)(c) to verify the correction of the violations.

(10)~~(11)~~ The agency, as an alternative to or in conjunction with an administrative action against a facility for violations of this part and adopted rules, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner or administrator of the facility, prior to written notification. The agency, instead of fixing a period within

which the facility shall enter into compliance with standards, may request a plan of corrective action from the facility which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(11)~~(12)~~ Administrative fines paid by any facility under this section shall be deposited into the Health Care Trust Fund and expended as provided in s. 400.418.

(12)~~(13)~~ The agency shall develop and disseminate an annual list of all facilities sanctioned or fined $5,000 or more for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Family Services, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list.

Section 36. Section 400.423, Florida Statutes, is created to read:

400.423 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences.

(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, “adverse incident” means:

(a) An event over which facility personnel could exercise control rather than as a result of the resident’s condition and results in:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

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

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident.

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

(c) Events reported to law enforcement; or

(d) Elopement.

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

(5) Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.

(6) The agency shall annually submit to the Legislature a report on assisted living facility adverse incident reports. The report must include the following information arranged by county:

(a) A total number of adverse incidents;

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

(c) A listing, by category, of the types of injuries, if any, and the number of injuries occurring within each category;

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

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

(7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or

may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply.

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

(9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board.

(10) The Department of Elderly Affairs may adopt rules necessary to administer this section.

Section 37. Present subsections (7), (8), (9), (10), and (11) of section 400.426, Florida Statutes, are redesignated as subsections (8), (9), (10), (11), and (12), respectively, and a new subsection (7) is added to that section, to read:

400.426 Appropriateness of placements; examinations of residents.—

(7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgement 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.

Section 38. Paragraph (k) of subsection (1) of section 400.428, Florida Statutes, is amended to read:

400.428 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(k) At least 45 ~~30~~ days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 ~~30~~ days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility

to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

Section 39. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.429, Florida Statutes, is amended to read:

400.429 Civil actions to enforce rights.—

(1) Any person or resident whose rights as specified in this part are violated shall have a cause of action ~~against any facility owner, administrator, or staff responsible for the violation~~. The action may be brought by the resident or his or her guardian, or by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death ~~when the cause of death resulted from a violation of the decedent's rights, to enforce such rights~~. If the action alleges a claim for the resident's rights or for negligence that caused the death of the resident, the claimant shall be required to elect either survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for the resident's rights or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident. The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual damages, and punitive damages for violation of the rights of a resident or negligence ~~when malicious, wanton, or willful disregard of the rights of others can be shown~~. Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover the costs of the action and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 400.429-400.4303 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in s. 400.428. This section does not preclude theories of recovery not arising out of negligence or s. 400.428 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 400.429-400.4303. ~~Any plaintiff who prevails in any such action may be entitled to recover reasonable attorney's fees, costs of the action, and damages, unless the court finds that the plaintiff has acted in bad faith, with malicious purpose, and that there was a complete absence of a justiciable issue of either law or fact. A prevailing defendant may be entitled to recover reasonable attorney's fees pursuant to s. 57.105. The remedies provided in this section are in addition to and cumulative with other legal and administrative remedies available to a resident or to the agency.~~

(2) In any claim brought pursuant to this part alleging a violation of resident's rights or negligence causing injury to or the death of a resident,

the claimant shall have the burden of proving, by a preponderance of the evidence, that:

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

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

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

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

Nothing in this part shall be interpreted to create strict liability. A violation of the rights set forth in s. 400.428 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency shall be evidence of negligence but shall not be considered negligence per se.

(3) In any claim brought pursuant to s. 400.429, 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. ~~To recover attorney's fees under this section, the following conditions precedent must be met:~~

~~(a) Within 120 days after the filing of a responsive pleading or defensive motion to a complaint brought under this section and before trial, the parties or their designated representatives shall meet in mediation to discuss the issues of liability and damages in accordance with this paragraph for the purpose of an early resolution of the matter.~~

~~1. Within 60 days after the filing of the responsive pleading or defensive motion, the parties shall:~~

~~a. Agree on a mediator. If the parties cannot agree on a mediator, the defendant shall immediately notify the court, which shall appoint a mediator within 10 days after such notice.~~

~~b. Set a date for mediation.~~

~~c. Prepare an order for the court that identifies the mediator, the scheduled date of the mediation, and other terms of the mediation. Absent any disagreement between the parties, the court may issue the order for the mediation submitted by the parties without a hearing.~~

~~2. The mediation must be concluded within 120 days after the filing of a responsive pleading or defensive motion. The date may be extended only by agreement of all parties subject to mediation under this subsection.~~

~~3. The mediation shall be conducted in the following manner:~~

~~a. Each party shall ensure that all persons necessary for complete settlement authority are present at the mediation.~~

~~b. Each party shall mediate in good faith.~~

~~4. All aspects of the mediation which are not specifically established by this subsection must be conducted according to the rules of practice and procedure adopted by the Supreme Court of this state.~~

~~(b) If the parties do not settle the case pursuant to mediation, the last offer of the defendant made at mediation shall be recorded by the mediator in a written report that states the amount of the offer, the date the offer was made in writing, and the date the offer was rejected. If the matter subsequently proceeds to trial under this section and the plaintiff prevails but is awarded an amount in damages, exclusive of attorney's fees, which is equal to or less than the last offer made by the defendant at mediation, the plaintiff is not entitled to recover any attorney's fees.~~

~~(c) This subsection applies only to claims for liability and damages and does not apply to actions for injunctive relief.~~

~~(d) This subsection applies to all causes of action that accrue on or after October 1, 1999.~~

(5)~~(3)~~ Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(6)~~(4)~~ In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.

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

Section 40. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.4293, Florida Statutes, is created to read:

400.4293 Presuit notice; investigation; notification of violation of residents' rights or alleged negligence; claims evaluation procedure; informal discovery; review.—

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

(a) "Claim for residents' rights violation or negligence" means a negligence claim alleging injury to or the death of a resident arising out of an asserted violation of the rights of a resident under s. 400.428 or an asserted deviation from the applicable standard of care.

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

(2) Prior to filing a claim for a violation of a resident's rights or a claim for negligence, a claimant alleging injury to or the death of a resident shall notify each prospective defendant by certified mail, return receipt requested, of an asserted violation of a resident's rights provided in s. 400.428 or deviation from the standard of care. Such notification shall include an identification of the rights the prospective defendant has violated and the negligence alleged to have caused the incident or incidents and a brief description of the injuries sustained by the resident which are reasonably identifiable at the time of notice. The notice shall contain a certificate of counsel that counsel's reasonable investigation gave rise to a good-faith belief that grounds exist for an action against each prospective defendant.

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

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

2. Internal review by counsel for each prospective defendant;

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

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

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

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

1. Rejecting the claim; or

2. Making a settlement offer.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt re-

quested. Failure of the prospective defendant or insurer of the defendant to reply to the notice within 75 days after receipt shall be deemed a rejection of the claim for purposes of this section.

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

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

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

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

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

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

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

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

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

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

Section 41. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.4294, Florida Statutes, is created to read:

400.4294 Availability of facility records for investigation of resident's rights violations and defenses; penalty.—

(1) Failure to provide complete copies of a resident's records, including, but not limited to, all medical records and the resident's chart, within the control or possession of the facility within 10 days, in accordance with the provisions of s. 400.145, shall constitute evidence of failure of that party to comply with good-faith discovery requirements and shall waive the good-faith certificate and presuit notice requirements under this part by the requesting party.

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

Section 42. Effective May 15, 2001, and applying to causes of action accruing on or after that date, section 400.4295, Florida Statutes, is created to read:

400.4295 Certain provisions not applicable to actions under this part.—An action under this part for a violation of rights or negligence recognized herein is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

Section 43. Effective May 15, 2001, section 400.4296, Florida Statutes, is created to read:

400.4296 Statute of limitations.—

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

(2) In those actions covered by this subsection in which it can be shown that fraudulent concealment or intentional misrepresentation of fact prevented the discovery of the injury, the period of limitations is extended forward 2 years from the time that the injury is discovered with the exercise of due diligence, but in no event not more than 6 years from the date the incident giving rise to the injury occurred.

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

Section 44. Section 400.4297, Florida Statutes, is created to read:

400.4297 Punitive damages; pleading; burden of proof.—

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

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

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

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

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

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

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

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

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

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

Section 45. Section 400.4298, Florida Statutes, is created to read:

400.4298 Punitive damages; limitation.—

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

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

2. The sum of $1 million.

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

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

2. The sum of $4 million.

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

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

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

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

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

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

(a) The clerk of the court shall transmit a copy of the jury verdict to the State Treasurer 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 Banking and Finance shall collect or cause to be collected all payments due the state under this section. Such payments are made to the Comptroller 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.

Section 46. Section 400.434, Florida Statutes, is amended to read:

400.434 Right of entry and inspection.—Any duly designated officer or employee of the department, the Department of Children and Family Services, the agency, the state or local fire marshal, or a member of the state or local long-term care ombudsman council shall have the right to enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with the provisions of this part and of rules or standards in force pursuant thereto. The right of entry and inspection shall also extend to any premises which the agency has reason to believe is being operated or maintained as a facility without a license; but no such entry or inspection of any premises may be made without the permission of the owner or person in charge thereof, unless a warrant is first obtained from the circuit court authorizing such entry. The warrant requirement shall extend only to a facility which the agency has reason to believe is being operated or maintained as a facility without a license. Any application for a license or renewal thereof made pursuant to this part shall constitute permission for, and complete acquiescence in, any entry or inspection of the premises for which the license is sought, in order to facilitate verification of the information submitted on or in connection with the application; to discover, investigate, and determine the existence of abuse or neglect; or to elicit, receive, respond to, and resolve complaints. Any current valid license shall constitute unconditional permission for, and complete acquiescence in, any entry or inspection of the premises by authorized personnel. The agency shall retain the right of entry and inspection of facilities that have had a license revoked or suspended within the previous 24 months, to ensure that the facility is not operating unlawfully. However, before entering the facility, a statement of probable cause must be filed with the director of the agency, who must approve or disapprove the action within 48 hours. Probable cause shall include, but is not limited to, evidence that the facility holds itself out to the public as a provider of personal care services or the receipt of a complaint by the long-term care ombudsman council about the facility. Data collected by the state or local long-term care ombudsman councils or the state or local advocacy councils may be used by the agency in investigations involving violations of regulatory standards.

Section 47. Paragraph (h) of subsection (1) and subsection (4) of section 400.441, Florida Statutes, are amended to read:

400.441 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also

ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Family Services, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(h) The care and maintenance of residents, which must include, but is not limited to:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The arrangement for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication;

6. The nutritional needs of residents; ~~and~~

7. Resident records; and~~.~~

8. Internal risk management and quality assurance.

(4) The agency may use an abbreviated biennial standard licensure inspection that ~~which~~ consists of a review of key quality-of-care standards in lieu of a full inspection in facilities which have a good record of past performance. However, a full inspection shall be conducted in facilities which have had a history of class I or class II violations, uncorrected class III violations, confirmed ombudsman council complaints, or confirmed licensure complaints, within the previous licensure period immediately preceding the inspection or when a potentially serious problem is identified during the abbreviated inspection. The agency, in consultation with the department, shall develop the key quality-of-care standards with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules. ~~Beginning on or before March 1, 1991,~~ The department, in consultation with the agency, shall report annually to the Legislature concerning its implementation of this subsection. The report shall include, at a minimum, the key quality-of-care standards which have been developed; the number of facilities identified as being eligible for the abbreviated inspection; the number of facilities which have received the abbreviated inspection and, of those, the number that were converted to full inspection; the number and type of subsequent complaints received by the agency or department on facilities which have had abbreviated inspections; any recommendations for modification to this subsection; any plans by the agency to modify its implementation of this subsection; and any other information which the department believes should be reported.

Section 48. Section 400.449, Florida Statutes, is created to read:

400.449 Resident records; penalties for alteration.—

(1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

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

Section 49. Paragraph (b) of subsection (2) of section 409.908, Florida Statutes, is amended and subsection (22) is added to that section, to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The agency shall amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.

2. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents

of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling and the indirect care subcomponent shall be limited by the lower of the cost-based class ceiling, by the target rate class ceiling or by the individual provider target. The agency shall adjust the patient care component effective January 1, 2002. The cost to adjust the direct care subcomponent shall be net of the total funds previously allocated for the case mix add-on. The agency shall make the required changes to the nursing home cost reporting forms to implement this requirement effective January 1, 2002.

3. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

4. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company.

5. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

6. Under the plan, interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria are met: have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the agency, and the increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5 percent. This rate adjustment shall not result in the per diem exceeding the class ceiling. This provision shall ~~apply only to fiscal year 2000-2001 and shall~~ be implemented to the extent existing appropriations are available. ~~The agency shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate by December 31, 2000, on the cost of liability insurance for Florida nursing homes for fiscal years 1999 and 2000 and the extent to which these costs are not being compensated by the Medicaid program. Medicaid-participating nursing homes shall be required to report to the agency information necessary to compile this report. Effective no earlier than the rate-setting period beginning April 1, 1999, the agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate~~

~~data. The case-mix methodology developed by the agency shall take into account the medical, behavioral, and cognitive deficits of residents. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. In the event adequate data are not available, the agency is authorized to adjust the patient's care component or the per diem rate to more adequately cover the cost of services provided in the patient's care component. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the methodology.~~

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(22) The agency shall request and implement Medicaid waivers from the federal Health Care Financing Administration to advance and treat a portion of the Medicaid nursing home per diem as capital for creating and operating a risk-retention group for self-insurance purposes, consistent with federal and state laws and rules.

Section 50. Section 464.203, Florida Statutes, is amended to read:

464.203 Certified nursing assistants; certification requirement.—

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required Level I or Level II screening pursuant to s. 400.215 and meets one of the following requirements:

(a) Has successfully completed an approved training program and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion approved by the board and administered at a site and by personnel approved by the department.

(b) Has achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department and:

1. Has a high school diploma, or its equivalent; or

2. Is at least 18 years of age.

(c) Is currently certified in another state; is listed on that state's certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that state.

(d) Has completed the curriculum developed under the Enterprise Florida Jobs and Education Partnership Grant and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department.

(2) If an applicant fails to pass the nursing assistant competency examination in three attempts, the applicant is not eligible for reexamination unless the applicant completes an approved training program.

(3) An oral examination shall be administered as a substitute for the written portion of the examination upon request. The oral examination shall be administered at a site and by personnel approved by the department.

(4) The board shall adopt rules to provide for the initial certification of certified nursing assistants.

(5) Certification as a nursing assistant, in accordance with this part, continues in effect until such time as the nursing assistant allows a period of 24 consecutive months to pass during which period the nursing assistant fails to perform any nursing-related services for monetary compensation. When a nursing assistant fails to perform any nursing-related services for monetary compensation for a period of 24 consecutive months, the nursing assistant must complete a new training and competency evaluation program or a new competency evaluation program.

(6)~~(5)~~ A certified nursing assistant shall maintain a current address with the board in accordance with s. 456.035.

(7) A certified nursing assistant shall complete 18 hours of inservice training during each calendar year. The certified nursing assistant shall be responsible for maintaining documentation demonstrating compliance with these provisions. The Council on Certified Nursing Assistants, in accordance with s. 464.0285(2)(b), shall propose rules to implement this subsection.

Section 51. Subsection (2) of section 397.405, Florida Statutes, is amended to read:

397.405 Exemptions from licensure.—The following are exempt from the licensing provisions of this chapter:

(2) A nursing home facility as defined in s. 400.021 ~~s. 400.021(12)~~.

The exemptions from licensure in this section do not apply to any facility or entity which receives an appropriation, grant, or contract from the state to operate as a service provider as defined in this chapter or to any substance abuse program regulated pursuant to s. 397.406. No provision of this chapter shall be construed to limit the practice of a physician licensed under

chapter 458 or chapter 459, a psychologist licensed under chapter 490, or a psychotherapist licensed under chapter 491, providing outpatient or inpatient substance abuse treatment to a voluntary patient, so long as the physician, psychologist, or psychotherapist does not represent to the public that he or she is a licensed service provider under this act. Failure to comply with any requirement necessary to maintain an exempt status under this section is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 52. Notwithstanding the establishment of need as provided for in chapter 408, Florida Statutes, no certificate of need for additional community nursing home beds shall be approved by the agency until July 1, 2006. The Legislature finds that the continued growth in the Medicaid budget for nursing home care has constrained the ability of the state to meet the needs of its elderly residents through the use of less restrictive and less institutional methods of long-term care. It is therefore the intent of the Legislature to limit the increase in Medicaid nursing home expenditures in order to provide funds to invest in long-term care that is community-based and provides supportive services in a manner that is both more cost-effective and more in keeping with the wishes of the elderly residents of this state. This moratorium on certificates of need shall not apply to sheltered nursing home beds in a continuing care retirement community certified by the Department of Insurance pursuant to chapter 651, Florida Statutes.

Section 53. Subsections (3) and (8) of section 400.0255, Florida Statutes, as amended by section 138 of chapter 2000-349, section 3 of chapter 2000-350, and section 58 of chapter 2000-367, Laws of Florida, are reenacted to read:

400.0255 Resident transfer or discharge; requirements and procedures; hearings.—

(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.

(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.

Section 54. Subsection (5) of section 400.23, Florida Statutes, as amended by section 6 of chapter 2000-350, Laws of Florida, is reenacted to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(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.

Section 55. Subsection (2) of section 400.191, Florida Statutes, as amended by section 5 of chapter 2000-350, Laws of Florida, and subsection (6) of that section, as created by section 5 of chapter 2000-350, Laws of Florida, are reenacted to read:

400.191 Availability, distribution, and posting of reports and records.—

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

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

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

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

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

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

5. The total number of beds in each facility.

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

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

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

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

10. Recreational and other programs available at each facility.

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

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

13. The results of consumer and family satisfaction surveys for each facility, as described in s. 400.0225. The results may be converted to a score or scores, which may be presented in either numeric or symbolic form for the intended consumer audience.

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

15. A summary of the Online Survey Certification and Reporting (OSCAR) data for each facility over the past 45 months. Such summary may include a score, rating, or comparison ranking with respect to other facilities based on the number of citations received by the facility of annual, revisit, and complaint surveys; the severity and scope of the citations; and the number of annual recertification surveys the facility has had during the past 45 months. The score, rating, or comparison ranking may be presented in either numeric or symbolic form for the intended consumer audience.

(b) The agency shall provide the following information in printed form:

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

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

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

4. The total number of beds, and of private and semiprivate rooms, in each facility.

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

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

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

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

9. Recreational programs, special care units, and other programs available at each facility.

10. The results of consumer and family satisfaction surveys for each facility, as described in s. 400.0225. The results may be converted to a score or scores, which may be presented in either numeric or symbolic form for the intended consumer audience.

11. The Internet address for the site where more detailed information can be seen.

12. A statement advising consumers that each facility will have its own policies and procedures related to protecting resident property.

13. A summary of the Online Survey Certification and Reporting (OSCAR) data for each facility over the past 45 months. Such summary may include a score, rating, or comparison ranking with respect to other facilities based on the number of citations received by the facility on annual, revisit, and complaint surveys; the severity and scope of the citations; the number of citations; and the number of annual recertification surveys the facility has had during the past 45 months. The score, rating, or comparison ranking may be presented in either numeric or symbolic form for the intended consumer audience.

(c) For purposes of this subsection, references to the Online Survey Certification and Reporting (OSCAR) system shall refer to any future system that the Health Care Financing Administration develops to replace the current OSCAR system.

(d) The agency may provide the following additional information on an Internet site or in printed form as the information becomes available:

1. The licensure status history of each facility.

2. The rating history of each facility.

3. The regulatory history of each facility, which may include federal sanctions, state sanctions, federal fines, state fines, and other actions.

4. Whether the facility currently possesses the Gold Seal designation awarded pursuant to s. 400.235.

5. Internet links to the Internet sites of the facilities or their affiliates.

(6) The agency may adopt rules as necessary to administer this section.

Section 56. Section 400.0225, Florida Statutes, as amended by section 2 of chapter 2000-350, Laws of Florida, is reenacted to read:

400.0225 Consumer satisfaction surveys.—The agency, or its contractor, in consultation with the nursing home industry and consumer representatives, shall develop an easy-to-use consumer satisfaction survey, shall ensure that every nursing facility licensed pursuant to this part participates in assessing consumer satisfaction, and shall establish procedures to ensure that, at least annually, a representative sample of residents of each facility is selected to participate in the survey. The sample shall be of sufficient size to allow comparisons between and among facilities. Family members, guardians, or other resident designees may assist the resident in completing the survey. Employees and volunteers of the nursing facility or of a corporation or business entity with an ownership interest in the facility are prohibited from assisting a resident with or attempting to influence a resident's responses to the consumer satisfaction survey. The agency, or its contractor, shall survey family members, guardians, or other resident designees. The agency, or its contractor, shall specify the protocol for conducting and reporting the consumer satisfaction surveys. Reports of consumer satisfaction surveys shall protect the identity of individual respondents. The agency shall contract for consumer satisfaction surveys and report the results of those surveys in the consumer information materials prepared and distributed by the agency. The agency may adopt rules as necessary to administer this section.

Section 57. Subsections (4) and (5) of section 400.141, Florida Statutes, as renumbered and amended by section 4 of chapter 2000-350, Laws of Florida, are reenacted to read:

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

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

from the repackaging. In order to be eligible for the repackaging, a nursing facility resident for whom the medication is to be repackaged shall sign an informed consent form provided by the facility which includes an explanation of the repackaging process and which notifies the resident of the immunities from liability provided herein. A pharmacist who repackages and relabels prescription medications, as authorized under this subsection, may charge a reasonable fee for costs resulting from the implementation of this provision.

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

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 its program.

Section 58. Paragraph (a) of subsection (3) and subsection (4) of section 400.235, Florida Statutes, as amended by section 12 of chapter 2000-305 and section 7 of chapter 2000-350, Laws of Florida, and subsection (9) of section 400.235, Florida Statutes, as created by section 7 of chapter 2000-350, Laws of Florida, are reenacted to read:

400.235 Nursing home quality and licensure status; Gold Seal Program.—

(3)(a) The Gold Seal Program shall be developed and implemented by the Governor's Panel on Excellence in Long-Term Care which shall operate under the authority of the Executive Office of the Governor. The panel shall be composed of three persons appointed by the Governor, to include a consumer advocate for senior citizens and two persons with expertise in the fields of quality management, service delivery excellence, or public sector accountability; three persons appointed by the Secretary of Elderly Affairs, to include an active member of a nursing facility family and resident care council and a member of the University Consortium on Aging; the State Long-Term Care Ombudsman; one person appointed by the Florida Life Care Residents Association; one person appointed by the Secretary of Health; two persons appointed by the Secretary of Health Care Administration; one person appointed by the Florida Association of Homes for the Aging; and one person appointed by the Florida Health Care Association. Vacancies on the panel shall be filled in the same manner as the original appointments.

(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.

(9) The agency may adopt rules as necessary to administer this section.

Section 59. Subsection (1) of section 400.962, Florida Statutes, as amended by section 8 of chapter 2000-350, Laws of Florida, is reenacted to read:

400.962 License required; license application.—

(1) It is unlawful to operate an intermediate care facility for the developmentally disabled without a license.

Section 60. Section 10 of chapter 2000-350, Laws of Florida, is reenacted to read:

Section 10. The Board of Pharmacy, in cooperation with the Agency for Health Care Administration, shall undertake a study of the feasibility, efficiency, cost-effectiveness, and safety of using automated medication dispensing machines in nursing facilities. The board and the agency may authorize the establishment of demonstration projects in up to five nursing facilities with a class I institutional pharmacy as part of the study. Demonstration projects may be allowed to continue for up to 12 months. A report summarizing the results of the study shall be submitted by the board and the agency to the Speaker of the House of Representatives and the President of the Senate by January 1, 2001. If the study determines that such dispensing machines would benefit residents of nursing facilities and should be allowed, the report shall identify those specific statutory changes necessary to allow nursing facilities to use automated medication dispensing machines.

Section 61. Paragraph (g) is added to subsection (1) of section 400.562, Florida Statutes, to read:

400.562 Rules establishing standards.—

(1) The Department of Elderly Affairs, in conjunction with the agency, shall adopt rules to implement the provisions of this part. The rules must include reasonable and fair standards. Any conflict between these standards and those that may be set forth in local, county, or municipal ordinances shall be resolved in favor of those having statewide effect. Such standards must relate to:

(g) Components of a comprehensive emergency management plan, developed in consultation with the Department of Health, the Agency for Health Care Administration, and the Department of Community Affairs.

Section 62. Notwithstanding any other provision of this act to the contrary, sections 400.0237, 400.0238, 400.4297, 400.4298, Florida Statutes, as created by this act, and section 768.735, Florida Statutes, as amended by this act, shall become effective May 15, 2001; shall apply to causes of action accruing on or after May 15, 2001; and shall be applied retroactively to causes of action accruing before May 15, 2001, for which no case has been filed prior to October 5, 2001.

Section 63. The Agency for Health Care Administration shall develop by October 31, 2001, a standard chart of accounts to govern the content and manner of presentation of financial information to be submitted by Medicaid long-term care providers in their cost reports. The Auditor General shall approve the standard chart of accounts developed by the Agency for Health Care Administration not later than December 31, 2001. The agency shall amend the Florida Title XIX Long-Term Care Reimbursement Plan to incorporate this standard chart of accounts and shall implement use of this standard chart of accounts effective for cost reports filed for the periods ending on or after December 31, 2002. The standard chart of accounts shall include specific accounts for each component of direct care staff by type of personnel and may not be revised without the written consent of the Auditor General.

Section 64. The Agency for Health Care Administration shall amend the Medicaid Title XIX Long-Term Care Reimbursement Plan effective December 31, 2001, to include the following provisions:

(1) Effective with nursing facility cost reports filed for periods ending on or after December 31, 2002, the cost report shall contain detailed information on the salary, benefits, agency, and overtime costs and corresponding hours for direct care staffing for registered nurses, licensed practical nurses, and certified nursing assistants.

(2) Effective for cost reports filed for periods ending on or after December 31, 2003, the cost reports shall be submitted electronically in a format and manner prescribed by the agency.

Section 65. The Office of State Long-Term Care Ombudsman shall be responsible for the cost of leasing its own office space, but shall not be colocated with the headquarters office of the Department of Elderly Affairs.

Section 66. The Agency for Health Care Administration shall not take any administrative action to enforce the requirement that nursing home facilities and assisted living facilities maintain liability insurance until after January 1, 2002.

Section 67. (1) The sum of $5,035,636 is appropriated from the General Revenue Fund, the sum of $3,428,975 is appropriated from the Health Care Trust Fund, and the sum of $6,710,164 is appropriated from the Medical Care Trust Fund to the Agency for Health Care Administration, and 79 positions are authorized, for the purposes of implementing this act during the 2001-2002 fiscal year.

(2) The sum of $100,000 is appropriated from the General Revenue Fund to the Department of Elderly Affairs for the purposes of implementing this act during the 2001-2002 fiscal year.

Section 68. The sum of $948,782 is appropriated from the General Revenue Fund to the Department of Elderly Affairs for the purpose of paying the salaries and other administrative expenses of the Office of State Long-Term Care Ombudsman to carry out the provisions of this act during the 2001-2002 fiscal year.

Section 69. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 70. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

Approved by the Governor May 15, 2001.

Filed in Office Secretary of State May 15, 2001.