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A bill to be entitled An act relating to healthcare; amending s. 400.408, F.S.; requiring the Agency for Health Care Administration in cooperation with other specified entities to establish a statewide and local coordinating workgroup to identify the operation of unlicensed assisted living facilities and to develop a plan to enforce state laws relating to unlicensed assisted living facilities; requiring a report to the agency of the workgroup's findings and recommendations; requiring health care practitioners to report known operations of unlicensed facilities; prohibiting hospitals and community mental health centers from discharging a patient or client to an unlicensed facility; amending s. 415.1034, F.S.; requiring paramedics and emergency medical technicians to report acts of abuse committed against a disabled adult or elderly person; amending s. 509.032, F.S.; requiring the Division of Hotels and Restaurants of the Department of Business and Professional Regulation to report to specified agencies known incidents of abuse committed against disabled adults or elderly persons at a public lodging; requiring the division to develop procedures and maintain records; providing an effective date. 31 Be It Enacted by the Legislature of the State of Florida:

CODING: Words stricken are deletions; words underlined are additions.

 Section 1. Subsections (1) and (2) of section 400.408, Florida Statutes, are amended to read:

400.408 Unlicensed facilities; referral of person for residency to unlicensed facility; penalties; verification of licensure status.--

- (1)(a) It is unlawful to own, operate, or maintain an assisted living facility without obtaining a license under this part.
- (b) Except as provided under paragraph (d), any person who owns, operates, or maintains an unlicensed assisted living facility commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.
- (c) Any person found guilty of violating paragraph (a) a second or subsequent time commits a felony of the second degree, punishable as provided under s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.
- (d) Any person who owns, operates, or maintains an unlicensed assisted living facility due to a change in this part or a modification in department rule within 6 months after the effective date of such change and who, within 10 working days after receiving notification from the agency, fails to cease operation or apply for a license under this part commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. Each day of continued operation is a separate offense.
- (e) Any facility that fails to cease operation after agency notification may be fined for each day of noncompliance pursuant to s. 400.419.

- (f) When a licensee has an interest in more than one assisted living facility, and fails to license any one of these facilities, the agency may revoke the license, impose a moratorium, or impose a fine pursuant to s. 400.419, on any or all of the licensed facilities until such time as the unlicensed facility is licensed or ceases operation.
- (g) If the agency determines that an owner is operating or maintaining an assisted living facility without obtaining a license and determines that a condition exists in the facility that poses a threat to the health, safety, or welfare of a resident of the facility, the owner is subject to the same actions and fines imposed against a licensed facility as specified in ss. 400.414 and 400.419.
- (h) Any person aware of the operation of an unlicensed assisted living facility must report that facility to the agency. The agency shall provide to the department's elder information and referral providers a list, by county, of licensed assisted living facilities, to assist persons who are considering an assisted living facility placement in locating a licensed facility.
- (i) The Agency for Health Care Administration in cooperation with the Office of State Long-Term Care Ombudsman, the Statewide Human Rights Advocacy Committee, the Department of Children and Family Services, the Department of Elderly Affairs, the Department of Law Enforcement, the Department of Legal Affairs, the Division of State Fire Marshal of the Department of Insurance, the state attorneys in each judicial circuit, and the Florida Sheriffs' Association shall establish a statewide and local coordinating workgroup to identify the operation of unlicensed assisted living facilities, to develop and implement a plan to ensure appropriate enforcement of

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state laws relating to unlicensed assisted living facilities. The workgroup shall report its findings, actions, and recommendations quarterly to the Director of the Agency for Health Care Administration.

- (2) It is unlawful to knowingly refer a person for residency to an unlicensed assisted living facility; to an assisted living facility the license of which is under denial or has been suspended or revoked; or to an assisted living facility that has a moratorium on admissions. Any person who violates this subsection commits a noncriminal violation, punishable by a fine not exceeding \$500 as provided in s. 775.083.
- (a) Any health care practitioner, as defined in s. 455.501, which is aware of the operation of an unlicensed assisted living facility shall report that facility to the agency. Failure to report a facility that the practitioner knows or has reasonable cause to suspect is unlicensed shall be reported to the practitioner's licensing board.
- (b) Any hospital or community mental health center licensed under chapter 395 or chapter 394 which discharges a patient or client to an assisted living facility that the hospital or community mental health center knows or has reasonable cause to suspect is operating as an unlicensed assisted living facility is subject to an automatic sanction under chapter 394 or chapter 395.
- (c) (a) Any employee of the agency or department, or the Department of Children and Family Services, who knowingly refers a person for residency to an unlicensed facility; to a facility the license of which is under denial or has been suspended or revoked; or to a facility that has a moratorium 31 on admissions is subject to disciplinary action by the agency

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or department, or the Department of Children and Family Services.

(d) (b) The employer of any person who is under contract with the agency or department, or the Department of Children and Family Services, and who knowingly refers a person for residency to an unlicensed facility; to a facility the license of which is under denial or has been suspended or revoked; or to a facility that has a moratorium on admissions shall be fined and required to prepare a corrective action plan designed to prevent such referrals.

(e)(c) The agency shall provide the department and the Department of Children and Family Services with a list of licensed facilities within each county and shall update the list at least quarterly.

(f) (d) At least annually, the agency shall notify, in appropriate trade publications, physicians licensed under chapter 458 or chapter 459, hospitals licensed under chapter 395, nursing home facilities licensed under part II of this chapter, and employees of the agency or the department, or the Department of Children and Family Services, who are responsible for referring persons for residency, that it is unlawful to knowingly refer a person for residency to an unlicensed assisted living facility and shall notify them of the penalty for violating such prohibition. The department and the Department of Children and Family Services shall, in turn, notify service providers under contract to the respective departments who have responsibility for resident referrals to facilities. Further, the notice must direct each noticed facility and individual to contact the appropriate agency office in order to verify the licensure status of any facility 31 prior to referring any person for residency. Each notice must

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include the name, telephone number, and mailing address of the appropriate office to contact.

Section 2. Subsection (1) of section 415.1034, Florida Statutes, is amended to read:

415.1034 Mandatory reporting of abuse, neglect, or exploitation of disabled adults or elderly persons; mandatory reports of death.--

- (1) MANDATORY REPORTING. --
- (a) Any person, including, but not limited to, any:
- 1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, <u>paramedic</u>, <u>emergency medical</u> <u>technician</u>, or hospital personnel engaged in the admission, examination, care, or treatment of disabled adults or elderly persons;
- 2. Health professional or mental health professional other than one listed in subparagraph 1.;
- 3. Practitioner who relies solely on spiritual means for healing;
- 4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;
- 5. State, county, or municipal criminal justice employee or law enforcement officer;
- 6. An employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments under s. 509.032;
- 7.6. Human rights advocacy committee or long-term care ombudsman council member; or
- 30 <u>8.7.</u> Bank, savings and loan, or credit union officer, 31 trustee, or employee,

who knows, or has reasonable cause to suspect, that a disabled adult or an elderly person has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse registry and tracking system on the single statewide toll-free telephone number.

- (b) To the extent possible, a report made pursuant to paragraph (a) must contain, but need not be limited to, the following information:
- 1. Name, age, race, sex, physical description, and location of each disabled adult or an elderly person alleged to have been abused, neglected, or exploited.
- 2. Names, addresses, and telephone numbers of the disabled adult's or elderly person's family members.
- 3. Name, address, and telephone number of each alleged perpetrator. $\ensuremath{\text{a}}$
- 4. Name, address, and telephone number of the caregiver of the disabled adult or elderly person, if different from the alleged perpetrator.
- 5. Name, address, and telephone number of the person reporting the alleged abuse, neglect, or exploitation.
- 6. Description of the physical or psychological injuries sustained.
- 7. Actions taken by the reporter, if any, such as notification of the criminal justice agency.
- 8. Any other information available to the reporting person which may establish the cause of abuse, neglect, or exploitation that occurred or is occurring.
- Section 3. Paragraph (a) of subsection (2) of section 31 509.032, Florida Statutes, is amended to read:

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509.032 Duties.--

- (2) INSPECTION OF PREMISES.--
- (a) The division has responsibility and jurisdiction for all inspections required by this chapter. The division has responsibility for quality assurance. Each licensed establishment shall be inspected at least biannually and at such other times as the division determines is necessary to ensure the public's health, safety, and welfare. shall establish a system to determine inspection frequency. Public lodging units classified as resort condominiums or resort dwellings are not subject to this requirement, but shall be made available to the division upon request. during the inspection of a public lodging establishment classified for renting to transient or nontransient tenants, an inspector identifies disabled adults or elderly persons who appear to be victims of neglect, as defined in s. 415.102, or, in the case of a building that is not equipped with automatic sprinkler systems, tenants or clients who may be unable to self-preserve in an emergency, the division shall report such incidents to the Agency for Health Care Administration, the Office of State Long-Term Care Ombudsman, and the Statewide Human Rights Advocacy Committee and shall make a report to the central abuse registry and tracking system. The division in cooperation with the agency shall develop procedures for reporting possible acts of abuse by public lodging establishments housing frail elderly persons and disabled adults to the agency, the Office of State Long-Term Care Ombudsman, the Statewide Human Rights Advocacy Committee, and the central abuse registry and tracking system. The division shall maintain a statewide record of reports and actions taken by division staff. convene meetings with the following

agencies as appropriate to the individual situation: the Department of Health, the Department of Elderly Affairs, the area agency on aging, the local fire marshal, the landlord and affected tenants and clients, and other relevant organizations, to develop a plan which improves the prospects for safety of affected residents and, if necessary, identifies alternative living arrangements such as facilities licensed under part II or part III of chapter 400. Section 4. This act shall take effect July 1, 2000. *********** SENATE SUMMARY Requires the Agency for Health Care Administration in cooperation with other specified entities to establish a statewide and local coordinating workgroup to identify the operation of unlicensed assisted living facilities and to develop a plan to enforce state laws relating to unlicensed assisted living facilities. Requires a report to the agency of the workgroup's findings and recommendations. Requires health care practitioners to report known operation of unlicensed facilities. Prohibits hospital and community mental health centers from discharging a patient or client to an unlicensed facility. Requires paramedics and emergency medical technicians to report acts of abuse committed against a disabled adult or elderly person. Requires the Division of Hotels and Restaurants of the Department of Business and Professional Regulation to report to specified and Professional Regulation to report to specified agencies any known incidents of abuse committed against disabled adults or elderly persons at a public lodging. Requires the division to develop procedures and maintain records.