SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/CS/SB 1202

SPONSOR: Appropriations Committee, Judiciary Committee, Health, Aging and Long-Term Care Committee and Senator Brown-Waite

SUBJECT: Long-Term Care

DATE: April 19, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Liem/Thomas	Wilson	HC	Favorable/CS
2.	Forgas	Johnson	JU	Favorable/CS
3.			AHS	Withdrawn
4.	Peters	Wood	AP	Favorable/CS
5.				
6.				

I. Summary:

The Committee Substitute for CS/CS/SB 1202 modifies regulatory provisions and standards for long-term care facilities (nursing homes and assisted living facilities) regulated under parts II and III of chapter 400, Florida Statutes; makes changes to provisions regarding civil actions to enforce nursing home and assisted living facilities residents' rights and to seek damages in negligence actions; revises qualifications for certified nursing assistants; creates the Senior-Care-Facility Joint Underwriting Association; and provides appropriations.

The bill amends ss. 397.405; 400.0073; 400.021; 400.023; 400.0255; 400.062; 400.071; 400.102; 400.111; 400.118; 400.121; 400.126; 400.141; 400.19; 400.191; 400.211; 400.23; 400.235; 400.407; 400.414; 400.417; 400.419; 400.426; 400.4275; 400.428; 400.429; 400.434; 400.435; 400.441; 400.442; 415.1111; 464.201; 464.203, 627.351, and 768.735 Florida Statutes.

The bill creates ss. 400.0223; 400.0233; 400.0234; 400.0235; 400.0236; 400.0237; 400.0238; 400.0247; 400.147; 400; 400.148; 400.1413; 400.1755; 400.275; 400.423; 400.4293; 400.4294; 400.4295; 400.4296; 400.4297; 400.4298; 400.4303; and 400.449, Florida Statutes.

The bill creates four undesignated sections of law.

The bill reenacts provisions of law adopted last year in chapter 2000-350, Laws of Florida.

II. Present Situation:

Nursing homes have long been seen as care settings of last resort for the elderly, both because they were seen as institutions where the elderly went to die, and because of perceptions of indifferent, callous and uncaring treatment by nursing home staff. Patient advocates, family members of people in nursing homes and attorneys representing nursing home residents often have taken the position that the state system for assuring quality and humane care in nursing homes has failed and that recourse to the courts is the method of last resort to force nursing homes to provide quality care and to punish those who do not.

For more than 20 years, the State of Florida has grappled with issues relating to the quality of care that nursing homes provide to their residents. A staff analysis for Committee Substitute for Senate Bill 1218 (1980), describes the findings of a Dade County grand jury convened to investigate nursing homes operating in that county. At the time, there were 331 state-licensed nursing homes operating in Florida. The analysis states:

> The report described health hazards and deficiencies in patient care that allegedly have been allowed to continue for years. Of the 38 Dade County nursing homes surveyed by the Grand Jury, 60 percent provided either generally unacceptable or consistently very poor care. The Jury found that sanctions against homes are invoked 'rarely, timidly, and ineffectively,' and that once a deficiency is identified, on-site follow-up visits are too infrequent to ensure correction. [p. 1, *Senate Staff Analysis and Economic Impact Statement*, June 10, 1980]

The quality of nursing home care continues to be a concern because residents are generally showing increasing levels of acuity and disability and require increasingly more complex treatments. These concerns about problems in the quality of long-term care persist despite some improvements in recent years, and are reflected in, and spurred by, recent government reports, congressional hearings, newspaper stories, and criminal and civil court cases. Debate also continues over the effectiveness and appropriate scope of state and national policies to regulate long-term care, reduce poor performance of providers, and improve the health and well being of those receiving care. These questions and debates extend beyond nursing homes to home and community-based services and residential care facilities.

Regulation of Nursing Homes and Assisted Living Facilities by State Government

Nursing Homes and Related Facilities is the subject of ch. 400, F.S. Part I of ch. 400, F.S., establishes the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council, and the local long-term care ombudsman councils. Part II of ch. 400, F.S., provides for the regulation of nursing homes and part III of ch. 400, F.S., provides for the regulation of assisted living facilities. The Agency for Health Care Administration is charged with the responsibility of developing rules related to the operation of nursing homes. The Department of Elderly Affairs develops rules relating to assisted living facilities. The Agency for Health Care Administration licenses and inspects both nursing homes and assisted living facilities. The Department of Health performs inspections of facilities for sanitation and physical safety purposes and local authorities have jurisdiction over fire safety inspections.

Residents' Rights Suits

There is a growing concern among long-term care policy experts that lawsuits against nursing homes are growing nationwide and, in Florida, growing at a disproportionate rate compared to the rest of the country. The purported cause of these suits is reported to be Florida's unique statutory scheme of liability which combines a broad residents' rights civil liability cause of action with unlimited compensatory and punitive damages, combined with the lure of add-on attorney's fees. The long-term care industry perspective is that this has created an atmosphere in which nursing homes are an easy and lucrative target for litigation, and that conditions produced by the normal process of aging and frailty at the end of life are responsible for a substantial portion of the lawsuits.

Section 400.023, F.S., creates a statutory cause of action against nursing homes that deprive or infringe upon the rights of residents specified in s. 400.022, F.S. Sections 400.428 and 400.429, F.S., contain similar provisions for assisted living facilities. Proof that a facility has violated one of these statutory rights is negligence per se., that is, the facility is deemed to be negligent based solely on the violation of the statute. However, to recover damages the resident must prove the statutory violation resulted in actual damages to the resident which, typically, means the resident must have suffered some type of physical injury. Prevailing plaintiffs may be entitled to recover reasonable attorney's fees, and costs of the action, along with actual and punitive damages. Prevailing defendants may be entitled to receive attorney's fees. The statutes require that attorney's fees be based on a number of factors including time and labor involved, difficulty of the case and other similar factors.

Suits may be brought by the resident, the resident's guardian, a person or organization acting on behalf of the resident, or the personal representative of the estate of a deceased resident. Research conducted by the Task Force on the Availability and Affordability of Long-Term Care on nursing home lawsuits filed in Hillsborough County from 1990 to 2000 indicated that residents brought 11.4 percent of the suits. Family members (sons, daughters and spouses) brought 54.7 percent of the suits. If the suit alleges a deprivation of the right to receive adequate health care which results in injury or death, claimants are required to conduct an investigation which includes a review of the case by a physician or registered nurse familiar with standards of care for nursing home residents, and a statement that the deprivation of the right occurred during the resident's stay in the nursing home.

Punitive damages may be awarded for conduct which is willful, wanton, gross or flagrant, reckless, or consciously indifferent to the rights of the resident. In addition to any other standards for punitive damages, any award for punitive damages must be reasonable in light of actual harm suffered, and the egregiousness of the conduct which caused the harm. Section 768.735, F.S., limits punitive damages against nursing homes pursuant to ch. 400, F.S., to three times compensatory damages unless the claimant demonstrates to the court by clear and convincing evidence that an award in excess of the limitation is not excessive in light of the facts and circumstances that were presented.

Other Causes of Action

In addition to bringing actions under the civil enforcement provisions of ss. 400.023 and 400.429, F.S., residents can also sue nursing homes and assisted living facilities under a variety of statutory and common law theories. If a resident is injured or dies, the facility may be liable, depending on the particular facts of the situation, under theories of common law negligence, common law intentional torts such as battery, or abuse of a vulnerable adult under s. 415.1111, F.S. Most of these lawsuits must be filed within four years of the injury or two years of the resident's death. Although each of these legal theories has different elements, the common element the resident must prove in all of the causes of action is that the resident suffered actual damages as a result of the facility's conduct. Typically, these damages are related to the injury or death and are called compensatory damages, which are economic (i.e. medical bills, lost wages, etc.) and noneconomic (i.e. pain, suffering, mental anguish, etc.) in nature.

Although a nursing home and an assisted living facility are not health care providers as defined in chapter 766, F.S., (Medical Malpractice), there is authority for the proposition that the medical malpractice provisions in ch. 766, F.S., may apply to a resident's suit against a facility when the facility is vicariously liable for the professional medical negligence of the facility's employee or agent. *See, NME Properties, Inc. v. McCullough,* 590 So.2d 439 (Fla. 2d DCA 1991). If chapter 766 is applicable, the resident must engage in statutorily prescribed presuit screening and investigation measures. Additionally, chapter 766 sets limitations, in certain situations, on a resident's ability to collect economic, noneconomic and punitive damages.

The critical issue in determining whether a resident's case will have to comply with the medical malpractice provisions is whether the facility's employee or agent was negligent in providing "medical care, treatment, or services." Florida courts have struggled with this issue as many nursing home and assisted living facility cases involve mixed issues of medical care and non-medical care (i.e. custodial care.) However, recent decisions have indicated that the medical malpractice provisions will not apply when the resident only alleges a violation of the resident's right to receive adequate and appropriate health care and treatment pursuant to chapter 400, even when the violation of that right involves medical care, treatment, or services. *See, Integrated Health Care Services, Inc. v. Pauline Lang-Redway,* No. 2D00-2905 (Fla. 2d DCA March 9, 2001); *Preston v. Health Care and Retirement Corporation of America,* No. 4D00-1141 (Fla. 4th DCA April 4, 2001).

In some cases, the resident may recover punitive damages when the defendant's conduct is particularly egregious. Currently, residents of nursing homes can recover punitive damages under s. 400.023(5), F.S., when the nursing home's conduct is willful, wanton, gross or flagrant, reckless, or consciously indifferent to the rights of the resident. Residents of assisted living facilities can recover punitive damages under s. 400.429(1), F.S., when the facility's conduct is malicious, wanton, or a willful disregard of the rights of others. If the resident pursues his or her case under a common law negligence theory, he or she may recover punitive damages when the facility's conduct is of a "gross and flagrant character, evincing reckless disregard of human life, or of the safety of persons exposed to its dangerous effects, or there is that entire want of care which would raise the presumption of a conscious indifference to consequences, or which shows wantonness or recklessness, or grossly careless disregard of the safety and welfare of the public, or that reckless indifference to the rights of others which is the equivalent to an intentional

violation of them." *See White Construction Co. v. Dupont*, 455 So.2d 1026, 1029 (Fla. 1984). Florida courts have interpreted the punitive damages provisions of s. 400.023(5), F.S., as being the equivalent of the common law punitive damage standard. *See e.g., First Healthcare Corp. v. Hamilton*, 740 So.2d 1189, 1197 (Fla. 4th DCA 1999)

In 1999, ch. 99-225, L.O.F., was enacted and provided a series of measures that established new standards for pleading, proving, and recovering punitive damages in civil actions. These changes, found in ss. 768.72-768.737, F.S., also provided new limitations on the amount of punitive damages that could be recovered. However, civil actions under chapter 400, including actions against nursing homes and assisted living facilities, were expressly exempted from the new standards in s. 768.735(1), F.S., and the provisions under s. 768.735(2), F.S., apply.

Hospital Adverse Incident Reporting

Ambulatory surgical centers and hospitals must be licensed under chapter 395, F.S. Chapter 395, F.S., imposes requirements on ambulatory surgical centers and hospitals, which include inspection and accreditation. Under s. 395.0197, F.S., these facilities must have an internal risk management program. The risk management program must include the reporting of adverse incidents that result in serious patient injury. Ambulatory surgical centers and hospitals, under s. 395.0197(8), F.S., must report the following incidents, within 15 calendar days after they occur, to the Agency for Health Care Administration: death of a patient; brain or spinal damage to a patient; performance of a surgical procedure on the wrong patient; performance of a wrong-site surgical procedure; performance of a wrong surgical procedure; performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition; surgical repair of damage resulting to the patient from a planned surgical procedure where damage is not a recognized specific risk, as disclosed to the patient and documented through the informed consent process; or performance of procedures to remove unplanned foreign objects remaining in a patient following surgery.

Under s. 395.0197(8), F.S., the incident reports filed with the Agency for Health Care Administration may not be made available to the public under s. 119.07(1), F.S., or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Health or the appropriate regulatory board. The incident reports may not be made available to the public as part of the records of investigation for and prosecution in disciplinary proceedings that are made available to the public. The Department of Health or the appropriate regulatory board must make available, upon written request by a health care professional against whom probable cause has been found, any such records, which form the basis of the determination of probable cause. The Department of Health must review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action under the provisions of s. 456.073, F.S.

Patient Confidentiality under Disciplinary Procedures

Section 456.073, F.S., provides procedures to be used for the discipline of health care practitioners. Disciplinary complaints and all information obtained by the Department of Health are confidential and exempt from the public records and meetings laws until 10 days after

probable cause is found or the subject of the complaint waives confidentiality. Section 456.057(8), F.S., provides that all patient records obtained by the Department of Health and any other documents maintained by the department which identify the patient by name are confidential and exempt from the public records and meetings laws, and may be used solely by the department and the appropriate regulatory board in their investigation, prosecution, and appeal of disciplinary proceedings. The patient records may not be made available to the public as part of the record of investigation for and prosecution in disciplinary proceedings.

Chapter 2000-235, Laws of Florida, amended the following sections:

- s. 400.0255(3), (8), F.S., relating to discharge or transfer of residents;
- s. 400.034(5), F.S., relating to rules for standards of care for persons under a specified age residing in nursing home facilities;
- s. 400.191(2), (6), F.S., relating to requirements for providing information to consumers;
- s. 400.0225, F.S., relating to consumer satisfaction surveys for nursing homes;
- s. 400.141(4), (5), F.S., relating to the repackaging of residents' medication and access to other health-related services;
- s. 400.235(3)(a), (4), (9), F.S., relating to designation under the nursing home Gold Seal Program;
- s. 400.962(1), F.S., relating to the requirement for licensure under pt. IX of ch. 400, F.S.;
- 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.

Joint Underwriting Associations

Section 627.351, F.S., contains provisions creating six separate joint underwriting associations to provide insurance coverage in areas where coverage is otherwise impossible to obtain or excessively expensive. Subsection (1) creates the Motor Vehicle Insurance Risk Apportionment, subsection (2) creates the Windstorm Insurance Risk apportionment, subsection (3) creates the political subdivision; casualty insurance risk apportionment, subsection (4) creates the Medical Malpractice Risk Apportionment, subsection (5) creates the Property and Casualty Insurance Risk Apportionment, and subsection (6) creates the Residential Property and Casualty Joint Underwriting Association. The political subdivision; casualty insurance risk apportionment in subsection (3) and the Property and Casualty Insurance Risk Apportionment in subsection (5) are no longer active associations.

The Task Force on the Availability and Affordability of Long-Term Care

The Legislature created, in the 2000 Session, the Task Force on the Availability and Affordability of Long-Term Care. The purpose of the task force was to assess the current long-term care system in terms of the availability of alternatives to nursing homes, the quality of care in nursing homes and the impact of lawsuits against nursing homes and other long-term care facilities on the costs of care and the financial stability of the long-term care industry. On February 16, 2001, the task force submitted an extensive report to the Legislature. The full report is available electronically at:
http://www.fpeca.usf.edu/Task%20Force/Publications/Documents/finalreportnew.PDF

Senate Interim Project 2001-25

Staff of the Committee on Health, Aging, and Long-Term Care published an interim report on long-term care issues. The report provides recommendations in three areas: developing a coordinated planning structure for the long-term care system, improving the quality of care in long-term care facilities and developing ways to make liability insurance more affordable for long-term care facilities. The report is available electronically at: http://www.leg.state.fl.us/data/Publications/2001/Senate/reports/interim_reports/pdf/2001-025hc.pdf

III. Effect of Proposed Changes:

Section 1. Amends s. 400.0073, F.S., to require local ombudsman annual administrative inspections to focus on the rights, health, safety and welfare of the residents.

Section 2. Amends s. 400.021, F.S., to define "controlling interest" as applied to nursing home licensure applicants or nursing home licensees; modify the definition of "resident care plan" to provide for the highest level of function of the resident and require signatures of the director of nursing and the resident; and define "voluntary board member."

Section 3. Creates s. 400.0223, F.S., providing for electronic monitoring devices in resident rooms, to require: nursing homes to permit residents to use electronic monitoring devices; posting of notice of the use of such devices; residents to pay for the devices; protection of the privacy rights of other residents; and nursing homes to make certain physical accommodations for electronic monitoring. Subject to the Florida Rules of Evidence, electronic monitoring tapes are admissible as evidence in either civil or criminal actions. The section provides penalties for violations of these provisions and for obstructing, tampering with, or destroying devices or tapes.

Section 4. Substantially revises s. 400.023, F.S., providing for civil enforcement of resident's rights. A negligence standard is incorporated for all causes of action brought pursuant to this section for a violation of the resident's rights or negligence. A resident will be required to prove that a defendant owed a duty to the resident, the duty was breached, the breach of that duty was the cause of injury, and damages resulted therefrom. The section provides that a licensee, person or entity has a duty to exercise reasonable care, which is that degree of care a reasonably careful licensee, person, or entity would use under like circumstances. A nurse licensed under Part I of chapter 464, F.S., has a duty to exercise care consistent with the prevailing professional standard of care for a nurse, which is 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. A violation of any right contained in s. 400.022, F.S., is evidence of negligence, but not negligence per se or strict liability.

An action alleging a claim for resident's rights or negligence that caused the death of the resident requires the claimant to elect either survival damages pursuant to s. 46.021, F.S., or wrongful death damages pursuant to s. 768.21, F.S. This effectively allows the personal representative of the estate of the deceased resident to recover: (1) on behalf of the estate, economic damages and noneconomic damages for the resident's pain and suffering from the time of injury until the

resident's death (i.e. survival damages); or (2) economic damages for the estate and noneconomic damages for the pain and suffering of the deceased resident's survivors, as set forth in s. 768.21, F.S., (i.e. spouse, adult children, and/or minor children.)

A resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover costs, and attorney's fees not to exceed $25,000. This section eliminates the recovery of attorney's fees for cases involving injury or death.

The theories of recovery in this section are in addition to, and cumulative with, other legal and administrative actions. However, this section expressly provides that the medical malpractice provisions of chapter 766, F.S., do not apply.

This section applies to causes of action accruing on or after July 1, 2001.

Section 5. Creates s. 400.0233, F.S., to provide for presuit investigation, notification, discovery, and mediation requirements. Prior to filing a lawsuit alleging a violation of resident's rights or negligence, the claimant's attorney must conduct a reasonable investigation that gives rise to a good faith belief that grounds exist for an action against a defendant. The attorney is also required to provide each prospective defendant with written notification of the asserted claim, which must identify the rights that were violated and the negligence that caused the incident and injuries.

After receiving notice of the claim, the defendant must conduct an investigation to evaluate the potential liability and damages. The investigation must be completed no later than 75 days after receipt of the notice. The statute of limitations is tolled during the 75-day investigation period. During the investigation, the parties may engage in informal discovery, which includes the production of records and documents, as well as the taking of unsworn statements of parties. The unsworn statements and other statements, discussions, documents, reports, or work product generated by this presuit process are not discoverable or admissible in any civil action, for any purpose, by the opposing party.

Upon completing its presuit investigation, a defendant can reject the claim or make a settlement offer. If the defendant makes an offer, the claimant has 15 days from the date of the receipt of the offer to accept it by written notice. If the defendant rejects the claim or the claimant does not accept an offer from the defendant, the parties must meet in mediation within 30 days of the defendant's response to the claim.

This section is effective July 1, 2001, and applies to causes of action accruing on or after that date.

Section 6. Creates s. 400.0234, F.S., to provide that failure to furnish complete copies of a resident's records, which are in the possession and control of a facility, shall constitute evidence of a failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements for the requesting party.

Section 7. Creates s. 400.0235, F.S., to expressly provide that actions under this part are not claims for medical malpractice and that the provisions of s. 768.21(8), F.S., do not apply to a claim alleging the death of a resident.

Section 8. Creating s. 400.0236, F.S., to provide a statute of limitations. Actions for damages brought pursuant to this part must be commenced within 2 years from the time the incident occurred or within 2 years from the time the incident is discovered or should have been discovered with the exercise of due diligence. The action cannot be brought later than 4 years from the date of the incident or occurrence. However, when 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 the injury is discovered with the exercise of due diligence, but in no event to exceed 6 years from the date of the incident.

This section applies to causes of action that have accrued prior to the effective date of this act (July 1, 2001.) However, a savings clause is instituted to preserve those claims that would not have been barred under prior law.

Section 9. Creating s. 400.0237, F.S., to provide standards relating to the pleading and recovery of punitive damages. To recover punitive damages, a claimant must prove by clear and convincing evidence that a defendant was personally guilty of intentional misconduct or gross negligence, as those terms are defined in this section. An employer will be responsible for punitive damages resulting from an employee's conduct only if: (1) the employer actively and knowingly participated in the employee's conduct; (2) the officers, directors, or managers of the employer knowingly condoned, ratified, or consented to the employee's conduct; or (3) the employer engaged in conduct that constitutes gross negligence that contributed to the loss, damages, or injury suffered by the claimant. This section is stated to be remedial in nature and takes effect upon becoming law.

Section 10. Creates s. 400.0238, F.S., to provide limitations on punitive damages. This section provides that punitive damages are generally limited to the greater of three times compensatory damages or $1,000,000. Where the defendant's conduct was motivated solely by unreasonable financial gain and 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, punitive damages are limited to the greater of four times compensatory damages or $4,000,000. However, when the defendant had a specific intent to harm the claimant and the defendant's conduct did in fact harm the claimant, there is no cap on punitive damages.

This section also provides that a court may use its discretion pursuant to s. 768.74, F.S., relating to additur and remittitur of damage awards, when considering the reasonableness of a punitive damage award that is less than three times compensatory damages. A jury may not be informed of the provisions of this section. Also, claimant's attorney's fees may only be based upon the amount of punitive damages entered in the final judgment, as opposed to the amount awarded by the jury.

This section is stated to be remedial in nature and takes effect upon becoming law.

Section 11. Amends s. 768.735, F.S., relating to exceptions to punitive damages standards in certain sections of ch. 768, F.S., to conform this section with changes made by this act.

Section 12. Amends s. 415.1111, F.S., relating to civil actions for abuse, neglect or exploitation of vulnerable adults, to provide that it does not apply to any licensee or entity who establishes, controls, conducts, manages, or operates a nursing home or assisted living facility.

Section 13. Creates s. 400.0247, F.S., to provide that, in any action where punitive damages are awarded in lawsuits against nursing homes, the clerk of the court shall forward to the state attorney of that circuit a copy of the complaint, any amended complaints, the verdict form, and the final judgment.

Section 14. Amends s. 400.0255, F.S., relating to transfer or discharge from a nursing home, to provide that the provisions of that section only apply to transfers or discharges initiated by the nursing home and not those actions initiated by the resident, resident's representative, or resident's physician.

Section 15. Amends s. 400.062, F.S., to increase the maximum base license fee for nursing homes from $35 to $50 per bed and provides that the agency may adjust the per bed licensure fees by the Consumer Price Index based on the 12 months immediately preceding the increase to cover the cost of regulation. The bill revises the minimum deposit amount from $500,000 to $1 million in the Resident Protection Trust Fund and provides for rate adjustments when funds are below that level to bring up the balance in the trust fund. It also revises the balance in the trust fund from $500,000 to $1 million for which the increased rates must revert back to the minimum rate per bed. Additionally, the bill revises the threshold amount from $800,000 to $2 million for reversions to the Health Care Trust Fund.

Section 16. Amends s. 400.071, F.S., to require an applicant for licensure to provide identifying information for any controlling interest. A subsection is added requiring a signed affidavit disclosing any financial or ownership interest held by specified individuals in the last 5 years in an entity in this or any other state which has closed voluntarily or involuntarily; which 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. The agency is required to establish standards for reporting this information. The agency is authorized to issue an inactive license to a nursing home temporarily unable to provide services, which is reasonably expected to resume services. A nursing home seeking an inactive license must obtain agency approval prior to suspending services or notifying residents of the need to be transferred or discharged. Facilities must establish and submit plans for quality assurance and risk management with applications for licensure.

Section 17. Amends s. 400.102, F.S., authorizing the agency to take action against a licensee for fraudulently altering, or falsifying or causing the fraudulent altering or falsifying of, medial records or nursing home records.

Section 18. Amends s. 400.111, F.S., to prohibit the renewal of a license if the applicant has failed to pay state or federal fines except where the applicant places the fine amount in escrow

for the period of the appeal. Requires licensure disclosure of bankruptcy, licensed denials, suspensions, revocations or injunctions.

Section 19. Amends s. 400.118, F.S., to require quality-of-care monitors to visit each nursing facility at least quarterly, and to require that priority for additional visits be given to facilities with a history of patient care deficiencies. A requirement that quality-of-care monitors assess operations of internal quality-improvement and risk-management programs and adverse incident reports is added. Quality of care monitors are required to immediately report conditions that represent repeated observations of deficient practice to area office supervisors for appropriate regulatory action.

Section 20. Amends s. 400.121, F.S., to allow the agency to deny, suspend or revoke a license, or levy a fine of no more than $500 per day on a facility which has a demonstrated pattern of deficient practice, failed to pay state or federal fines, been excluded from Medicaid or Medicare or been the subject of an adverse action against any controlling interest including the appointment of a receiver, denial or suspension or revocation of a license or the issuance of an injunction by a regulatory agency. If the adverse action involves solely a management company, the applicant or licensee is to be given 30 days to remedy before final action is taken. The bill replaces permissive language, which allowed the agency to deem the proper level of such fines up to a limit of $500, with a requirement that these fines be $500 per violation. The bill specifies that administrative proceedings challenging agency action must be reviewed based on facts and conditions that resulted in the initial agency action. Where the licensee has appealed a fine the agency may not deny, suspend or revoke the license if the fine amount is placed in escrow.

Section 21. Amends s. 400.126, F.S., to require a Comprehensive Assessment and Review for Long-Term-Care for residents in a nursing home for which a receiver has been appointed.

Section 22. Amends 400.141, F.S., to require nursing facilities to submit the information regarding controlling interests in a management company within 30 days of the effective date of the management agreement; submit semiannually or more often if required, 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. Reporting of vacant beds in a facility is required monthly. The bill provides formulas for calculating ratios and turnover, and exempts employees terminated in a probationary period from the turnover calculation.

The bill requires nursing facilities to notify a licensed physician when a resident exhibits signs of mental, psychosocial, or adjustment difficulty. The physician must be notified within 30 days of acknowledgement of signs by facility staff. The facility is required to arrange for necessary care and services to treat any underlying condition.

If the facility implements a dining and hospitality attendant program, it must be developed and implemented under the supervision of the facility director of nursing; a licensed nurse, licensed speech or occupational therapist, or dietitian must conduct the training of the attendants; and a person employed in this program must perform tasks under the direct supervision of a licensed nurse.

Each nursing facility is required to report to the agency, within 30 days, any filing for bankruptcy protection by the facility or a parent corporation, spin-off or divestiture of assets, and corporate reorganization.

Each facility is required to maintain liability insurance coverage that is in force at all times.

Section 23. Section 400.1413, F.S., is created to provide nursing homes the authority to place requirements on volunteers in the facility.

Section 24. Creates s. 400.147, F.S., to require nursing facilities to implement an internal risk-management and quality-assurance program. The purpose of this program is to assess patient care practices; review facility quality indicators, facility incident reports, deficiencies cited by the agency, shared-risk agreements, and resident grievances; and to develop plans of action to correct and respond quickly to identified quality deficiencies. The program must include a risk manager who is responsible for implementation and oversight of the facility's risk-management and quality-assurance program.

The bill requires each nursing facility to have a risk-management and quality-assurance committee that is required to meet monthly. Facilities must develop policies and procedures to implement the program, including the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents. The internal risk-management and quality-assurance program is the responsibility of the facility administrator.

The risk-management and quality-assurance program must include an education and training component for all non-physician personnel as part of an initial orientation and at least 1 hour annually of such training for all non-physician personnel working in clinical areas and providing resident care; analysis of resident grievances which relate to resident care and quality of clinical services; and the development of an incident reporting system. The bill specifies that in addition to the other programs mandated, the program must encourage development, implementation and operation of other innovative approaches intended to reduce the frequency and severity of adverse incidents to residents and violations of resident's rights.

The internal risk-management and quality-assurance program must include the use of incident reports that are to be filed with the risk manager and the facility administrator. The risk manager is to have free access to all resident records of the facility. Incident reports are to be used to develop categories of incidents, which identify problem areas. Once identified, procedures are to be adjusted to correct the problem area. The incident reports are part of the work papers of an attorney and, though subject to discovery, are not admissible as evidence in court.

Adverse incident is defined as an event over which the facility staff could have exercised control and which is associated in whole or in part with the facility's intervention, rather than the condition for which the intervention occurred. Adverse incidents are those events which result in death; brain or spinal damage; permanent disfigurement; fracture or dislocation of bones or joints; a resulting limitation of neurological, physical, or sensory function; any condition requiring medical attention to which the resident has not given his or her informed consent including failure to honor advance directives; 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; abuse, neglect, or exploitation; resident elopement; or an event that is reported to law enforcement.

The facility is required to notify the agency within 1 business day after the risk manager or his or her designee receives the report of an adverse incident. The agency is allowed to investigate any such incident, as it deems appropriate, and is allowed to prescribe measures that must or may be taken in response to the incident. The agency is to review each incident and determine whether the incident potentially involved conduct by a health care professional who is subject to disciplinary action. If this is the case, the provisions related to disciplinary proceedings of s. 456.073, F.S., apply. The notification is confidential and not discoverable or admissible in any civil or administrative action, except disciplinary proceedings by the agency or regulatory boards.

Each facility must complete the investigation and submit an adverse incident report to the agency for each adverse incident within 15 calendar days after its occurrence, on a form developed by the agency. The agency is to review the information, and determine whether the incident potentially involved conduct subject to the disciplinary proceedings of s. 456.073, F.S. The adverse incident report must contain the name and license number of the risk manager. The report is confidential and not discoverable or admissible in any civil or administrative action, except disciplinary proceedings by the agency or a professional board.

Each facility must report monthly any liability claim filed against it to include the name of the resident, the date of the incident, and the type of injury or violation alleged.

Internal risk managers are required to investigate every allegation of sexual misconduct against a member of the facility's personnel who has direct resident contact, if it is alleged that the sexual misconduct occurred at the facility or on its grounds. The risk manager is required to 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.

Witnesses or those possessing actual knowledge of the act that is the basis of an allegation of sexual misconduct are required to notify local law enforcement, the central abuse hotline, the facility risk manager and administrator. The term "sexual abuse" is defined.

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

There is no monetary liability or cause of action against any licensed risk manager for the implementation and oversight of the internal risk-management and quality-assurance program or acts or proceedings within the scope of the program, if the risk manager acts without intentional fraud.

If the agency has a reasonable belief that conduct of a facility employee is grounds for disciplinary action by a regulatory board, the agency is required to report this to the regulatory board.

The agency is authorized to adopt rules to administer this section, and is required to submit an annual report to the Legislature about nursing home internal risk-management. The information in the report is to be arrayed by county and include the total number of adverse incidents, listings by category and types of injuries, types of staff involved, types of claims filed based on an adverse incident or reportable injury and disciplinary action taken against staff, categorized by type of staff involved.

Section 25. Creates s. 400.148, F.S., to require the agency to develop a pilot project to ensure the quality of care of residents by placing skilled and trained medical personnel in the highest-scoring nursing homes in the Florida Nursing Home Guide. The agency is authorized to begin the pilot, subject to an appropriation, in the highest scoring homes in counties where Evercare services are immediately available. The agency is required to report to the Legislature and Governor and assess the program and submit a proposal for expansion to additional facilities. The bill specifies several criteria that the project must ensure. The agency is authorized to provide this service through contract.

Section 26. Creates s. 400.1755, F.S., to provide that individuals who provide care to persons with Alzheimer's disease must complete dementia-specific training. The duration of the training and the time within which the training must be completed are specified. Upon completion of the training, the trainee must be issued a certificate. The Department of Elderly Affairs, or its designee, must approve training courses and providers. The department is authorized to adopt rules.

Section 27. Amends s. 400.19, F.S., to require that unannounced on-site visits be conducted every 3 months for each facility with a conditional license.

Section 28. Amends s. 400.191, F.S., to: require the Agency for Health Care Administration to publish a "Nursing Home Guide Watch List"; specify the content of the watch list; require that the agency transmit the watch list to each facility by mail and make the watch list available on its web site; and to require nursing facilities to post the most recent version of the nursing home watch list.

Section 29. Amends s. 400.211, F.S., to allow nursing facilities to employ, for up to 4 months, individuals as nursing assistants who are not yet certified as nursing assistants but who are enrolled in or have completed state-approved nursing assistant programs, or who are actively certified and on the registry in another state and who have not been found guilty of abuse, neglect, or exploitation in that state. Nursing assistants employed by nursing facilities for 12 months or longer must, as a condition of maintaining certification, submit to performance reviews and receive regular in-service education based on the outcome of performance reviews. In-service education must be sufficient to ensure continuing competence of nursing assistants, be at least 18 hours per year and may include hours accrued under certified nursing assistant continuing education requirements. Annual training must include techniques for assisting with eating and proper feeding; principles of adequate nutrition and hydration; techniques for assisting and responding to cognitively impaired residents or residents with difficult behaviors; end-of-life care techniques; and recognizing changes that place a resident at risk for pressure ulcers and

falls. The training must address areas of weakness as determined in performance reviews and may address the special needs of residents as determined by the facility staff.

Section 30. Amends s. 400.23, F.S., to require adoption of rules regarding the implementation of the consumer-satisfaction survey; the availability, distribution and posting of reports and records; and the Gold Seal Program. The agency is required to adopt rules specifying a minimum staffing standard for certified nursing assistants of 2.3 hours of direct care per resident per day beginning January 1, 2002, increasing to 2.6 hours beginning January 1, 2003, increasing to 2.8 hours beginning January 1, 2004, and increasing to 2.9 hours beginning January 1, 2005. The nursing assistant staff ratio is never to be below 1 certified nursing assistant per 20 residents. A minimum licensed nursing standard of 1.0 hour direct resident care per resident per day is established. The licensed nursing staff ratio is to never be below one licensed nurse per 40 residents. Each nursing home is required to document compliance with these staffing standards and post daily the names of staff on duty. Nursing assistants employed under s. 400.211(2), F.S., may be included in the staffing ratios only if they provide services on a full-time basis.

The fines for violation of each of the three classes of deficiency with which a nursing home can be charged are subdivided into three categories, "isolated", "patterned", or "widespread". An isolated deficiency is a deficiency affecting one or a very limited number of residents or staff, or is a situation that occurs 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 or staff are involved, the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the deficient practice, but the effect is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency where the problems causing the deficiency are pervasive in the facility or represent systemic failure that affected or could affect a large portion of the residents.

The fines for each level of deficiency are based on whether the deficiency was isolated, patterned or widespread, with the fine increasing for each type.

Section 31. Amends s. 400.235, F.S., to modify the Gold Seal Program stable workforce requirement to use the calculation methodology described in s. 400.141, F.S.

Section 32. Creates s. 400.275, F.S., to require the agency to assign newly-hired surveyors, as part of basic training, to a nursing home for at least 2 days within a 7 day period to observe facility operations before the surveyor begins survey responsibilities. The agency may not assign a surveyor to perform a survey, evaluation, or consultation at a nursing home in which the surveyor was an employee within the preceding 5 years. The agency is required to provide semiannual joint training for nursing home surveyors and facility staff on at least one of the 10 federal citations most frequently issued against nursing homes in Florida. The bill requires members of nursing home survey teams who are licensed as nurses, dieticians or nutritionists, or clinical counselors and psychotherapists, to earn no less than 50% of the required continuing education credits in geriatric care. Surveyors who are pharmacists are required to earn no less than 30% of the required continuing education hours in geriatric care. The agency is to ensure that a physician or nurse with geriatric experience participates in the agency's informal dispute resolution process.

Section 33. Amends s. 400.407, F.S., to increase the frequency of agency monitoring visits for assisted living facilities licensed to provide extended congregate care services from 2 times per year to quarterly and assisted living facilities licensed to provide limited nursing services from once a year to twice a year. Conforming changes relating to the frequency of licensure inspections are made. The fee structure for licensure of assisted living facilities is modified. Under current statutes licenses are biennial, with a base fee for standard facilities of $240 plus an additional $30 per bed to a maximum fee of $10,000. No fee is assessed for beds designated for recipients of optional state supplementation payments. Facilities licensed as extended congregate care facilities are charged an additional base fee of $400. Facilities licensed to provide limited nursing services are charged an additional base fee of $200 per license with an additional fee of $10 per resident. The total biennial fee may not exceed $2,000. The bill revises the biennial standard license fee to $50 per bed, exempts optional state supplementation beds from this fee, requires a minimum standard licensure fee of $261 and limits the fee to a maximum of $10,000 for assisted living facilities. An additional fee of $100 is charged for each bed approved for extended congregate care and an additional fee of $75 for each bed approved for limited nursing services to a maximum fee of $10,000. The agency is required to annually adjust each per bed licensure fee and the minimum and maximum limits by the Consumer Price Index based on the 12 months immediately preceding the increase.

Section 34. Amends s. 400.414, F.S., to include, as grounds for which the agency may deny, revoke, or suspend a license or impose an administrative fine, any act which constitutes a ground upon which application for a license may be denied. The agency may issue a temporary license pending disposition of a proceeding involving the suspension or revocation of an assisted living facility license.

Section 35. Amends s. 400.417, F.S., to change the name of the biennial licenses to a standard license.

Section 36. Amends s. 400.419, F.S., to increase the minimum administrative fines for all classes of violations in assisted living facilities. Penalties for class I violations (deficiencies which present an imminent danger to residents or guests or a substantial probability of death or physical harm) are set at no less than $5,000 not to exceed $10,000. The current levels for these violations are from $1,000 to $10,000. The agency may levy such a fine notwithstanding the correction of the violation. Penalties for class II violations (those that directly threaten the health, safety or security of residents) are set at an amount no less than $1,000 not to exceed $5,000. The current levels for these violations are from $500 to $5,000 for each violation. The bill specifies that a citation for a class II violation must specify the time within which the violation is to be corrected and deletes a provision, which prevented imposition of the penalty for class II violations if the violation is corrected within specified time limits, unless it is a repeat offense. The penalty for class III violations (an indirect or potential relationship to health, safety, or security of residents) is set at no less than $500 not to exceed $1,000 for each violation. The current levels for these violations are from $100 to $1,000 for each violation. The bill specifies that a citation for a class III violation must specify the time within which the violation is to be corrected. The penalty for uncorrected class IV violations (those which do not have the potential of negatively affecting residents) is set from $100 to $200 per violation. The current levels for these violations are $50 to $200 for each violation. The bill deletes a provision allowing the agency to impose fines for violations, which cannot be classified according to the classification system.

The bill increases the penalty for operation of an unlicensed assisted living facility to $1,000 per day from the current level of $500 per day for each day beyond 5 days after agency notification. In the instance of an unlicensed facility operated by an owner or administrator who concurrently operates a licensed facility, the fine is increased from $500 per day to $5,000 per day. The bill removes the discretion of the agency to set the level of a fine at up to $5,000 for owners who fail to apply for a change-of-ownership license, replacing it with a flat fine of $5,000.

Section 37. Creates s. 400.423, F.S., providing for voluntary internal risk-management and quality-assurance programs in assisted living facilities. The purpose of this program is to assess patient care practices; review facility quality indicators, facility incident reports, deficiencies cited by the agency, shared-risk agreements, and resident grievances; and develop plans of action to correct and respond quickly to identified quality deficiencies.

Each facility is required to maintain adverse incident reports. Adverse incident is defined as an event over which the facility staff could have exercised control and which is associated in whole or in part with the facility's intervention, rather than the condition for which the intervention occurred. Adverse incidents are those events which result in death; brain or spinal damage; permanent disfigurement; fracture or dislocation of bones or joints; any condition requiring medical attention to which the resident has not given his or her informed consent including failure to honor advance directives; 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; abuse, neglect, or exploitation; resident elopement; or an event that is reported to law enforcement.

The facility, regardless of the number of beds, is required to notify the agency within 1 business day after the occurrence an adverse incident. The agency is to review each incident and determine whether the incident potentially involved conduct by the health care professional who is subject to disciplinary action. If this is the case, the provisions related to disciplinary proceedings of s. 456.073, F.S., apply. The notification is confidential and not discoverable or admissible in any civil or administrative action, except disciplinary proceedings by the agency or regulatory boards.

Each facility, regardless of the number of beds, must submit an adverse incident report to the agency for each adverse incident within 15 calendar days after its occurrence.

If the agency has a reasonable belief that conduct of a facility employee is grounds for disciplinary action by a regulatory board, the agency is required to report this to the regulatory board.

The agency is required to submit an annual report to the Legislature about assisted living facility internal risk-management. The information in the report is to be arrayed by county and include the total number of adverse incidents, listings by category and types of injuries, types of claims filed based on an adverse incident or reportable injury and disciplinary action taken against staff, categorized by type of staff involved.

The adverse incident reports and preliminary adverse incident reports 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.

Section 38. Amends s. 400.426, F.S., to require assisted living facilities to notify a licensed physician when a resident exhibits signs of mental, psychosocial, or adjustment difficulty. The physician must be notified within 30 days of acknowledgement of signs by facility staff. The facility is required to arrange for necessary care and services to treat any underlying condition.

Section 39. Amends s. 400.4275, F.S., to require an assisted living facility to maintain liability coverage of at least $250,000 per claim with an annual aggregate amount of $500,000.

Section 40. Amends s. 400.428, F.S., to make conforming changes relating to the frequency of licensure surveys.

Section 41. Amends s. 400.429, F.S., relating to civil actions to enforce assisted living facility resident's rights. A negligence standard is incorporated for all causes of action brought pursuant to this section for a violation of the resident's rights or negligence. A resident will be required to prove that a defendant owed a duty to the resident, the duty was breached, the breach of that duty was the cause of injury, and damages resulted therefrom. The section provides that a licensee, person or entity has a duty to exercise reasonable care, which is that degree of care a reasonably careful licensee, person, or entity would use under like circumstances. A nurse licensed under Part I of chapter 464, F.S., has a duty to exercise care consistent with the prevailing professional standard of care for a nurse, which is 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. A violation of any right contained in s. 400.428, F.S., is evidence of negligence, but not negligence per se or strict liability.

An action alleging a claim for resident's rights or negligence that caused the death of the resident requires the claimant to elect either survival damages pursuant to s. 46.021, F.S., or wrongful death damages pursuant to s. 768.21, F.S. This effectively allows the personal representative of the estate of the deceased resident to recover: (1) on behalf of the estate, economic damages and noneconomic damages for the resident's pain and suffering from the time of injury until the resident's death (i.e. survival damages); or (2) economic damages for the estate and noneconomic damages for the pain and suffering of the deceased resident's survivors as set forth in s. 768.21, F.S., (i.e. spouse, adult children, and/or minor children.)

A resident who prevails in seeking injunctive relief or a claim for an administrative remedy is entitled to recover costs, and attorney's fees not to exceed $25,000. This section eliminates the recovery of attorney's fees for cases involving injury or death.

The theories of recovery in this section are in addition to, and cumulative with, other legal and administrative actions. However, this section expressly provides that the medical malpractice provisions of chapter 766, F.S., do not apply.

This section applies to causes of action accruing on or after July 1, 2001.

Section 42. Creates s. 400.4293, F.S., to provide presuit notice, investigation, discovery, and mediation requirements. Prior to filing a lawsuit alleging a violation of resident's rights or negligence, the claimant's attorney must conduct a reasonable investigation that gives rise to a good faith belief that grounds exist for an action against a defendant. The attorney is also required to provide each prospective defendant with written notification of the asserted claim, which must identify the rights that were violated and the negligence that caused the incident and injuries.

After receiving notice of the claim, the defendant must conduct an investigation to evaluate the potential liability and damages. The investigation must be completed no later than 75 days after receipt of the notice. The statute of limitations is tolled during the 75-day investigation period. During the investigation, the parties may engage in informal discovery, which includes the production of records and documents, as well as the taking of unsworn statements of parties. The unsworn statements and other statements, discussions, documents, reports, or work product generated by this presuit process are not discoverable or admissible in any civil action, for any purpose, by the opposing party.

Upon completing its presuit investigation, a defendant can reject the claim or make a settlement offer. If the defendant makes an offer, the claimant has 15 days from the date of the receipt of the offer to accept it by written notice. If the defendant rejects the claim or the claimant does not accept an offer from the defendant, the parties must meet in mediation within 30 days of the defendant's response to the claim.

This section is effective July 1, 2001, and applies to causes of action accruing on or after that date.

Section 43. Creates s. 400.4294, F.S., to provide that failure to furnish complete copies of a resident's records, which are in the possession and control of a facility, shall constitute evidence of a failure of that party to comply with good faith discovery requirements and shall waive the good faith certificate and presuit notice requirements for the requesting party.

Section 44. Creates s. 400.4295, F.S., to expressly provide that actions under this part are not claims for medical malpractice and that the provisions of s. 768.21(8), F.S., do not apply to a claim alleging the death of a resident.

Section 45. Creates s. 400.4296, F.S., to provide a statute of limitations. Actions for damages brought pursuant to this part must be commenced within 2 years from the time the incident occurred or within 2 years from the time the incident is discovered or should have been discovered with the exercise of due diligence. The action cannot be brought later than 4 years from the date of the incident or occurrence. However, when 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 the injury is discovered with the exercise of due diligence, but in no event to exceed 6 years from the date of the incident.

This section applies to causes of action that have accrued prior to the effective date of this act (July 1, 2001.) However, a savings clause is instituted to preserve those claims that would not have been barred under prior law.

Section 46. Creates s. 400.4297, F.S., to provide standards relating to the pleading and recovery of punitive damages. To recover punitive damages, a claimant must prove by clear and convincing evidence that a defendant was personally guilty of intentional misconduct or gross negligence, as those terms are defined in this section. An employer will be responsible for punitive damages resulting from an employee's conduct only if: (1) the employer actively and knowingly participated in the employee's conduct; (2) the officers, directors, or managers of the employer knowingly condoned, ratified, or consented to the employee's conduct; or (3) the employer engaged in conduct that constitutes gross negligence that contributed to the loss, damages, or injury suffered by the claimant. This section is stated to be remedial in nature and takes effect upon becoming law.

Section 47. Creates s. 400.4298, F.S., to provide limitations on punitive damages. This section provides that punitive damages are generally limited to the greater of three times compensatory damages or $1,000,000. Where the defendant's conduct was motivated solely by unreasonable financial gain and 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, punitive damages are limited to the greater of four times compensatory damages or $4,000,000. However, when the defendant had a specific intent to harm the claimant and the defendant's conduct did in fact harm the claimant, there is no cap on punitive damages.

This section also provides that a court may use its discretion pursuant to s. 768.74, F.S., relating to additur and remittitur of damage awards, when considering the reasonableness of a punitive damage award that is less than three times compensatory damages. A jury may not be informed of the provisions of this section. Also, claimant's attorney's fees may only be based upon the amount of punitive damages entered in the final judgment, as opposed to the amount awarded by the jury.

This section is stated to be remedial in nature and takes effect upon becoming law.

Section 48. Creates s. 400.4303, F.S., to provide that, in any action where punitive damages are awarded in a lawsuit against an assisted living facility, the clerk of the court shall forward to the state attorney of that circuit a copy of the complaint, any amended complaints, the verdict form, and the final judgment.

Section 49. Amends s. 400.434, F.S., to allow the agency to use data collected by long-term care ombudsman councils in investigations involving violations of regulatory standards.

Section 50. Amends s. 400.435, F.S., to make conforming changes regarding frequency of assisted living facility licensure inspections.

Section 51. Amends s. 400.441, F.S., to require the Department of Elderly Affairs, in consultation with the agency, the Department of Children and Family Services, and the Department of Health to adopt rules, policies and procedures regarding the use of internal risk-management and quality-assurance in assisted living facilities, and to make conforming changes regarding the frequency of licensure inspections and delete obsolete provisions.

Section 52. Amends s. 400.442, F.S., to make conforming changes regarding the frequency of assisted living facility licensure surveys.

Section 53. Creates s. 400.449, F.S., to make fraudulent alteration, falsification, or defacement of medical or other records of assisted living facilities, or causing or procuring such offense to be committed, a second-degree misdemeanor, and specify that conviction for such offense is grounds for restriction, suspension or termination of license privileges.

Section 54. Amends s. 464.203, F.S., to require a certified nursing assistant who has not performed nursing-related services for monetary compensation for a period of 24 consecutive months to be re-certified; and require a minimum of 18 hours of continuing education during each calendar year of certification. The Council on Certified Nursing Assistants are to propose rules to implement this part.

Section 55. Amends s. 397.405, F.S., to correct a cross-reference.

Section 56. The agency is prohibited from approving any additional certificates of need for nursing home beds until July 1, 2006

Sections 57 through 64. These sections reenact provisions of law adopted last year in chapter 2000-350, Laws of Florida.

Section 65. Section 627.351, F.S., is amended to add a Senior-Care-Facility Joint Underwriting Association. The association will provide insurance coverage for senior-care facilities, long-term-care facilities, nursing homes, continuing care facilities and assisted living facilities. The association will operate under the supervision and approval of a board of governors to be appointed by the Insurance Commissioner. The association will operate pursuant to a plan of operation approved by the Department of Insurance. Participating insurers will include insurers writing liability insurance as defined in s. 624.605 (1) (b), F.S. These liability lines do not include lines of insurance defined in 624.605, F.S., or homeowners liability insurance. The bill specifies the provision that must be included in the association plan and specifies how participating insurers will be assessed should a deficit occur. Rate filing must be made pursuant to s. 627.062, F.S., and the rates are not to be competitive with the authorized market. Agent commissions are limited to 5 percent of the premium. Finally, the association may not write any new or renewal policies after July 1, 2004. This will allow the association to phase out as all existing claims are paid.

Section 66. Provides an appropriation of $500,000 from general revenue funds to fund the Senior-Care-Facility Joint Underwriting Association.

Section 67. Appropriates $5,251,821 from the Health Care Trust Fund and 76.5 positions to the Agency for Health Care Administration for the purpose of implementing the provisions of this act during the 2001-2002 fiscal year.

Section 68. Appropriates $100,000 from the General Revenue Fund to the Department of Elderly Affairs for the purpose of paying the salaries and other expenses of the Office of the Long-Term Care Ombudsman to carry out the provisions of this act during the 2001-2002 fiscal year.

Section 69. Provides a severability clause.

Section 70. Provides an effective date of upon becoming a law except as otherwise expressly provided in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

The bill restricts public access to certain documents and meetings related to internal risk management and quality assurance programs in long-term care facilities. Senate Bill 1200 has been filed to provide for the public records and public meetings exemptions relating to risk management and quality assurance programs in long-term care facilities.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

The bill increases licensure fees for nursing homes and assisted living facilities.

B. Private Sector Impact:

The bill could have a significant impact on the residents, employees, operators and owners of nursing homes and assisted living facilities. The bill's quality of care measures, ranging from increased staffing requirements to meaningful risk management, could result in improved care and treatment of residents, along with a better overall living environment. The costs associated with implementing the increased staffing requirements and risk management measures could be substantial. The exact impact is indeterminate.

The bill's litigation measures, coupled with the quality of care components, could result in the reduction of the severity and frequency of claims against nursing homes and assisted living facilities. This could result in the return of available and affordable liability insurance. Additionally, the bill's provision for a joint underwriting association should provide a short-term alternative to facilities to obtain liability insurance until the standard market returns. The precise impact cannot be determined at this time.

C. Government Sector Impact:

The following estimates the fiscal impact related to the Agency for Health Care Administration and the Department of Elderly Affairs:

	FY 2001-02	**FY 2002-03**
Section 19		
AHCA		
Quarterly Quality-of-Care monitor visits (costs for 21 FTE)	$1,395,911	$1,284,632
Trust (Licensure Fees)	$ 783,596	$ 721,064
Trust (Medicaid Title XIX)	$ 612,315	$ 563,568
Sections 4, 16, 24, 37		
AHCA		
Data System/Reporting And Risk Management and Quality Assurance (3 FTE and data system)	$ 696,461	$ 242,122
Trust (ALF Fees)		
Section 24		
AHCA		
Management and Quality Assurance Investigative Services (23.5 FTE)	$1,424,501	$1,299,820
Trust (MQATF Professional Licensure Fees)		

Note: Current projections reflect that the MQATF will be in a cash deficit of more than $7 million by the end of FY 2002-03.

Section 24		
AHCA		
Managed Care and Health Quality Field Staff Adverse Incident (19 FTE)	$1,187,613	$1,081,794
Trust (Nursing Home/ALF Fees)		
Section 25		
AHCA		
Medicaid "Up-or-Out" Quality of Care Contract Management Program (Evercare)	$ 3,000,000	$ 3,000,000
General Revenue	$ 1,306,500	$ 1,306,500
Trust (Medicaid Title XIX)	$ 1,693,500	$ 1,693,500

Note: Assumes Medicare does not fund

Section 26

AHCA		
Nursing Home Care Alzheimer's Training	$10,480,299	$ 6,872,955
General Revenue	$ 4,564,170	$ 2,993,172
Trust (Title XIX)	$ 5,916,129	$ 3,879,783
DOEA		
Approving dimentia-specific training Courses and providers and maintaining a List of approved (1 FTE)	$ 68,868	$ 68,868
General Revenue		

Section 29

AHCA		
CNA Training Medicaid	$ 4,447,386	$ 4,447,386
General Revenue	$ 1,936,837	$ 1,936,837
Trust (Medicaid Title XIX)	$ 2,510,549	$ 2,510,549

Sections 30 and 36

AHCA		
Assisted Living Facilities and Nursing Home Legal Actions (2 FTE)	$ 122,019	$ 112,004
Trust (Nursing Home/ALF Fees)		

Section 30

AHCA		
Nursing Home Care Staffing Increase (Year 1 is effective January 1, 2002)	$42,496,532	$121,918,349
General Revenue	$18,507,240	$ 53,095,441
Trust (Title XIX)	$23,989,292	$ 68,822,908

Note: The Senate Budget for FY 2001-02 includes $46.2 million ($20.1 million General Revenue and $26.1 million Trust) for enhanced staffing related to quality of care issues in nursing homes.

Section 32

AHCA		
Nursing Home Surveyor Training (OPS RN/Physician Participation)	$ 66,413	$ 66,413
Trust (Nursing Home Fines)		

Section 33

AHCA		
Assisted Living Facilities Monitoring (8 FTE)	$ 488,189	$ 448,364
Trust (ALF Fees)		

Section 56		
AHCA		
CON Moratorium (2 FTE Reduction)	($ 129,286)	($ 129,286)
Trust (CON Fees/Cash Balance)		
SUB-TOTAL	$ 65,744,906	$140,713,421
Trust (Licensure Fees)	$ 4,639,506	$ 3,842,295
General Revenue	$ 26,383,615	$ 59,400,818
Trust (Medicaid XIX)	$ 34,721,785	$ 77,470,308
Section 66		
Senior Care Facility Joint Underwriting Association.(General Revenue)	$ 500,000	$ 500,000
Section 68		
Office of State Long-Term Care Ombudsman (General Revenue)	$ 100,000	$ 100,000
TOTAL IMPACT	$ 66,344,906	$141,313,421
Trust (Licensure Fees)	$ 4,639,506	$ 3,842,295
General Revenue	$ 26,983,615	$ 60,000,818
Trust (Medicaid XIX)	$ 34,721,785	$ 77,470,308

The bill provides for the following appropriations:

Section 68 - The sum of $500,000 from the General Revenue Fund for the Senior Care Facility Joint Underwriting Association.

Section 67 – Appropriates $5,251,821 from the Health Care Trust Fund and 76.5 positions to the Agency for Health Care Administration to implement the provisions of the act during FY 2001-02.

Section 68 - The sum of $100,000 is appropriated from the General Revenue Fund to the Department of Elderly Affairs for administrative expenses of the Office of State Long-Term Care Ombudsman during FY 2001-02.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.