A bill to be entitled

An act relating to health care facilities; amending s. 408.032, F.S.; revising the definition of "tertiary health service" under the Health Facility and Services Development Act; amending s. 408.033, F.S.; providing for the level of funding for local health councils; amending s. 408.034, F.S.; requiring the nursing-home-bed-need methodology established by the Agency for Health Care Administration by rule to include a goal of maintaining a specified district average occupancy rate; amending s. 408.036, F.S., relating to health-care-related projects subject to review for a certificate of need; removing certain projects from and subjecting certain projects to expedited review and revising requirements for other projects subject to expedited review; removing the exemption from review for certain projects; revising requirements for certain projects that are exempt from review; exempting certain projects from review; amending s. 408.038, F.S.; increasing fees of the certificate-of-need program; amending s. 408.039, F.S.; providing for approval of recommended orders of the Division of Administrative Hearings when the Agency for Health Care Administration fails to take action on an application for a certificate of need within a specified time period; amending s. 400.021, F.S.; revising the definition of "resident care plan"; amending s. 400.147, F.S.; revising the definition of "adverse incident"; revising adverse incident reporting requirements; amending s. 400.195,F.S.;

conforming a cross reference; amending s. 400.211, F.S.; requiring nursing assistants to meet certain inservice training requirements to maintain certification; amending s. 400.23, F.S.; requiring agency records, reports, ranking systems, Internet information, and publications to reflect final agency actions; creating s. 400.244, F.S.; allowing nursing homes to convert beds to alternative uses as specified; providing restrictions on uses of funding under assisted-living Medicaid waivers; providing procedures; providing for the applicability of certain fire and life safety codes; providing applicability of certain laws; requiring a nursing home to submit to the Agency for Health Care Administration a written request for permission to convert beds to alternative uses; providing conditions for disapproving such a request; providing for periodic review; providing for retention of nursing home licensure for converted beds; providing for reconversion of the beds; providing applicability of licensure fees; requiring a report to the agency; creating the Hospital Statutory and Regulatory Reform Council; providing legislative intent; providing for membership and duties of the council; providing an effective date.

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

Section 1. Subsection (17) of section 408.032, Florida Statutes, is amended to read:

408.032 Definitions relating to Health Facility and Services Development Act.--As used in ss. 408.031-408.045, the term:

(17) "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, adult and pediatric open heart surgery, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.

Section 2. Paragraph (g) is added to subsection (2) of section 408.033, Florida Statutes, to read:

408.033 Local and state health planning.--

(2) FUNDING.--

(g) Effective July 1, 2003, funding for the local health councils shall be at the level provided on July 1, 2002.

Section 3. Subsection (5) of section 408.034, Florida Statutes, is amended to read:

408.034 Duties and responsibilities of agency; rules.--

(5) The agency shall establish by rule a nursing-home-bed-need methodology that has a goal of maintaining a district average occupancy rate of 94 percent and that reduces the community nursing home bed need for the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program.

Section 4. Section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review; exemptions.--

(1) APPLICABILITY.--Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.

(a) The addition of beds by new construction or alteration.

(b) The new construction or establishment of additional health care facilities, including a replacement health care facility when the proposed project site is not located on the same site as the existing health care facility.

(c) The conversion from one type of health care facility to another.

(d) An increase in the total licensed bed capacity of a health care facility.

(e) The establishment of a hospice or hospice inpatient facility, except as provided in s. 408.043.

(f) The establishment of inpatient health services by a health care facility, or a substantial change in such services.

(g) An increase in the number of beds for acute care, nursing home care beds, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, mental health services, or hospital-based distinct part skilled nursing units, or at a long-term care hospital.

(h) The establishment of tertiary health services.

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.--Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

(a) Research, education, and training programs.

~~(b) Shared services contracts or projects.~~

(b)~~(c)~~ A transfer of a certificate of need, except when an existing hospital is acquired by a purchaser, in which case all pending certificates of need filed by the existing hospital and all approved certificates of need owned by that hospital would be acquired by the purchaser.

(c)~~(d)~~ A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1988, which has a licensed nursing home facility located on a campus providing a variety of residential settings and supportive services. The increased nursing home beds shall be for the exclusive use of the campus residents. ~~Any application on behalf of an applicant meeting this requirement shall be subject to the base fee of $5,000 provided in s. 408.038.~~

(d)~~(e)~~ Replacement of a health care facility when the proposed project site is located in the same district and within a 1-mile radius of the replaced health care facility.

(e)~~(f)~~ The conversion of mental health services beds licensed under chapter 395 ~~or hospital-based distinct part skilled nursing unit beds~~ to general acute care beds~~; the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services;~~ or the conversion of general acute care beds to beds for mental health services.

1. Conversion under this paragraph shall not establish a new licensed bed category at the hospital but shall apply only to categories of beds licensed at that hospital.

2. Beds converted under this paragraph must be licensed and operational for at least 12 months before the hospital may apply for additional conversion affecting beds of the same type.

(f) Replacement of a nursing home within the same district, provided the proposed project site is located within a geographic area that contains at least 65 percent of the facility's current residents and is within a 30-mile radius of the replaced nursing home.

(g) Relocation of a portion of a nursing home's licensed beds to a replacement facility within the same district, provided the relocation is within a 30-mile radius of the existing facility and the total number of nursing home beds in the district does not increase.

The agency shall develop rules to implement the provisions for expedited review, including time schedule, application content which may be reduced from the full requirements of s. 408.037(1), and application processing.

(3) EXEMPTIONS.--Upon request, the following projects are subject to exemption from the provisions of subsection (1):

(a) For replacement of a licensed health care facility on the same site, provided that the number of beds in each licensed bed category will not increase.

(b) For hospice services or for swing beds in a rural hospital, as defined in s. 395.602, in a number that does not exceed one-half of its licensed beds.

(c) For the conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, so long as the conversion of the beds does not involve the construction of new facilities. The total number of skilled nursing beds, including swing beds, may not exceed one-half of the total number of licensed beds in the rural hospital as of July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, shall be included in the community nursing home bed inventory. A rural hospital which subsequently decertifies any acute care beds exempted under this paragraph shall notify the agency of the decertification, and the agency shall adjust the community nursing home bed inventory accordingly.

(d) For the addition of nursing home beds at a skilled nursing facility that is part of a retirement community that

provides a variety of residential settings and supportive services and that has been incorporated and operated in this state for at least 65 years on or before July 1, 1994. All nursing home beds must not be available to the public but must be for the exclusive use of the community residents.

(e) For an increase in the bed capacity of a nursing facility licensed for at least 50 beds as of January 1, 1994, under part II of chapter 400 which is not part of a continuing care facility if, after the increase, the total licensed bed capacity of that facility is not more than 60 beds and if the facility has been continuously licensed since 1950 and has received a superior rating on each of its two most recent licensure surveys.

(f) For an inmate health care facility built by or for the exclusive use of the Department of Corrections as provided in chapter 945. This exemption expires when such facility is converted to other uses.

(g) For the termination of an inpatient health care service, upon 30 days' written notice to the agency.

(h) For the delicensure of beds, upon 30 days' written notice to the agency. A request for exemption submitted under this paragraph must identify the number, the category of beds, and the name of the facility in which the beds to be delicensed are located.

(i) For the provision of adult inpatient diagnostic cardiac catheterization services in a hospital.

1. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following criteria:

a. The applicant must certify it will not provide therapeutic cardiac catheterization pursuant to the grant of the exemption.

b. The applicant must certify it will meet and continuously maintain the minimum licensure requirements adopted by the agency governing such programs pursuant to subparagraph 2.

c. The applicant must certify it will provide a minimum of 2 percent of its services to charity and Medicaid patients.

2. The agency shall adopt licensure requirements by rule which govern the operation of adult inpatient diagnostic cardiac catheterization programs established pursuant to the exemption provided in this paragraph. The rules shall ensure that such programs:

a. Perform only adult inpatient diagnostic cardiac catheterization services authorized by the exemption and will not provide therapeutic cardiac catheterization or any other services not authorized by the exemption.

b. Maintain sufficient appropriate equipment and health personnel to ensure quality and safety.

c. Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

d. Maintain appropriate program volumes to ensure quality and safety.

e. Provide a minimum of 2 percent of its services to charity and Medicaid patients each year.

3.a. The exemption provided by this paragraph shall not apply unless the agency determines that the program is in compliance with the requirements of subparagraph 1. and that the program will, after beginning operation, continuously comply with the rules adopted pursuant to subparagraph 2. The agency shall monitor such programs to ensure compliance with the requirements of subparagraph 2.

b.(I) The exemption for a program shall expire immediately when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.a., b., and c.

(II) Beginning 18 months after a program first begins treating patients, the exemption for a program shall expire when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.d. and e.

(III) If the exemption for a program expires pursuant to sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the agency shall not grant an exemption pursuant to this paragraph for an adult inpatient diagnostic cardiac catheterization program located at the same hospital until 2 years following the date of the determination by the agency that the program failed to comply with the rules adopted pursuant to subparagraph 2.

(j) For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital without an approved adult open heart surgery program. In addition to any other documentation required

by the agency, a request for an exemption submitted under this paragraph must comply with the following:

1. The applicant must certify that it will meet and continuously maintain the requirements adopted by the agency for the provision of these services. These licensure requirements are to be adopted by rule pursuant to ss. 120.536(1) and 120.54 and are to be consistent with the guidelines published by the American College of Cardiology and the American Heart Association for the provision of percutaneous coronary interventions in hospitals without adult open heart services. At a minimum, the rules shall require the following:

a. Cardiologists must be experienced interventionalists who have performed a minimum of 75 interventions within the previous 12 months.

b. The hospital must provide a minimum of 36 emergency interventions annually in order to continue to provide the service.

c. The hospital must offer sufficient physician, nursing, and laboratory staff to provide the services 24 hours a day, 7 days a week.

d. Nursing and technical staff must have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers.

e. Cardiac care nursing staff must be adept in hemodynamic monitoring and Intra-aortic Balloon Pump (IABP) management.

f. Formalized written transfer agreements must be developed with a hospital with an adult open heart surgery

program, and written transport protocols must be in place to ensure safe and efficient transfer of a patient within 60 minutes. Transfer and transport agreements must be reviewed and tested, with appropriate documentation maintained at least every 3 months.

g. Hospitals implementing the service must first undertake a training program of 3 to 6 months which includes establishing standards, testing logistics, creating quality assessment and error management practices, and formalizing patient selection criteria.

2. The applicant must certify that it will utilize at all times the patient selection criteria for the performance of primary angioplasty at hospitals without adult open heart surgery programs issued by the American College of Cardiology and the American Heart Association. At a minimum, these criteria would provide for the following:

a. Avoidance of interventions in hemodynamically stable patients presenting with identified symptoms or medical histories.

b. Transfer of patients presenting with a history of coronary disease and clinical presentation of hemodynamic instability.

3. The applicant must agree to submit a quarterly report to the agency detailing patient characteristics, treatment, and outcomes for all patients receiving emergency percutaneous coronary interventions pursuant to this paragraph. This report must be submitted within 15 days after the close of each calendar quarter.

4. The exemption provided by this paragraph shall not apply unless the agency determines that the hospital has taken all necessary steps to be in compliance with all requirements of this paragraph, including the training program required pursuant to sub-subparagraph 1.g.

5. Failure of the hospital to continuously comply with the requirements of sub-subparagraphs 1.c.-f. and subparagraphs 2. and 3. will result in the immediate expiration of this exemption.

6. Failure of the hospital to meet the volume requirements of sub-subparagraphs 1.a.-b. within 18 months after the program begins offering the service will result in the immediate expiration of the exemption.

7. If the exemption for this service expires pursuant to subparagraph 5. or subparagraph 6., the agency shall not grant another exemption for this service to the same hospital for a period of 2 years and then only upon a showing that the hospital will remain in compliance with the requirements of this paragraph through a demonstration of corrections to the deficiencies which caused expiration of the exemption. Compliance with the requirements of this paragraph includes compliance with the rules adopted pursuant to this paragraph.

(k)~~(j)~~ For mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957.

(l)~~(k)~~ For state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs in

accordance with part II of chapter 296 for which at least 50 percent of the construction cost is federally funded and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care in such state nursing homes. These beds shall not be included in the nursing home bed inventory.

(m)~~(l)~~ For combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificates of need to be consolidated by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption. The longest validity period among the certificates shall be applicable to each of the combined certificates.

(n)~~(m)~~ For division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificate of need to be divided by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption.

(o)~~(n)~~ For the addition of hospital beds licensed under chapter 395 for acute care~~, mental health services,~~ or a hospital-based distinct part skilled nursing unit in a number that may not exceed 30 ~~10~~ total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater; for the addition of medical rehabilitation beds

licensed under chapter 395 in a number that may not exceed eight total beds or 10 percent of capacity, whichever is greater; or for the addition of mental health services beds licensed under chapter 395 in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater. Beds for specialty burn units or~~,~~ neonatal intensive care units~~, or comprehensive rehabilitation~~, or at a long-term care hospital, may not be increased under this paragraph.

1. In addition to any other documentation otherwise required by the agency, a request for exemption submitted under this paragraph must:

a. Certify that the prior 12-month average occupancy rate for the category of licensed beds being expanded at the facility meets or exceeds 75 ~~80~~ percent or, for a hospital-based distinct part skilled nursing unit, the prior 12-month average occupancy rate meets or exceeds 96 percent or, for medical rehabilitation beds, the prior 12-month average occupancy rate meets or exceeds 90 percent.

b. Certify that any beds of the same type authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.

2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of hospital beds until the beds are licensed.

(p)~~(o)~~ For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 30 ~~10~~ total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.

(q)~~(p)~~ For the addition of nursing home beds licensed under chapter 400 in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater.

1. In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:

a. ~~Effective until June 30, 2001,~~ Certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.

~~b. Effective on July 1, 2001, certify that the facility has been designated as a Gold Seal nursing home under s. 400.235.~~

b.~~c.~~ Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent.

c.~~d.~~ Certify that any beds authorized for the facility under this paragraph before the date of the current request for

an exemption have been licensed and operational for at least 12 months.

2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of nursing home beds until the beds are licensed.

~~(q) For establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county.~~

(r) For the conversion of hospital-based Medicare and Medicaid certified skilled nursing beds to acute care beds, if the conversion does not involve the construction of new facilities.

(s) For the replacement of a statutory rural hospital when the proposed project site is located in the same district and within 10 miles of the existing facility and within the current primary service area, defined as the least number of zip codes comprising 75 percent of the hospital's inpatient admissions. ~~For fiscal year 2001-2002 only, for transfer by a health care system of existing services and not more than 100 licensed and approved beds from a hospital in district 1, subdistrict 1, to another location within the same subdistrict in order to~~

~~establish a satellite facility that will improve access to outpatient and inpatient care for residents of the district and subdistrict and that will use new medical technologies, including advanced diagnostics, computer assisted imaging, and telemedicine to improve care. This paragraph is repealed on July 1, 2002.~~

(t) For the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services.

(u) For the creation of at least a 10-bed Level II neonatal intensive care unit upon demonstrating to the agency that the applicant hospital had a minimum of 1,500 live births during the previous 12 months.

(v) For the addition of Level II or Level III neonatal intensive care beds in a number not to exceed six beds or 10 percent of licensed capacity in that category, whichever is greater, provided that the hospital certifies that the prior 12-month average occupancy rate for the category of licensed neonatal intensive care beds meets or exceeds 75 percent.

(w) For replacement of a licensed nursing home on the same site, or within 3 miles of the same site, provided the number of licensed beds does not increase.

(x) For consolidation or combination of licensed nursing homes or transfer of beds between licensed nursing homes within the same district, by providers that operate multiple nursing homes within that district, provided there is no increase in the district total of nursing home beds and the relocation does not exceed 30 miles from the original location.

(4) A request for exemption under subsection (3) may be made at any time and is not subject to the batching requirements of this section. The request shall be supported by such documentation as the agency requires by rule. The agency shall assess a fee of $250 for each request for exemption submitted under subsection (3).

Section 5. Section 408.038, Florida Statutes, is amended to read:

408.038 Fees.--The agency shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the functions of the local health councils and the activities of the agency and shall be allocated as provided in s. 408.033. The fee shall be determined as follows:

(1) A minimum base fee of $10,000 ~~$5,000~~.

(2) In addition to the base fee of $10,000 ~~$5,000~~, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed $50,000 ~~$22,000~~.

Section 6. Paragraph (e) of subsection (5) and paragraph (c) of subsection (6) of section 408.039, Florida Statutes, are amended to read:

408.039 Review process.--The review process for certificates of need shall be as follows:

(5) ADMINISTRATIVE HEARINGS.--

(e) The agency shall issue its final order within 45 days after receipt of the recommended order. If the agency fails to take action within 45 days, the recommended order of the Division of Administrative Hearings is deemed approved ~~such time, or as otherwise agreed to by the applicant and the agency,~~

~~the applicant may take appropriate legal action to compel the agency to act~~. When making a determination on an application for a certificate of need, the agency is specifically exempt from the time limitations provided in s. 120.60(1).

(6) JUDICIAL REVIEW.--

(c) The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party. If the losing party is a hospital, the court shall order it to pay the reasonable attorney's fees and costs, which shall include fees and costs incurred as a result of the administrative hearing and the judicial appeal, of the prevailing hospital party.

Section 7. Subsection (17) of section 400.021, Florida Statutes, is amended to read:

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

(17) "Resident care plan" means a written plan developed, maintained, and reviewed not less than quarterly by a registered nurse, with participation from other facility staff and the resident or his or her designee or legal representative, which includes a comprehensive assessment of the needs of an individual resident; the type and frequency of services required to provide the necessary care for the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being; a listing of services provided within or outside the facility to meet those needs; and an explanation of service goals. The resident care plan must be signed by the

director of nursing or another registered nurse employed by the facility to whom institutional responsibilities have been delegated and by the resident, the resident's designee, or the resident's legal representative.

Section 8. Subsections (5) through (15) of section 400.147, Florida Statutes, are amended to read:

400.147 Internal risk management and quality assurance program.--

(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 for investigation.

(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.~~

(7)~~(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.

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

(9)~~(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.

(10)~~(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.

(11)~~(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. The agency must use the 15-day report to fulfill this reporting requirement. This subsection does not require dual reporting or additional, new documentation and reporting by the facility to the appropriate regulatory board.

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

(13)~~(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.

(14)~~(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 9. Paragraph (d) of subsection (1) of section 400.195, Florida Statutes, is amended to read:

400.195 Agency reporting requirements.--

(1) For the period beginning June 30, 2001, and ending June 30, 2005, the Agency for Health Care Administration shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives with respect to nursing homes. The first report shall be submitted no later than December 30, 2002, and subsequent reports shall be submitted every 6 months thereafter. The report shall identify facilities based on their ownership characteristics, size, business structure, for-profit or not-for-profit status, and any other

characteristics the agency determines useful in analyzing the varied segments of the nursing home industry and shall report:

(d) Information regarding deficiencies cited, including information used to develop the Nursing Home Guide WATCH LIST pursuant to s. 400.191, and applicable rules, a summary of data generated on nursing homes by Centers for Medicare and Medicaid Services Nursing Home Quality Information Project, and information collected pursuant to s. 400.147(8)~~(9)~~, relating to litigation.

Section 10. Subsection (4) of section 400.211, Florida Statutes, is amended to read:

400.211 Persons employed as nursing assistants; certification requirement.--

(4) When employed by a nursing home facility for a 12-month period or longer, a nursing assistant, to maintain certification, shall submit to a performance review every 12 months and must receive regular inservice education based on the outcome of such reviews. The inservice training must:

(a) Be sufficient to ensure the continuing competence of nursing assistants and must meet the standard specified in s. 464.203(7).~~, 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 the ~~this~~ training required by this subsection may not be reimbursed from additional Medicaid funding through interim rate adjustments.

Section 11. Subsection (10) is added to section 400.23, Florida Statutes, to read:

400.23 Rules; evaluation and deficiencies; licensure status.--

(10) Agency records, reports, ranking systems, Internet information, and publications must reflect final agency actions.

Section 12. Section 400.244, Florida Statutes, is created to read:

400.244 Alternative uses of nursing home beds; funding limitations; applicable codes and requirements; procedures; reconversion.--

(1) It is the intent of the Legislature to allow nursing home facilities to use licensed nursing home facility beds for

alternative uses other than nursing home care for extended periods of time exceeding 48 hours.

(2) A nursing home may use a contiguous portion of the nursing home facility to meet the needs of the elderly through the use of less restrictive and less institutional methods of long-term care, including, but not limited to, adult day care, assisted living, extended congregate care, or limited nursing services.

(3) Funding under assisted-living Medicaid waivers for nursing home facility beds that are used to provide extended congregate care or limited nursing services under this section may be provided only for residents who have resided in the nursing home facility for a minimum of 90 consecutive days.

(4) Nursing home facility beds that are used in providing alternative services may share common areas, services, and staff with beds that are designated for nursing home care. Fire codes and life safety codes applicable to nursing home facilities also apply to beds used for alternative purposes under this section. Any alternative use must meet other requirements specified by law for that use.

(5) In order to take beds out of service for nursing home care and use them to provide alternative services under this section, a nursing home must submit a written request for approval to the Agency for Health Care Administration in a format specified by the agency. The agency shall approve the request unless it determines that such action will adversely affect access to nursing home care in the geographical area in which the nursing home is located. The agency shall, in its

review, consider a district average occupancy of 94 percent or greater at the time of the application as an indicator of an adverse impact. The agency shall review the request for alternative use at each annual license renewal.

(6) A nursing home facility that converts beds to an alternative use under this section retains its license for all of the nursing home facility beds and may return those beds to nursing home operation upon 60 days' advance notice to the agency unless notice requirements are specified elsewhere in law. The nursing home facility shall continue to pay all licensure fees as required by s. 400.062 and applicable rules but is not required to pay any other state licensure fee for the alternative service.

(7) Within 45 days after the end of each calendar quarter, each facility that has nursing facility beds licensed under this chapter shall report to the agency or its designee the total number of patient days which occurred in each month of the quarter and the number of such days which were Medicaid patient days.

Section 13. Hospital Statutory and Regulatory Reform Council; legislative intent; creation; membership; duties.--

(1) It is the intent of the Legislature to provide for the protection of the public health and safety in the establishment, construction, maintenance, and operation of hospitals. However, the Legislature further intends that the police power of the state be exercised toward that purpose only to the extent necessary and that regulation remain current with the ever-

changing standard of care and not restrict the introduction and use of new medical technologies and procedures.

(2) In order to achieve the purposes expressed in subsection (1), it is necessary that the state establish a mechanism for the ongoing review and updating of laws regulating hospitals. The Hospital Statutory and Regulatory Reform Council is created and located, for administrative purposes only, within the Agency for Health Care Administration. The council shall consist of no more than 15 members, including:

(a) Nine members appointed by the Florida Hospital Association who represent acute care, teaching, specialty, rural, government-owned, for-profit, and not-for-profit hospitals.

(b) Two members appointed by the Governor who represent patients.

(c) Two members appointed by the President of the Senate who represent private businesses that provide health insurance coverage for their employees, one of whom represents small private businesses and one of whom represents large private businesses. As used in this paragraph, the term "private business" does not include an entity licensed under chapter 627, Florida Statutes, or chapter 641, Florida Statutes, or otherwise licensed or authorized to provide health insurance services, either directly or indirectly, in this state.

(d) Two members appointed by the Speaker of the House of Representatives who represent physicians.

(3) Council members shall be appointed to serve 2-year terms and may be reappointed. A member shall serve until his or

her successor is appointed. The council shall annually elect from among its members a chair and a vice chair. The council shall meet at least twice a year and shall hold additional meetings as it considers necessary. Members appointed by the Florida Hospital Association may not receive compensation or reimbursement of expenses for their services. Members appointed by the Governor, the President of the Senate, or the Speaker of the House of Representatives may be reimbursed for travel expenses by the agency.

(4) The council, as its first priority, shall review chapters 395 and 408, Florida Statutes, and shall make recommendations to the Legislature for the repeal of regulatory provisions that are no longer necessary or that fail to promote cost-efficient, high-quality medicine.

(5) The council, as its second priority, shall recommend to the Secretary of Health and the Secretary of Health Care Administration regulatory changes relating to hospital licensure and regulation to assist the Department of Health and the Agency for Health Care Administration in carrying out their duties and to ensure that the intent of the Legislature as expressed in this section is carried out.

(6) In determining whether a statute or rule is appropriate or necessary, the council shall consider whether:

(a) The statute or rule is necessary to prevent substantial harm, which is recognizable and not remote, to the public health, safety, or welfare.

(b) The statute or rule restricts the use of new medical technologies or encourages the implementation of more cost-effective medical procedures.

(c) The statute or rule has an unreasonable effect on job creation or job retention in the state.

(d) The public is or can be effectively protected by other means.

(e) The overall cost-effectiveness and economic effect of the proposed statute or rule, including the indirect costs to consumers, will be favorable.

(f) A lower-cost regulatory alternative to the statute or rule could be adopted.

Section 14. This act shall take effect July 1, 2003.