HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/CS/HB 573 Health of Residents
SPONSOR(S): Health & Human Services Committee; Health Care Appropriations Subcommittee; Health Innovation Subcommittee; Ahern and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/SB 248

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N, As CS	Guzzo	Shaw
2) Health Care Appropriations Subcommittee	11 Y, 1 N, As CS	Clark	Pridgeon
3) Health & Human Services Committee	14 Y, 3 N, As CS	Poche	Calamas

SUMMARY ANALYSIS

CS/CS/CS/HB 573 addresses topics that impact the health of residents, including assisted living facilities, recovery care centers, transitional living facilities, mental and emotional harm to children, specialty-licensed hospitals, and home health agencies. The bill:

- Strengthens the regulation of Assisted Living Facilities (ALFs) and makes other regulatory changes to improve the quality of ALFs, by:
  - Requiring ALFs to provide information to new residents upon admission that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right;
  - Creating a provisional Extended Congregate Care (ECC) license for new ALFs and specifies when the Agency for Health Care Administration (AHCA) may deny or revoke a facility's ECC license;
  - Requiring facilities with one or more, rather than three or more, state supported mental health residents obtain a Limited Mental Health license;
  - Allowing AHCA to revoke the license of a facility with a controlling interest that has or had a 25 percent or greater financial or ownership interest in a second facility which closed due to financial inability to operate or was the subject of other specified administrative sanctions;
  - Setting fine amounts for class I – IV violations based on the scope of the deficiency, which can be categorized as isolated, patterned, or widespread and doubling fines for repeated serious violations;
  - Authorizing ALF staff to perform certain additional duties to assist with self-administration of medication and increases the applicable staff training requirements from 4 hours to 6 hours; and
  - Requiring AHCA to conduct an additional inspection of a facility cited for certain serious violations.
- Changes the allowable length of stay in an Ambulatory Surgical Center from less than one working day to no more than 24 hours.
- Creates a new license for a Recovery Care Center, a facility the primary purpose of which is to provide recovery care services, including postsurgical and post-diagnostic medical and general nursing care to patients for whom acute-hospitalization is not required and an uncomplicated recovery is reasonably expected and postsurgical rehabilitation services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital.
- Requires Transitional Living Facilities (TLFs) to maintain accreditation by an accrediting organization specializing in evaluating rehabilitation facilities.
- Adds care and service plan requirements for TLFs detailing orders for medical care, client functional capability and goals, and transition plans.
- Requires TLFs to provide specific professional services directed toward improving the client's functional status.
- Provides standards for medication management, assistance with medication, use of restraints, seclusion procedures, infection control, safeguards for clients' funds, and emergency preparedness.
- Adds provisions to protect clients from abuse including, proper staff screening, training, prevention, identification, and investigation.
- Revises the Brain and Spinal Cord Injury Advisory Council's rights to entry and inspection of TLFs.
- Creates a limited grandparent visitation statute.
- Reduces the frequency for a home health agency to report certain information to the AHCA from quarterly to semiannually, requires the reports to be submitted electronically, and repeals the reporting requirement for a home health agency that has an interest in an entity that is a Medicaid or Medicare provider, but is not a Medicaid or Medicare provider itself.

The bill has an indeterminate negative fiscal impact and indeterminate positive fiscal impact on state government. See Fiscal Comments. The bill provides an effective date of July 1, 2014, except as otherwise provided.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Assisted Living Facilities (ALFs)

ALFs in General

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1,2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[4]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[5] The owner or facility administrator determines whether it is appropriate to admit an individual to the facility based on certain criteria.[6] If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[7]

As of February 3, 2014, there were 3,035 licensed ALFs in Florida with 86,707 beds.[8] An ALF must have a standard license issued by Agency for Health Care Administration (AHCA), pursuant to part I of ch. 429, F.S., and part II of ch. 408, F.S.

In addition to a standard license, an ALF may have one or more specialty licenses that allow the ALF to provide additional care. These specialty licenses include: limited nursing services,[9] limited mental health services,[10] and extended congregate care services.[11]

Limited Mental Health License

A mental health resident is "an individual who receives social security disability income due to a mental disorder as determined by the Social Security Administration or receives supplemental security income due to a mental disorder as determined by the Social Security Administration and receives optional state supplementation."[12] A Limited Mental Health (LMH) license is required for any facility serving 3 or more mental health residents. [13] To obtain this license, the facility may not have any current uncorrected deficiencies or violations and the facility administrator, as well as staff providing direct care to residents must complete 6 hours of training related to LMH duties, which is either provided by or approved by the Department of Children and Families (DCF).[14] The facility is required to have documentation, provided by DCF, evidencing each mental health resident has been assessed and

[1] S. 429.02(5), F.S.
[2] An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[3] S. 429.02(16), F.S.
[4] S. 429.02(1), F.S.
[5] For specific minimum standards see Rule 58A-5.0182, F.A.C.
[6] S. 429.26, F.S., and Rule 58A-5.0181, F.A.C.
[7] S. 429.28, F.S.
[8] Agency for Health Care Administration, *Assisted Living Directory*, February 3, 2014, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/docs/alf/Directory_ALF.pdf (last visited on April 8, 2014).
[9] S. 429.07(3)(c), F.S.
[10] S. 429.075, F.S.
[11] S. 429.07(3)(b), F.S.
[12] S. 429.02, F.S.
[13] S. 429.075, F.S.
[14] S. 429.075, F.S.

approved to live in the ALF. A LMH license can be obtained during initial licensure, during relicensure, or upon request of the licensee.[15] There are 1,022 facilities with LMH licenses.[16]

Extended Congregate Care License

The Extended Congregate Care (ECC) specialty license allows an ALF to provide, directly or through contract, services performed by licensed nurses and supportive services to individuals who would otherwise be disqualified from continued residency in an ALF.[17] There are 277 facilities with ECC licenses.[18]

In order for ECC services to be provided, AHCA must first determine that all requirements in law and rule are met. ECC licensure is regulated pursuant to s. 429.07, F.S., and Rule 58A-5, F.A.C.

The primary purpose of ECC services is to allow residents, as their acuity level rises, to remain in a familiar setting. An ALF licensed to provide ECC services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if the individual is determined appropriate for admission to the ECC facility. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour supervision.

Licensed ECC facilities may provide the following additional services:[19]

- Total help with bathing, dressing, grooming, and toileting;
- Nursing assessments conducted more frequently than monthly;
- Measuring and recording basic vital functions and weight;
- Dietary management, including providing special diets, monitoring nutrition, and observing the resident's food and fluid intake and output;
- Assisting with self-administered medications;
- Supervising residents with dementia and cognitive impairments;
- Health education, counseling, and implementing health-promoting programs;
- Rehabilitative services; and
- Escort services to health-related appointments.

Before being admitted to an ECC licensed facility to receive ECC services, the prospective resident must undergo a medical examination.[20] The ALF must develop a service plan that sets forth how the facility will meet the resident's needs and must maintain a written progress report on each resident who receives ECC services.

ALFs with an ECC license must meet the following staffing requirements:[21]

- Specify a staff member to serve as the ECC supervisor if the administrator does not perform this function;
- The administrator of an ECC licensed facility must have a minimum of 2 years of managerial, nursing, social work, therapeutic recreation, or counseling experience in a residential, long-term care, or acute care setting; and
- A baccalaureate degree may be substituted for one year of the required experience and a nursing home administrator licensed under chapter 468, F.S., shall be considered qualified.

[15] S. 429.075, F.S.
[16] Agency for Health Care Administration, *Assisted Living Facility*, available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Assisted_Living/alf.shtml (last visited April 8, 2014).
[17] S. 429.07(3)(b), F.S.
[18] See supra, FN 16.
[19] Rule 58A-5.030(8)(b), F.A.C.
[20] Rule 58A-5.030(6), F.A.C.
[21] Rule 58A-5.030(4), F.A.C.

An ECC administrator or supervisor, if different from the administrator, must complete the core training required of a standard licensed ALF administrator (26 hours plus a competency test), and 4 hours of initial training in ECC care within 3 months of beginning employment. The administrator must complete a minimum of 4 hours of continued education every 2 years. [22]

All staff providing direct ECC care to residents must complete at least 2 hours of initial service training, provided by the administrator, within 6 months of beginning employment.[23]

ALFs with a standard license must pay a biennial license fee of $300 per license, with an additional fee of $50 per resident. The total fee may not exceed $10,000. In addition to the total fee assessed for standard licensed ALFs, facilities providing ECC services must pay an additional fee of $400 per license, with an additional fee of $10 per resident.[24]

Limited Nursing Services License

Limited nursing services (LNS) are services beyond those provided by standard licensed ALFs. A facility with a LNS specialty license may provide the following services:[25]

- Passive range of motion exercises;
- Ice caps or heat relief;
- Cutting toenails of diabetic residents;
- Ear and Eye irrigations;
- Urine dipstick tests;
- Replacement of urinary catheters;
- Digital stool removal therapies;
- Applying and changing routine dressings that do not require packing or irrigation;
- Care for stage 2 pressure sores;
- Caring for casts, braces and splints;
- Conducting nursing assessments;
- Caring for and monitoring the application of anti-embolism stockings or hosiery;
- Administration and regulation of portable oxygen;
- Applying, caring for and monitoring a transcutaneous electric nerve stimulator; and
- Catheter, colostomy, ileostomy care and maintenance.

A facility holding only a standard or LNS license must meet the admission and continued residency criteria contained in Rule 59A-5.0181, F.A.C.[26] The following admission and continued residency criteria for potential residents must be met:[27]

- Be at least 18 years of age;
- Be free from signs and symptoms of any communicable disease;
- Be able to perform the activities of daily living;
- Be able to transfer, with assistance if necessary;
- Be capable of taking their own medications with assistance from staff if necessary;
- Not be a danger to themselves or others;
- Not require licensed professional mental health treatment on a 24-hour a day basis;
- Not be bedridden;
- Not have any stage 3 or 4 pressure sores;
- Not require nursing services for oral or other suctioning, assistance with tube feeding, monitoring of blood gases, intermittent positive pressure breathing therapy, or treatment of surgical incisions or wounds;

[22] Rule 58A-5.0191(7), F.A.C.
[23] Id.
[24] S. 429.07(4), F.S.
[25] Rule 58A-5.031(1), F.A.C.
[26] Rule 58A-5.031(2), F.A.C.
[27] Rule 58A-5.0181(1), F.A.C.

- Not require 24-hour nursing supervision;
- Not require skilled rehabilitative services; and
- Have been determined by the administrator to be appropriate for admission to the facility.

Facilities licensed to provide limited nursing services must employ or contract with a nurse to provide necessary services to facility residents.[28] Licensed LNS facilities must maintain written progress reports on each resident receiving LNS. A registered nurse representing AHCA must visit these facilities at least twice a year to monitor residents and determine compliance.[29] A nursing assessment must be conducted at least monthly on each resident receiving limited nursing services.[30]

Facilities licensed to provide LNS must pay the standard licensure fee of $300 per license, with an additional fee of $50 per resident and the total fee may not exceed $10,000. In addition to the standard fee, in order to obtain the LNS specialty license facilities must pay an additional biennial fee of $250 per license, with an additional fee of $10 per bed.[31] There are 999 facilities with LNS licenses.[32]

ALF Reform

In April of 2011, the Miami Herald completed a three part investigative series relating to ALFs. This series highlighted concerns with the management and administration of ALFs and garnered the attention of not only the public, but many state lawmakers, stakeholders, and facility residents and their families.

Assisted Living Facility Workgroups

In July 2011, Governor Rick Scott directed AHCA to examine the regulation and oversight of ALFs. In response, AHCA created the ALF workgroup. The workgroup's objective was to make recommendations to the Governor and Legislature that would improve the monitoring of safety in ALFs to help ensure the well-being of residents. After a series of meetings, the workgroup produced a final report and recommendations that they felt could strengthen oversight and reassure the public that ALFs are safe. Such recommendations included increasing administrator qualifications, expanding training for administrators and other staff, increasing survey inspection activity, and improving the integration of information among all agencies involved in the regulation of ALFs. The workgroup also noted several other issues that would require more time to evaluate and recommended they be examined by a Phase II workgroup.

Phase II of the workgroup began meeting in June 2012 to resume examining those issues not addressed by Phase I of the workgroup. Phase II of the workgroup concluded in October 2012 and produced a final report with recommendations to the Governor and the Legislature on November 26, 2012.

The issue of improving inter-agency communication was included in the workgroup's recommendations. Specifically, the workgroup recommended improving coordination between various federal, state and local agencies with any role in long-term care facilities oversight, especially ALFs. This includes AHCA, the Long Term Care Ombudsman Program, local fire authorities, local health departments, the DCF, the Department of Elder Affairs (DOEA), local law enforcement and the Attorney General's Office.[33]

Assisted Living Facility Negotiated Rulemaking Committee

In June 2012, DOEA, in consultation with AHCA, DCF, and the Department of Health (DOH), began conducting negotiated rulemaking meetings to address ALF regulation. The purpose of the meetings

[28] Rule 58A-5.031(2), F.A.C.
[29] S. 429.07(2)(c), F.S.
[30] Id.
[31] S. 429.07(4)(c), F.S.
[32] See supra, FN 16.
[33] Florida Assisted Living Workgroup, *Phase II Recommendations*, November 26, 2012, available at http://www.ahca.myflorida.com/SCHSCommitteesCouncils/ALWG/index.shtm.

was to draft and amend mutually acceptable proposed rules addressing the safety and quality of services and care provided to residents within ALFs. Most of the issues addressed by the Committee were identified by Phase I of the workgroup as areas of concern that could be reformed via the rulemaking process. The Committee produced a Final Summary Report containing all the proposed rule changes agreed upon by the Committee. These proposed rule changes are currently in the final stages of the standard proposed rule making process required by law.

Optional State Supplementation (OSS) Program

The Optional State Supplementation (OSS) Program provides monthly cash payments to indigent elderly or disabled individuals who live in special non-institutional, residential living facilities, including assisted living facilities, adult family care homes and mental health residential treatment facilities. To qualify for OSS, an individual must need assistance with the activities of daily living due to physical and/or mental conditions. The program provides a monthly check that supplements the individual's income so they can pay the facility a provider rate established by the Department. The current OSS provider rate for assisted living facilities is $776.40/ month for an individual. [34] However, the average cost of assisted living in Florida is $2,750/ month.[35]

Current law allows for supplementation of the OSS rate by third party sources, such as family members, to help cover the cost of care. The amount of third party supplementation is limited by law at 2 times the provider rate, or $1,553/month.[36]

ALF Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established by the DOEA by rule.[37,38] This training and education is intended to assist facilities to appropriately respond to the needs of residents, maintain resident care and facility standards, and meet licensure requirements.[39]

The current ALF core training requirements established by the DOEA consist of a minimum of 26 hours of training and passing a competency test. Administrators and managers must successfully complete the core training requirements within 3 months after becoming a facility administrator or manager. The minimum passing score for the competency test is 75 percent.[40]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every 2 years. A newly hired administrator or manager, who has successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager, who successfully completed the core training but has not maintained the continuing education requirements, must retake the core training and retake the competency test.[41]

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for 6 hours of in-service training for facility staff who provide direct care to residents. The training covers a variety of topics as provided

[34] Florida Department of Elder Affairs, *Optional State Supplementation (OSS),* available at http://elderaffairs.state.fl.us/faal/developer/statesupp.html (last viewed on April 9, 2014).
[35] Florida Assisted Living Association, *Cost of Florida Assisted Living Facilities*, available at http://www.assistedlivingfacilities.org/directory/fl/ (last viewed on April 9, 2014).
[36] S. 409.212(4), F.S.
[37] Rule 58A-5.0191, F.A.C.
[38] Many of the training requirements in rule may be subject to change due to the recent DOEA negotiated rulemaking process.
[39] S. 429.52(1), F.S.
[40] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement.
[41] Rule 58A-5.0191, F.A.C.

by rule.[42] Staff training requirements must generally be met within 30 days after staff begin employment at the facility, however, staff must have at least 1 hour of infection control training before providing direct care to residents. Also, nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard 6 hours of in-service training, staff must also complete 1 hour of elopement training and 1 hour of training on do not resuscitate orders, and may have to complete training on special topics such as self-administration of medication and persons with Alzheimer's disease, if applicable.

ECC Specific Training

The administrator and ECC supervisor, if different from the administrator, must complete 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months after beginning employment in the facility as an administrator or ECC supervisor. They must also complete a minimum of 4 hours of continuing education every 2 years in topics relating to the physical, psychological, or social needs of frail elderly and disabled persons, or persons with Alzheimer's disease or related disorders.[43]

All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months after beginning employment in the facility. The training must address ECC concepts and requirements, including the delivery of personal care and supportive services in an ECC facility.[44]

LMH Specific Training

Administrators, managers, and staff, who have direct contact with mental health residents in a licensed LMH facility must receive a minimum of 6 hours of specialized training in working with individuals with mental health diagnoses and a minimum of 3 hours of continuing education dealing with mental health diagnoses or mental health treatment every 2 years.[45]

Inspections and Surveys

AHCA is required to conduct a survey, investigation, or monitoring visit of an ALF:

- Prior to the issuance of a license.
- Prior to biennial renewal of a license.
- When there is a change of ownership.
- To monitor facilities licensed to provide LNS or ECC services, or facilities cited in the previous year for a class I or class II, or four or more uncorrected class III, violations.[46]
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If AHCA has reason to believe a facility is violating a provision of part III of ch. 429, F.S., relating to adult day care centers, or an administrative rule.
- To determine if cited deficiencies have been corrected.
- To determine if a facility is operating without a license.[47]

Abbreviated Surveys

An applicant for licensure renewal is eligible for an abbreviated biennial survey by AHCA if the applicant does not have any:

- Class I or class II violations or uncorrected class III violations.

[42] See supra, FN 28.
[43] Rule 58A-5.0191(7)(b), F.A.C.
[44] Rule 58A-5.0191(7)(c), F.A.C.
[45] S. 429.075, F.S. and Rule 58A-5.0191(8), F.A.C.
[46] See below, "Violations and Penalties," for a description of each class of violation.
[47] S. 429.34, F.S., and Rule 58A-5.033, F.A.C.

- Confirmed long-term care ombudsman council complaints reported to AHCA by the council.
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[48]

An abbreviated survey allows for a quicker and less intrusive survey by narrowing the range of items that AHCA must inspect.[49] AHCA is required to expand an abbreviated survey or conduct a full survey if violations which threaten or potentially threaten the health, safety, or security of residents are identified during an abbreviated survey.[50]

Monitoring Visits

Facilities with LNS or ECC licenses are subject to monitoring visits by AHCA in which the agency inspects the facility for compliance with the requirements of the specialty license type. An LNS licensee is subject to monitoring inspections at least twice a year. At least one registered nurse must be included in the inspection team to monitor residents receiving LNS and to determine if the facility is complying with applicable regulatory requirements.[51] An ECC licensee is subject to quarterly monitoring inspections. At least one registered nurse must be included in the inspection team. AHCA may waive one of the required yearly monitoring visits for an ECC facility that has been licensed for at least 24 months, if the registered nurse who participated in the monitoring inspections determines that the ECC services are being provided appropriately, and there are no serious violations or substantiated complaints about the quality of service or care.[52]

Violations and Penalties

Part II of ch. 408, F.S., provides general licensure standards for all facilities regulated by AHCA. Under s. 408.813, F.S., ALFs may be subject to administrative fines imposed by AHCA for certain types of violations. Violations are categorized into four classes according to the nature of the violation and the gravity of its probable effect on residents.

- Class I violations are those conditions that AHCA determines present an imminent danger to residents or a substantial probability of death or serious physical or emotional harm. Examples include resident death due to medical neglect, risk of resident death due to inability to exit in an emergency, and the suicide of a mental health resident in an ALF with an LMH license. AHCA must issue a fine between $5,000 and $10,000 for each violation.
- Class II violations are those conditions that AHCA determines directly threaten the physical or emotional health, safety, or security of the clients. Examples include having no qualified staff in the facility, the failure to call 911 in a timely manner for resident in a semi-comatose state, and rodents in food storage area. AHCA must issue a fine between $1,000 and $5,000 for each violation.
- Class III violations are those conditions that AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients. Examples include missing or incomplete resident assessments, erroneous documentation of medication administration, and failure to correct unsatisfactory DOH food service inspection findings in a timely manner. AHCA must issue a fine between $500 and $1,000 for each violation, but no fine may be imposed if the facility corrects the violation.
- Class IV violations are those conditions that do not have the potential of negatively affecting clients. Examples include failure to file an adverse incident report, incorrect phone numbers posted for advocacy resources, and failure to post current menus. AHCA can only fine a facility (between $100 and $200 for each violation) if the problem is not corrected. [53,54]

[48] Rule 58A-5.033(2), F.A.C.
[49] Rule 58A-5.033(2)(b)
[50] Id.
[51] S. 429.07(3)(c), F.S.
[52] S. 429.07(3)(b), F.S.
[53] When fixing the amount of the fine, AHCA must consider the following factors: the gravity of the violation and the extent to which any laws or rules were violated, actions taken to correct the violations, any previous violations, the financial benefit of committing or continuing the violation, and the licensed capacity of the facility. S. 429.19(3), F.S.
[54] S. 429.19(2), F.S.

Violations for Fiscal Years 2011-13

	Class I Violations	Class II Violations	Class III Violations	Class IV Violations
Total Violations	115	749	507	18
Average Fine Amount : ALFs With Under 100 beds	$6,585	$1,542	$766	$165
Average Fine Amount: ALFs With Over 100 Beds	$7,454	$1,843	$614	$100

In addition to financial penalties, AHCA can take other actions against a facility. AHCA may deny, revoke, and suspend any license for any of the actions listed in s. 429.14(1)(a)-(k), F.S. AHCA is required to deny or revoke the license of an ALF that has two or more class I violations that are similar to violations identified during a survey, inspection, monitoring visit, or complaint investigation occurring within the previous 2 years.[55] AHCA may also impose an immediate moratorium or emergency suspension on any provider if it determines that any condition presents a threat to the health, safety, or welfare of a client.[56] AHCA is required to publicly post notification of a license suspension or revocation, or denial of a license renewal, at the facility.[57] Finally, Florida's Criminal Code, under ch. 825, F.S., provides criminal penalties for the abuse, neglect, and exploitation of elderly persons[58] and disabled adults.[59]

ALF License Suspensions, Revocations, Denials, Failed to Renew and Closed

	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	Total
Suspensions	2	1	2	5	6	16
Revocations	4	12	7	17	15	55
Denials	11	7	5	9	12	44
Closed/Failed to Renew During Legal Case	37	40	46	38	28	189
Total	54	60	60	69	61	304

Central Abuse Hotline

The DCF is required under s. 415.103, F.S., to establish and maintain a central abuse hotline to receive reports, in writing or through a single statewide toll-free telephone number, of known or suspected abuse, neglect, or exploitation of a vulnerable adult[60] at any hour of the day or night, any day of the week.[61] Persons listed in s. 415.1034, F.S., who know, or have reasonable cause to suspect, that a

[55] S. 429.14(4), F.S.
[56] S. 408.814, F.S.
[57] S. 429.14(7), F.S.
[58] "Elderly person" means a person 60 years of age or older who is suffering from the infirmities of aging as manifested by advanced age or organic brain damage, or other physical, mental, or emotional dysfunction, to the extent that the ability of the person to provide adequately for the person's own care or protection is impaired. S. 825.101(5), F.S. It does not constitute a defense to a prosecution for any violation of this chapter that the accused did not know the age of the victim. S. 825.104, F.S.
[59] "Disabled adult" means a person 18 years of age or older who suffers from a condition of physical or mental incapacitation due to a developmental disability, organic brain damage, or mental illness, or who has one or more physical or mental limitations that restrict the person's ability to perform the normal activities of daily living. S. 825.101(4), F.S.
[60] "Vulnerable adult" means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. S. 415.102(27), F.S.
[61] The central abuse hotline is operated by the DCF to: accept reports for investigation when there is a reasonable cause to suspect that a vulnerable adult has been or is being abused, neglected, or exploited; determine whether the allegations require an immediate, 24-hour, or next-working-day response priority; when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; immediately identify and locate prior reports of

vulnerable adult has been or is being abused, neglected, or exploited are required to immediately report such knowledge or suspicion to the central abuse hotline.[62]

Personal Property of Residents

Facilities are required under s. 429.27(3), F.S., upon mutual consent with the resident, to provide for the safekeeping of a resident's personal effects not in excess of $500 and funds not in excess of $200 cash. The facility must keep complete and accurate records of all such funds and personal effects received. If a resident is absent from a facility for 24 hours or more, the facility may provide for the safekeeping of the resident's personal effects in excess of $500.

Long-Term Care Ombudsman Program

The federal Older Americans Act (OAA) requires each state to create a Long-Term Care Ombudsman Program to be eligible to receive funding associated with programs under the OAA.[63] In Florida, the program is a statewide, volunteer-based system of district councils that protect, defend, and advocate on behalf of long-term care facility residents, including residents of nursing homes, ALFs, and adult family-care homes. The ombudsman program is administratively housed in the DOEA and is headed by the State Long-Term Care Ombudsman, who is appointed by the DOEA Secretary.[64] The ombudsman program is required to establish a statewide toll-free telephone number for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents of ALFs, nursing homes, and adult family care homes. Every resident or representative of a resident must receive, upon admission to a long-term care facility, information regarding the program and the statewide toll-free telephone number for receiving complaints.[65] The names or identities of the complainants or residents involved in a complaint, including any problem identified by an ombudsman council as a result of an investigation, are confidential and exempt from Florida's public records laws, unless the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure, or the disclosure is required by court order.[66] In addition to investigating and resolving complaints, ombudsmen conduct unannounced visits to assess the quality of care in facilities, referred to as administrative assessments.

Ambulatory Surgical Centers and Recovery Care Centers

Ambulatory Surgical Centers (ASCs) in General

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.[67]

Outpatient procedures account for a growing proportion of surgeries in the United States due to advances in surgical technology and anesthesia. Nationally, 63 percent of all surgeries in 2005 did not require an overnight hospital stay, compared to 51 percent in 1990 and 16 percent in 1980.[68]

---

abuse, neglect, or exploitation through the central abuse hotline. S. 415.103(1), F.S.
[62] S. 415.1034, F.S.
[63] 42 U.S.C. 3058, et seq.; see also s. 400.0061(1), F.S.
[64] S. 400.0063, F.S.
[65] S. 400.0078(2), F.S.
[66] S. 400.0077(1)(b), F.S.
[67] S. 395.002(3), F.S. "Ambulatory surgical center" or "mobile surgical facility" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.
[68] U.S. Department of Health and Human Services; Agency for Healthcare Research and Quality; *Healthcare Cost and Utilization Project; Statistical Brief #86*, February 2010, available at www.hcup-us.ahrq.gov/reports/statbriefs/sb86.pdf (last viewed on April 8, 2014).

In Florida, ambulatory procedures are performed in two settings, hospital-based outpatient facilities and freestanding ASCs. Currently, there are 633 ASCs in Florida, including 429 freestanding ASCs and 204 hospital-based facilities.[69]

In 2008, there were 3,121,428 visits to ASCs in Florida. The visits were equally split, with hospital outpatient facilities accounting for 50.8 percent and free standing ASCs accounting for 49.2 percent of the total number of visits. However, the breakdown of the $21 billion in total charges shows that hospital-based facilities accounted for 74 percent of the charges, while ASCs accounted for 26 percent. The average charge at the hospital-based facilities ($9,781) was larger than the average charge at the freestanding ASCs ($3,554).[70] These visits and charges were paid mainly by commercial Insurance and Medicare. Commercial insurance paid for 46.6 percent of all charges (a total of $9.8 billion), while Medicare paid for 39.1 percent ($8.2 billion). The other three payer groups (Medicaid, Other Government and Self-Pay/Charity) accounted for a total of 14.3% ($3.1 billion) of the charge total. The data and results have been similar since 2006.[71]

In 2012, there were 4,396,508 surgical procedures performed in ASCs in Florida. The top three procedures accounting for the highest percentage of visits to ASCs were upper gastrointestinal endoscopy, colonoscopy, and cataract removal.[72]

ASC Licensure

ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.[73]

Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including the:[74]

- Affidavit of compliance with fictitious name;
- Registration of articles of incorporation; and
- ASC's zoning certificate or proof of compliance with zoning requirements.

Upon receipt of an initial application, AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including the:[75]

- Governing body bylaws, rules and regulations;
- Roster of registered nurses and licensed practical nurses with current license numbers;
- Fire plan; and
- Comprehensive Emergency Management Plan.

Rules for ASCs

Pursuant to s. 395.1055, F.S., AHCA is authorized to adopt rules for hospitals and ASCs. Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals, but the rules for all hospitals and ASCs must include minimum standards for ensuring that:

[69] Agency for Health Care Administration, *Facilities: All Florida Outpatient Ambulatory Surgical Centers*, available at http://www.floridahealthfinder.gov/CompareCare/ListFacilities.aspx (report generated February 23, 2014).
[70] Agency for Health Care Administration, *Statistical Brief, Ambulatory Surgery Procedures in Florida, by Payer and Gender, 2008,* July 2010.
[71] Agency for Health Care Administration, *Data Summaries and Reports, Total Outpatient Visits by Facility Type 1992-2012,* available at http://www.floridahealthfinder.gov/researchers/QuickStat/quickstat.aspx (last visited April 8, 2014).
[72] Agency for Health Care Administration, *Ambulatory Surgery and Outpatient Procedures, 2012, Total Visits by Category*.
[73] SS. 395.001-395.1065, F.S., and Part II, Chapter 408, F.S.
[74] Rule 59A-5.003(4), F.A.C.
[75] Rule 59A-5.003(5), F.A.C.

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards

AHCA adopted rule 59A-5, F.A.C., to implement the minimum standards for ASCs.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, and laboratory and radiologic services. In providing these services, ACSs are required have certain professional staff available, including:[76]

- A Registered nurse to serve as operating room circulating nurse;
- An Anesthesiologist or other physician, or a certified registered nurse anesthetist under the on-site medical direction of a licensed physician in the ASC during the anesthesia and post-anesthesia recovery period until all patients are alert or discharged; and
- A Registered professional nurse in the recovery area during the patient's recovery period.

Infection Control Rules

ASCs are required to establish an infection control program, which must include written policies and procedures reflecting the scope of the infection control program. The written policies and procedures must be reviewed at least every two years by the infection control program members. The infection control program must include:[77]

- Surveillance, prevention, and control of infection among patients and personnel;
- A system for identifying, reporting, evaluating and maintaining records of infections;
- Ongoing review and evaluation of aseptic, isolation and sanitation techniques employed by the ASC; and
- Development and coordination of training programs in infection control for all personnel.

Emergency Management Plan Rules

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency. The ASC must review the plan and update it annually.

Accreditation

ASCs may seek voluntary accreditation by the Joint Commission for Health Care Organizations or the Accreditation Association for Ambulatory Health Care. AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs. AHCA is authorized to accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report are determined to document that the ASC is in substantial compliance with state licensure requirements. AHCA is required to conduct annual validation inspections on a minimum of 5 percent of the ASCs which were inspected by an accreditation organization.[78]

[76] Rule 59A-5.0085, F.A.C.
[77] Rule 59A-5.011, F.A.C.
[78] Rule 59A-5.004, F.A.C.

AHCA is required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements. However, the life-safety inspection may be waived if an accreditation inspection was conducted on an ASC by a certified life safety inspector and the ASC was found to be in compliance with the life safety requirements.[79]

Currently, 373 of the 429 total licensed ASCs in Florida are accredited by a national accrediting organization.[80]

Federal Requirements for ASCs

ASCs are required to have an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. CMS defines "ASC" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours[81] following an admission.[82]

CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body, or licensed by a state agency, that CMS determines provides reasonable assurance that the conditions are met.[83] All of the CMS conditions for coverage requirements are specifically required in AHCA rule 59A-5, F.A.C., and apply to all ASCs in Florida. The conditions for coverage require ASCs to have a:

- Governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- Quality assessment and performance improvement program;
- Transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- Disaster preparedness plan;
- Organized medical staff;
- Fire control plan;
- Sanitary environment;
- Infection control program;
- Procedure for patient admission, assessment and discharge;

Recovery Care Centers

Recovery care centers (RCCs) are entities that provide short-term nursing care, support, and pain control for patients that do not require acute hospitalization.[84] RCC patients are typically healthy persons that have had elective surgery. RCCs can be either freestanding or attached to an ASC or hospital. In practice, RCCs typically provide care to patients transferred from ASCs following surgery, which allows ASCs to perform more complex procedures.[85]

[79] Id.
[80] Agency for Health Care Administration, *Ambulatory Surgical Center Regulatory Overview,* March 2014. (on file with Health and Human Services Committee staff).
[81] State Operations Manual Appendix L, *Guidance for Surveyors: Ambulatory Surgical Centers* (Rev. 99, 01-31-14) exceeding the 24-hour time frame is expected to be a rare occurrence, and each rare occurrence is expected to be demonstrated to have been something which ordinarily could not have been foreseen. Not meeting this requirement constitutes condition-level noncompliance with §416.25. In addition, review of the cases that exceed the time frame may also reveal noncompliance with CfCs related to surgical services, patient admission and assessment, and quality assurance/performance improvement.
[82] 42 C.F.R. §416.2
[83] 42 C.F.R. §416.26(1)
[84] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment for Post-Surgical Recovery Care Centers 3* (2000).
[85] Id. at 4.

RCCs are not eligible for Medicare reimbursement.[86] One 1999 survey noted that RCCs received payment in the following breakdown: 41% from managed care plans, 29% from self-pay, 16% from indemnity plans, and 9% from workers' compensation.[87]

Three states, Arizona, Connecticut, and Illinois, have specific licenses for "recovery care centers."[88] Other states license RCCs as nursing facilities or hospitals.[89] One study found that eighteen states allow RCCs to have stays over 24 hours, usually with a max stay of 72 hours.[90]

[86] See supra, FN 84.
[87] See supra, FN 84, at 6 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).
[88] ARIZ. REV. STAT. ANN. §§ 36-448.51-36-448.55; CONN. AGENCIES REGS. § 19A-495-571; 210 ILL. COMP. STAT. ANN. 3/35.
[89] Breisch, Sandra Lee, *Profits in Short Stays*, AM. ACAD. OF ORTHOPAEDIC SURGEONS BULLETIN (June, 1999), *available at* http://www2.aaos.org/bulletin/jun99/asc.htm (last viewed on April 8, 2014).
[90] See supra, FN 84, at 4 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

Comparison of RCC Regulations in Arizona, Connecticut, and Illinois

	Arizona[91]	Connecticut[92]	Illinois[93]
Licensure Required	X	X	X
Written Policies	X	X	X
Maintain Medical Records	X	X	X
Patient's Bill of Rights	X	X	X
Allows Freestanding Facility or Attached	Not Available.	X	X
Length of Stay	Not Available.	Expected 3 days Max 21 days	Expected 48 hours Max 72 hours
Emergency Care Transfer Agreement	Not Available.	With a hospital and an ambulance service.	With a hospital within fifteen minutes travel time.
Prohibited Patients	Patients needing: • Intensive care • Coronary care • Critical care	Patients needing: • Intensive care • Coronary care • Critical care	• Patients with chronic infectious conditions • Children under 3 years of age
Prohibited Services	• Surgical • Radiological • Pediatric • Obstetrical	• Surgical • Radiological • Pre-adolescent pediatric • Hospice • OB services over 24 week gestation • IV therapy for non-hospital based RCC	• Blood administration (only blood products allowed)
Required Services	• Laboratory • Pharmaceutical • Food	• Pharmaceutical • Dietary • Personal care • Rehabilitation • Therapeutic • Social work	• Laboratory • Pharmaceutical • Food • Radiological
Bed Limitation	Not Available.	Not Available.	20
Required Staff	• Governing authority • Administrator	• Governing body • Administrator	• Consulting committee
Required Medical Personnel	• At least two physicians • Director of nursing	• Medical advisory board • Medical director • Director of nursing	• Medical director • Nursing supervisor
Required Personnel When Patients Are Present	• Director of nursing forty hours per week • One registered nurse • One other nurse	• Two persons for patient care	• One registered nurse • One other nurse

Transitional Living Facilities

Transitional Living Facilities (TLFs) in General

[91] ARIZ. REV. STAT. ANN. §§ 36-448.51-36-448.55; ARIZ. ADMIN. CODE §§ R9-10-501-R9-10-518 (updated in 2013, formerly R9-10-1401-R9-10-1412).
[92] CONN. AGENCIES REGS. § 19A-495-571.
[93] 210 ILL. COMP. STAT. ANN. 3/35; ILL. ADMIN. CODE tit. 77, §§ 210.2500 & 210.2800.

TLFs provide specialized health care services, including, but not limited to, rehabilitative services, community reentry training, aids for independent living, and counseling to spinal-cord-injured persons and head-injured persons.[94] There are currently thirteen TLFs licensed in Florida.[95] Three state agencies have a role in regulating TLFs.

The AHCA is the licensing authority for TLFs pursuant to chapter 408, part II, chapter 400, part V, F.S., and Rule 59A-17, F.A.C.

Compared to other types of facilities regulated by AHCA, the detail and scope of regulations for TLFs in statute and administrative rule is significantly narrower and less restrictive, as the regulations focus more on solvency than resident care.

Section 400.805, F.S., is the specific licensure authority for TLFs. However, this section only addresses fees for operation of a TLF, level 2 background screening requirements for TLF personnel, and rights to entry and inspection by AHCA investigative personnel. The current licensure fee is $4,588.00 with a $90 per bed fee per biennium.[96] Further, this section requires AHCA, in consultation with the DOH, to adopt rules governing the physical plant and the fiscal management of TLFs. Like the authorizing statute, the corresponding rule, Rule 59A-17, F.A.C., provides minimal regulatory guidance.

Section 381.75, F.S., requires DOH to administer the Brain and Spinal Cord Injury Program (BSCIP) to provide services for persons with traumatic brain and spinal cord injuries. Services provided by the BSCIP include:

- Case management;
- Acute care, and inpatient and outpatient rehabilitation;
- Transitional living;
- Assistive technology;
- Home and vehicle modifications;
- Nursing home transition facilitation; and
- Long-term support for survivors and families through contractual agreements with community based agencies.

Section 381.76, F.S., provides that a participant in the BSCIP must be a legal Florida resident who has sustained a brain or spinal cord injury. For purposes of the BSCIP, a brain or spinal cord injury means "a lesion to the spinal cord or cauda equina, resulting from external trauma."[97] However, s. 400.805 (1), F.S., relating to TLFs, provides that residents of a TLF must be "spinal-cord-injured persons or head-injured persons." These inconsistent definitions have led to uncertainty as to whether or not TLFs can provide services to individuals who are not participants in the BSCIP or to individuals who have a brain or spinal cord injury that was not the result of external trauma.

The Brain and Spinal Cord Injury Advisory Council (Council), created within DOH pursuant to s. 381.78, F.S., is tasked with providing advice and expertise to DOH in the preparation, implementation, and periodic review of the BSCIP. The Council has the same rights to entry and inspection of TLFs as those granted to AHCA under s. 400.805(4), F.S.

Investigations concerning allegations of abuse and neglect of vulnerable adults, including those in TLFs, are performed by the DCF.[98]

According to a news report from Bloomberg, dated January 24, 2012, clients at the Florida Institute for Neurologic Rehabilitation in Wauchula, Florida were abused, neglected and confined. The news report

[94] S. 400.805(1)(c), F.S.
[95] Agency for Health Care Administration, *Agency Legislative Bill Analysis- HB 799*, dated February 7, 2014 (on file with Health and Human Services Committee staff).
[96] Id.
[97] S. 381.745(2), F.S.
[98] S. 415.107, F.S.

was based on information from 20 current and former clients and their family members, criminal charging documents, civil complaints and advocates for the disabled.[99] In August, 2012, a multi-agency investigation was conducted at the Wauchula facility. As a result of the investigation, it was determined that 50 of the 98 residents reviewed did not have an appropriate diagnosis of spinal-cord injured or head injured, and thus may have been admitted to the TLF inappropriately.[100]

AHCA is responsible for the licensure of TLFs, while DOH monitors services for persons with traumatic brain and spinal cord injuries, and DCF investigates allegations of abuse and neglect of vulnerable adults. In working together during the investigation, gaps and deficiencies in the three-agency TLF regulatory structure were discovered.

Grandparents and Mental and Emotional Well-Being of Children

Chapter 752, Florida Statutes

The Legislature enacted ch. 752, F.S., titled "Grandparental Visitation Rights," in 1984, giving grandparents standing to petition the court for visitation in certain situations. At its broadest, s. 752.01(1), F.S., required visitation to be granted when the court determined it to be in the best interests of the child and one of the following situations existed:

- One or both of the child's parents were deceased;
- The parents were divorced;
- One parent had deserted the child;
- The child was born out of wedlock; or
- One or both parents, who were still married, had prohibited the formation of a relationship between the child and the grandparent(s).[101]

Grandparent visitation authorized under ch. 752, F.S., specifies that when there is a remarriage of one of the natural parents of a minor child for whom visitation rights may be or may have been granted to a grandparent pursuant to s. 752.01, any subsequent adoption by the stepparent will not terminate any grandparental rights. However, the court may determine that termination of such visitation rights is in the best interest of the child and rule accordingly, after affording the grandparent an opportunity to be heard.[102]

Florida courts have considered the constitutionality of s. 752.01, F.S., on several occasions and have "consistently held all statutes that have attempted to compel visitation or custody with a grandparent based solely on the best interest of the child standard…to be unconstitutional." [103] The courts' rulings are premised on the fact that the fundamental right of parenting is a long-standing liberty interest recognized by both the United States and Florida constitutions.[104]

In 1996, the Florida Supreme Court addressed its first major analysis of s. 752.01, F.S., in *Beagle v. Beagle*, 678 So. 2d 1271 (Fla. 1996). In *Beagle*, the Court determined that s. 752.01(e), F.S., which allowed grandparents to seek visitation when the child's family was intact, was facially unconstitutional. The Court announced the standard of review applicable when deciding whether a state's intrusion into a citizen's private life is constitutional:

---

[99] Bloomberg, *Abuse of Brain Injured Americans Scandalizes U.S.,* Jan. 7, 2012, available at http://www.bloomberg.com/news/2012-07-24/brain-injured-abuse-at-for-profit-center-scandalizes-u-s-.html (last visited April 8, 2014).
[100] Agency for Health Care Administration, *Statement of Deficiencies and Plan of Correction*, August 3, 2012, available at http://www.upps.ahca.myflorida.com/dm_web/(s(ner1fpywccezpxoyuqpyogfn))/doc_results.aspx?file_number=35930769&provider_type=TRANSITIONAL+LIVING+FACILITY++&client_code=34&provider_name=FLORIDA+INSTITUTE+FOR+NEUROLOGIC+REHAB%2c+INC&lic_id=28343 (last visited April 8, 2014).
[101] Ch. 93-279, Laws of Fla. (s. 752.01, F.S. (1993)). Subsequent amendments by the Legislature removed some of these criteria. See s. 752.01, F.S. (2008).
[102] S. 752.07, F.S.
[103] *Cranney v. Coronado*, 920 So. 2d 132, 134 (Fla. 2d DCA 2006) (quoting *Sullivan v. Sapp*, 866 So. 2d 28, 37 (Fla. 2004)).
[104] In 1980, Florida's citizens approved the addition of a privacy provision in the state constitution, which provides greater protection than the federal constitution. Specifically, Florida's right to privacy provision states: "Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein." FLA. CONST. art. I, s. 23.

> The right of privacy is a fundamental right which we believe demands the compelling state interest standard. This test shifts the burden of proof to the state to justify an intrusion on privacy. The burden can be met by demonstrating that the challenged regulation serves a compelling state interest and accomplishes its goal through the use of the least restrictive means.[105]

The Court held that "[b]ased upon the privacy provision in the Florida Constitution, … the State may not intrude upon the parents" fundamental right to raise their children except in cases where the child is threatened with harm."[106]

To date, almost all of the provisions in s. 752.01, F.S., have been found to be unconstitutional,[107] although these provisions are still found in the Florida Statutes because they have not been repealed by the Legislature.

Chapter 61, Florida Statutes

The courts have also struck down two grandparent rights provisions in ch. 61, F.S., which governs dissolution of marriage and parental responsibility for minor children. In 2000, the Florida Supreme Court struck down s. 61.13(7), F.S., which granted grandparents custodial rights in custody or dissolution of marriage proceedings.[108] In *Richardson v. Richardson*, 766 So. 2d 1036 (Fla. 2000), the Court recognized that when a custody dispute is between two fit parents, it is proper to use the best interests of the child standard. However, when the dispute is between a fit parent and a third party, there must be a showing of detrimental harm to the child in order for custody to be denied to the parent.

In 2004, the Florida Supreme Court struck down the statutory provision that awarded reasonable grandparent visitation in a dissolution proceeding if the court found that the visitation would be in the child's best interest.[109] Based on the rationale of earlier Florida cases, the Court declared the provision "unconstitutional as violative of Florida's right of privacy because it fails to require a showing of harm to the child prior to compelling and forcing the invasion of grandparent visitation into the parental privacy rights."[110]

Chapter 39, Florida Statutes

When a child has been adjudicated dependent and is removed from the physical custody of his or her parents, the child's grandparents are entitled to reasonable visitation, unless visitation is not in the best interests of the child.[111] Section 39.509(4), F.S., provides that when the child is returned to the custody of his or her parent, the visitation rights granted to a grandparent must be terminated.
None of the court rulings that have dealt with grandparent visitation rights have affected a grandparent's right to petition for visitation and custody in proceedings under ch. 39, F.S., where the issue of the child's health and welfare and possibly the parents' fitness is already at issue before the court.[112]

Troxel v. Granville

[105] *Beagle*, 678 So. 2d at 1276 (quoting *Winfield v. Division of Pari-Mutuel Wagering*, 477 So. 2d 544, 547 (Fla. 1985)).
[106] Id.
[107] *Von Eiff v. Azicri,* 720 So. 2d 510 (Fla. 1998); *Lonon v. Ferrell*, 739 So. 2d 650 (Fla. 2d DCA 1999); *Saul v. Brunetti*, 753 So. 2d 26 (Fla. 2000).
[108] The subsection read that "[i]n any case where the child is actually residing with a grandparent in a stable relationship, whether the court has awarded custody to the grandparent or not, the court may recognize the grandparents as having the same standing as parents for evaluating what custody arrangements are in the best interest of the child." S. 61.13(7), F.S. (1997).
[109] *Sullivan v. Sapp*, 866 So. 2d 28 (Fla. 2004). Specifically, s. 61.13(2)(b)2.c., F.S. (2001), provided: "The court may award the grandparents visitation rights with a minor child if it is in the child's best interest. Grandparents have legal standing to seek judicial enforcement of such an award. This section does not require that grandparents be made parties or given notice of dissolution pleadings or proceedings, nor do grandparents have legal standing as contestants. . ."
[110] S. 39.509, F.S.
[111] Id.
[112] *T.M. v. Department of Children and Families*, 927 So. 2d 1088 (Fla. 1st DCA 2006).

The U.S. Supreme Court ruled on the issue of grandparent visitation and custody rights in 2000 when the Court struck down a Washington state law as unconstitutional as applied. In *Troxel v. Granville*, 530 U.S. 57 (2000), the Court found the Washington law[113] to be "breathtakingly broad" within the context of a "best interest" determination.[114] The Court noted that no consideration had been given to the decision of the parent, the parent's fitness to make decisions had not been questioned, and no weight had been given to the fact that the mother had agreed to some visitation.[115] Based on these observations, the Court found the Washington statute unconstitutional as applied because "the Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a better decision could be made."[116]

Home Health Agencies (HHAs)

An HHA is an organization that provides home health services and staffing services.[117] Home health services include health and medical services, such as nursing care, physical and occupational therapy, home health aide services,[118] and medical equipment provided to an individual in his or her home. HHAs are regulated by AHCA under part III of chapter 400, F.S.

AHCA is authorized to deny, revoke, or suspend the license of a home health agency.[119] AHCA is required to impose a fine against a home health agency that commits certain acts.[120] One of these acts is the failure of the home health agency to submit a report to AHCA, within 15 days after the end of each calendar quarter, which includes the following information:

- The number of insulin dependent diabetic patients receiving insulin-injection services from the home health agency;
- The number of patients receiving both home health services from the home health agency and hospice services;
- The number of patients receiving home health services from that home health agency; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health agency in excess of $25,000 during the calendar quarter.[121]

These data items help identify possible fraud, such as billing for a high number of injection visits for insulin-dependent patients who could self-inject insulin, fraudulent billing for patients who did not receive the visits, possible duplicate payment for patients receiving both hospice and home health services, and nurses earning well above the average salary that could indicate false billing. The results of each quarter's reporting are shared with the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services' Medicare Program Integrity Miami Satellite Division, the AHCA's Medicaid Program Integrity Office, and the Medicare Fraud Investigations Manager at SafeGuard Services, LLC.[122] The data is also provided to the public in response to public records requests.[123]

Effect of Proposed Changes

<u>Assisted Living Facilities</u>

[113] The Washington statute provided that "Any person may petition the court for visitation rights at any time including, but not limited to, custody proceedings. The court may order visitation rights for any person when visitation may serve the best interest of the child whether or not there has been any change of circumstances." WA. REV. CODE s. 26.10.160(3).
[114] *Troxel v. Granville*, 530 U.S. at 67.
[115] Id.
[116] Id.
[117] S. 400.462(12), F.S.
[118] S. 400.462(14)(a)-(c), F.S.
[119] S. 400.474(1), F.S.
[120] S. 400.474(3)-(6), F.S.
[121] S. 400.474(6)(f), F.S.
[122] Agency for Health Care Administration, *2013 Bill Analysis & Economic Impact Statement-HB 4031*, page 1 (on file with Health and Human Services Committee staff).
[123] Id.

The bill amends s. 394.4574, F.S., to clarify that Medicaid prepaid behavioral health plans are responsible for enrolled state supported mental health residents and that managing entities under contract with the DCF are responsible for such residents who are not enrolled with a Medicaid prepaid behavioral health plan. This section requires a mental health resident's community living support plan be completed and provided to the administrator of the facility within 30 days of admitting a mental health resident and be updated when there is a significant change to the resident's behavioral health status. The resident's case manager must keep a 2-year record of any face-to-face interaction with the resident. Finally, this section charges the entity responsible for a mental health resident to ensure that there is adequate and consistent monitoring of the community living support plan and to report any concerns about a regulated provider failing to provide services or otherwise acting in a manner with the potential to cause harm to the resident.

The bill amends s. 400.0074, F.S., to require the administrative assessment performed by the Long-Term Care Ombudsman to be comprehensive. Further, the bill requires the local Ombudsman to conduct an exit consultation with the long-term care facility administrator.

The bill amends s. 400.0078, F.S., to require that ALFs provide information to new residents upon admission to the facility that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.

The bill amends s. 409.212, F.S., to increase the limit on OSS payments. The amount of third party supplementation is currently capped at 2 times the provider rate or $1,553 per month. The bill increases the cap to four times the provider rate, or $3,106 per month. This allowance is closer to the average cost of assisted living and will provide a cushion for future increases.

The bill amends s. 429.02, F.S., to revise the definition of "limited nursing services" to clarify that licensed nurses are not limited to only performing acts authorized by rule in providing limited nursing services.

The bill amends s. 429.07, F.S., to make changes to improve the regulation of facilities with ECC and LNS specialty licenses. These changes include:

- Requiring that an ALF be licensed for 2 or more years before being issued an ECC license that is not provisional.
- Clarifying under what circumstances AHCA may deny or revoke a facility's ECC license.
- Creating a provisional ECC license for ALFs that have been licensed for less than 2 years.
- The provisional license lasts for a period of 6 months.
- The facility must inform AHCA when it has admitted one or more residents requiring ECC services.
- After the facility admits one or more ECC residents, AHCA must inspect the facility for compliance with the requirements of the ECC license.
- If the licensee demonstrates compliance with the requirements of an ECC license, AHCA must grant the facility an ECC license.
- If the licensee fails to demonstrate compliance with the requirements of an ECC license or fails to admit an ECC resident within 3 months, the licensee must immediately suspend ECC services and the provisional ECC license expires.
- Authorizing AHCA to extend a provisional ECC license for 1 month in order to complete a follow-up visit.
- Reducing monitoring visits for facilities with ECC licenses from quarterly to twice a year, and for facilities with LNS licenses from twice a year to once a year.
- Clarifying under what circumstances AHCA may waive one of the required monitoring visits for facilities with ECC licenses and also allowing AHCA to waive the required monitoring visit for facilities with an LNS license under the same conditions.

The bill amends s. 429.075, F.S., to require facilities with one or more, instead of three or more, mental health residents to obtain a LMH license. Current law requires an ALF with a LMH license to have a copy of each mental health resident's community living support plan and the cooperative agreement

with the mental health care services provider.[124] The bill amends this section to allow an ALF with a LMH license to provide written evidence to AHCA that the ALF requested a copy of the mental health resident's community living support plan and cooperative agreement from the Medicaid managed care plan or managing entity within 72 hours of admitting a mental health resident.

Current law requires an ALF with a LMH license to have documentation from DCF that each LMH resident is suitable for the ALF.[125] The bill amends this section to allow ALFs to provide written evidence that a request for documentation was sent to DCF within 72 hours of admission.

The bill amends s. 429.14, F.S., to:

- Allow AHCA to revoke, rather than just deny, a license for a facility with a controlling interest that has, or had, a 25 percent or greater financial or ownership interest in a second facility that closed due to financial inability to operate or was the subject of other specified administrative sanctions.
- Add additional criteria under which AHCA must deny or revoke a facility's license. The criteria include:
    - There are 2 moratoria issued within a 2-year period.
    - The facility is cited for 2 or more class I violations arising from unrelated circumstances during the same investigation.
    - The facility is cited for 2 or more class I violations within 2 years.
- Require AHCA to impose an immediate moratorium on a facility that fails to provide AHCA with access to the facility, prohibits a regulatory inspection, denies access to records, or prohibits the confidential interview of facility staff or residents.
- Exempt a facility from the 45-day notice requirement in s. 429.28(k), F.S., if that facility is required to relocate all or some of its residents due to action by AHCA.

The bill amends s. 429.19, F.S., relating to the imposition of fines in order to reduce the discretion of AHCA in determining fine amounts, thus making such penalties more predictable. The bill revises the structure of administrative fines for the four classes of violations to be based on the scope of the violation. Basing the fine amount on the scope of the violation is consistent with other facilities licensed and regulated by AHCA including nursing homes. The scope of the violation may be cited as isolated, patterned or widespread.

An isolated deficiency is a deficiency that affects one or a very limited number of residents, or involves one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations.

A patterned deficiency is a deficiency in which:

- More than a very limited number of residents are affected; or
- More than a very limited number of staff are involved: or
- The situation has occurred in several locations; or
- The same resident or residents have been affected by repeated occurrences of the same deficient practice, but the effect of the deficient practice is not round to be pervasive throughout the facility.

A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected, or has the potential to affect, a large portion of the facility's residents.

The bill establishes fines for class I violations, as follows:

- $5,000 for an isolated deficiency;

[124] S. 429.075(3)(a), F.S.
[125] S. 429.075(3)(b), F.S.

- $7,500 for a patterned deficiency; and
- $10,000 for a widespread deficiency.

In addition, the bill allows AHCA to impose a fine on a facility for a class I violation, even if the facility corrects the violation before the AHCA conducts an investigation. Facilities can still challenge such fines through an administrative hearing pursuant to ch.120, F.S. Further, the bill allows AHCA to double the fines for facilities with repeat class I violations.

The bill establishes fines for class II violations, as follows:

- $1,000 for an isolated deficiency;
- $3,000 for a patterned deficiency; and
- $5,000 for a widespread deficiency.

In addition, the bill allows AHCA to double the fines for facilities with repeat class II violations.

The bill establishes fines for class III violations, as follows:

- $500 for an isolated deficiency;
- $750 for a patterned deficiency; and
- $1,000 for a widespread deficiency.

In addition, the bill allows AHCA to impose a fine on facilities for each class III violation if a facility is cited for ten or more class III violations during an inspection or survey.

The bill establishes fines for class IV violations, as follows:

- $100 for an isolated deficiency;
- $150 for a patterned deficiency; and
- $200 for a widespread deficiency.

The bill amends s. 429.256, F.S., to allow all facility staff who received the required training to provide several additional services in assisting with self-administration of medication.[126] Specifically, the additional duties are:

- Taking a prefilled insulin syringe from its place of storage and bringing it to a resident;

[126] Staff involved with the management of medications and assisting with the self-administration of medications under s. 429.256, F.S., must complete a minimum of 4 additional hours of training provided by a registered nurse, licensed pharmacist, or department staff. The department shall establish by rule the minimum requirements of this additional training. S. 429.52(5), F.S. Unlicensed persons who will be providing assistance with self-administered medications must meet the training requirements pursuant to s. 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: Read and understand a prescription label; Provide assistance with self-administration in accordance with s. 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: assist with oral dosage forms, topical dosage forms, and topical ophthalmic, otic and nasal dosage forms; measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; recognize the need to obtain clarification of an "as needed" prescription order; recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; complete a medication observation record; retrieve and store medication; and recognize the general signs of adverse reactions to medications and report such reactions. Unlicensed persons, as defined in s. 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. Rule 58A-5.0191(5), F.A.C.

- Removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the pre-measured dose of medication into the dispensing cup of the nebulizer;
- Assisting a resident in using a nebulizer;
- Using a glucometer to perform blood glucose checks;
- Assisting with anti-embolism stockings;
- Assisting with applying and removing an oxygen cannula;
- Assisting with the use of a continuous positive airway pressure device;
- Assisting with the measuring of vital signs; and
- Assisting with the use of colostomy bags.

The bill also increases the training requirements for staff that assist residents with medication from 4 to 6 hours.

The bill amends s. 429.27(3), F.S., to increase the amount of cash that a facility may provide safe-keeping of for a resident from $200 to $500.

The bill amends s. 429.28, F.S., to require the posted notice of a resident's rights, obligations, and prohibitions, to specify that complaints made to the ombudsman program, as well as the names and identities of the complainant and any residents involved, are confidential. This section also creates a fine of $2,500, which is imposed if a facility cannot show good cause in state court for terminating the residency of an individual who has exercised an enumerated right. The bill also provides AHCA with rulemaking authority to adopt uniform standards and criteria that will be used to determine if a facility is complying with facility standards and the resident's bill of rights.

The bill amends s. 429.34, F.S., to require certain state officials, such as Medicaid Fraud investigators and state or local fire marshals, to report any knowledge or reasonable suspicion that a vulnerable adult has been or is being abused, neglected, or exploited to the DCF central abuse hotline.

The bill provides that a facility having one or more class I violations, two or more class II violations arising from separate surveys within a 60-day period, or two or more unrelated class II violations cited during one survey be subject to an additional inspection within 6 months. The licensee must pay a fee to AHCA to cover the cost of the additional inspection.

The bill amends s. 429.41, F.S., to clarify that ALF staffing requirements for a continuing care facility or retirement community apply only to residents who receive personal limited nursing services or extended congregate care services.

The bill amends s. 429.52, F.S., to require facilities to provide a 2-hour pre-service orientation for all new facility employees who have not previously completed core training. The pre-service orientation must cover topics that help the employee provide responsible care and respond to the needs of the residents. The employee and the facility's administrator must sign a statement that the new ALF staff member has completed the pre-service orientation. The signed statement must be kept in that staff member's file. The bill clarifies that the pre-service orientation can be provided by the ALF instead of requiring that it be provided by a trainer registered with DOEA.

The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct a study of inter-surveyor reliability to determine if different surveyors consistently apply licensure standards. OPPAGA must report its findings and make recommendations to the Governor and Legislature by November 1, 2014.

The bill provides legislative findings that consumers need additional information in order to select an ALF. To facilitate this, the bill requires AHCA to create a consumer guide website, which contains information on each licensed ALF, including, but not limited to:

- The name and address of the facility;
- The number and type of licensed beds in the facility;
- The types of licenses held by the facility;

- The facility's license expiration date and status;
- Affiliations with any other organization who owns or manages more than one ALF in Florida;
- The total number of clients that the facility is licensed to serve and the most recent occupancy levels;
- The number of private and semi-private rooms offered;
- The bed-hold policy;
- The religious affiliation, if any, of the ALF;
- The languages spoken by the staff;
- Availability of nurses;
- Forms of payment accepted;
- Identification if the licensee is operating under bankruptcy protection;
- Recreational and other programs available;
- Special care units or programs offered;
- Whether the facility has mental health residents and, if so, how many;
- Whether the facility is part of a retirement community that offers other services;
- Links to the State Long-Term Care Ombudsman Program website and the program's statewide toll-free telephone number;
- Links to the internet websites of the providers or their affiliates;
- Other relevant information currently collected by AHCA; and
- Survey and violation information including a list of the facility's violations committed during the previous 60 months, which must be updated monthly.

In addition, the bill permits the consumer guide website to include a monitored comment page to help inform consumers of the quality and care of services in ALFs. The comment page must allow members of the public to post comments on their experiences with, or observations of, an ALF. A controlling interest in an ALF or an employee or owner of an ALF may not post comments on the page; however, a controlling interest, employee, or owner may respond to comments on the page, and AHCA is required to ensure that the responses are identified as being from a representative of the facility.

Recovery Care Centers

Pursuant to s. 395.002(3), F.S., patients receiving services in an ASC must be discharged on the same working day that they were admitted and they are not permitted to stay overnight. Federal regulations limit the length of stay in an ASC to 24 hours following admission. The bill amends s. 395.002(3), F.S., to allow a patient to stay at an ASC for no longer than 24 hours to conform to the federal length of stay requirements.

The bill creates a new license for a RCC. The new RCC license is modeled after the current licensing procedures for hospitals and ASCs in Chapters 395 and 408, F.S. The bill adds RCCs to the list of facilities subject to the provisions of Chapter 395, Part I. An applicant for RCC licensure will have to follow the general licensing procedures of Chapter 408, Part II. Additionally, the applicant will be subject to the license, inspection, safety, facility and other requirements of Chapter 395, Part I.

The bill defines RCC as a facility whose primary purpose is to provide recovery care services, to which the patient is admitted and discharged within 72 hours, and is not part of a hospital. Recovery care services are defined as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute-hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute-hospitalization by their attending or referring physician prior to admission in an RCC. A patient may receive recovery care services in an RCC upon:

- Discharge from an ASC after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving an out-patient medical treatment such as chemotherapy.

RCCs must have emergency care and transfer protocols, including transportation arrangements, and referral or admission agreements with at least one hospital.

Section 395.1055, F.S., directs AHCA to adopt rules for hospitals and ASCs that set standards to ensure patient safety, including requirements for:

- Staffing;
- Infection control;
- Housekeeping;
- Medical records;
- Emergency management;
- Inspections;
- Accreditation;
- Organization, including a governing body and organized medical staff;
- Departments and services;
- Quality assessment and improvement;
- Minimum space; and
- Equipment and furnishings.

The license fee for the RCC license will be set by rule by AHCA and must be at least $1,500.[127]

Transitional Living Facilities

The bill consolidates the oversight of care and services of clients of TLFs under specific licensure requirements of AHCA and promotes coordination between AHCA, DOH, and DCF.

The bill repeals the current TLF regulations in s. 400.805, F.S. and creates Part XI of chapter 400, to include ss. 400.997-400.9985, F.S.

The bill states the intent of the legislation to provide for the development, establishment and enforcement of basic standards for TLFs to ensure quality of care and services to residents. Further, the bill provides that it is the policy of this state that the use of restraint and seclusion of TLF clients is justified only as an emergency safety measure to be used in response to danger to the client or others. Therefore, it is the intent of the legislature to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving individuals with brain or spinal-cord injuries.

Section 400.9971, F.S., defines terms relating to TLFs, and adds new terminology to include seclusion, and chemical and physical restraints and their use. The bill adds “behavior modification” services to the list of specialized health care services contained in the definition of a TLF.

Section 400.9972, F.S., provides licensure requirements for TLFs, including compliance with local zoning, liability insurance, fire-safety inspection, and sanitation requirements. This section also provides the application fees for TLFs and adds language to clarify that the fees must be adjusted to conform with the annual cost of living adjustment, pursuant to s. 408.805(2), F.S. In addition, the bill requires TLFs to maintain accreditation by an accrediting organization specializing in evaluating rehabilitation facilities whose standards incorporate comparable licensure regulations required by the state. Applicants for licensure as a TLF must acquire accreditation within 12 months of the issuance of an initial license. The bill authorizes AHCA to accept an accreditation survey report by the accrediting

[127] S. 395.004, F.S.

organization in lieu of conducting a licensure inspection. Further, the bill authorizes AHCA to conduct inspections to assure compliance with licensure requirements, validate the inspection process of accrediting organizations, and to respond to licensure complaints or to protect public health and safety.

The bill clarifies that providers already licensed by AHCA, serving brain and spinal-cord injured persons under their existing license, are not required to obtain a separate license as a TLF.

Admission, Transfer and Discharge Requirements

The bill creates s. 400.9973, F.S., to establish requirements that TLFs must have in place for client admission, transfer and discharge from the facility. The facility is required to have admission, transfer and discharge policies and procedures in writing. The client's admission to the facility must be in line with facility policies and procedures.

Each resident admitted to the facility is required to be admitted upon prescription by a licensed physician, physician assistant (PA), or advanced registered nurse practitioner (ARNP), and must remain under the care of the physician for the duration of the client's stay in the facility. Clients admitted to the facility must have a brain and spinal cord injury, such as a lesion to the spinal cord or cauda equine syndrome, with evidence of significant involvement of two of the following deficits or dysfunctions:

- Motor deficit.
- Sensory deficit.
- Bowel and bladder dysfunction.
- An injury to the skull, brain, or tis covering which produces an altered state of consciousness or anatomic motor, sensory, cognitive, or behavioral deficits.

This definition of a brain or spinal cord injury, as it relates to admission requirements of TLFs, differs from the definition of a brain or spinal cord injury for purposes of the BSCIP, in that it does not require the injury to be the result of external trauma.

In cases where a client's medical diagnosis does not positively identify a cause of the client's condition, or whose symptoms are inconsistent with the known cause of injury, or whose recovery is inconsistent with the known medical condition, the bill allows for an individual to be admitted for an evaluation period not to exceed ninety-days.

The bill prohibits TLFs from admitting a client whose primary diagnosis is mental illness or an intellectual or developmental disability. In addition, the bill provides that a person may not be admitted to a TLF if the person:

- Presents a significant risk of infection to other clients or personnel;
    - In addition the bill requires a health care practitioner to provide documentation that the person is free of apparent signs and symptoms of communicable disease.
- Is a danger to self or others as determined by a physician, PA, ARNP, or mental health practitioner, unless the facility provides adequate staffing and support to ensure patient safety;
- Is bedridden; or
- Requires 24-hour nursing supervision.

Upon a client meeting the admission criteria, the medical or nursing director must complete an initial evaluation of the client's functional skills, behavioral status, cognitive status, educational/vocational potential, medical status, psychosocial status, sensorimotor capacity, and other related skills and abilities within the first seventy-two hours of admission. Further, the bill requires the facility to implement an initial comprehensive treatment plan that delineates services to be provided within the first four days of admission.

The bill requires TLFs to develop a discharge plan for each client prior to or upon admission to the facility. The discharge plan is required to identify intended discharge sites and possible alternate

discharge sites. For each discharge site identified, the discharge plan must identify the skills, behaviors, and other conditions that the client must achieve to be eligible for discharge. The bill requires discharge plans to be reviewed and updated at least once a month.

The bill allows for the discharge of clients, as soon as practicable, if the TLF is no longer the most appropriate, least restrictive treatment option, and for clients who:

- No longer require any of the specialized services described in s. 400.9971(7), F.S.; or
- Are not making measurable progress in accordance with their comprehensive treatment plan.

The bill requires TLFs to provide at least a thirty days' notice to clients of transfer or discharge plans, which must include an acceptable transfer location if the client is unable to live independently, unless the client voluntarily terminates residency.

Client Treatment Plans and Client Services

The bill requires each client in the facility to have a comprehensive treatment plan which is developed by an interdisciplinary team, consisting of the case manager, program director, ARNP, appropriate therapists, and the client and/or the client's representative. The comprehensive treatment plan must be completed no later than 30 days after development of the initial comprehensive treatment plan. Treatment plans must be reviewed and updated at least once a month. The plan must be reevaluated and updated if a client fails to meet the projected improvements outlined in the plan or if a significant change in the client's condition occurs. The facility must have qualified staff to carry out and monitor interventions in accordance with the stated goals of the individual's program plan.

Each comprehensive treatment plan must include the following:

- Orders obtained from the client's physician, PA, or ARNP, and the client's diagnosis, medical history, physical exams and rehab needs;
- A preliminary nursing evaluation, including orders for immediate care provided by the physician, PA, or ARNP, to be completed upon admission;
- A standardized assessment of the client's functional capability; and
- A plan to achieve transition to the community and the estimated length of time to achieve transition goals.

The bill requires a client or their representative to consent to the continued treatment at the TLF. The consent may be for a period of up to three months, and if consent is not given, the TLF must discharge the client as soon as possible.

The bill requires licensees to employ available qualified professional staff to carry out the various professional interventions in accordance with the goals and objectives of the individual program plan. Each client must receive a continuous treatment program that includes appropriate, consistent implementation of a program of specialized and general training, treatment, and services.

Provider Responsibilities

The bill requires TLF licensees to ensure that every client:

- Lives in a safe environment;
- Is treated with respect, recognition of personal dignity and privacy;
- Retains use of their own clothes and personal property;
- Has unrestricted private communications which includes mail, telephone and visitors;
- Participates in community services and activities;
- Manages their financial affairs unless the client or the client's representative authorizes the administrator of the facility to provide safekeeping for funds;
- Has reasonable opportunity for regular exercise and be outdoors more than once per week.

- Exercises civil and religious liberties;
- Has adequate access and appropriate health care services;
- Has the opportunity to present grievances and recommend changes in policies, procedures and services;
- Is enabled to have a representative participate in the process of treatment for the client;
- Receives prompt responses from the facility to communications from family and friends;
- Have visits by individuals with a relationship to the client and any reasonable hour; and
- Has the opportunity to leave the facility to visit, take trips or vacations.

To facilitate a client's ability to present grievances, the facility is required to provide a system for investigating, tracking, managing, and responding to complaints, which must include an appeals process. Additionally, the client's representative must be promptly notified of any significant incidents or changes in the client's condition.

The administrator is required to ensure a written notice of provider responsibilities is posted in a prominent place in the facility which includes the statewide toll-free telephone number for reporting complaints to the AHCA and the statewide toll-free number of Disability Rights of Florida. The facility must ensure the client has access to a telephone, which must have the telephone numbers posted for the AHCA, central abuse hotline, Disabilities Rights of Florida and the local advocacy council. The facility cannot take retaliatory action against any person for filing a complaint or grievance, or for appearing as a witness in any hearing.

Administration of Medication

The bill requires TLFs to maintain a medication administration record for each client, and for each dose, including medications that are self-administered. Each patient who is self-administering must be given a pill organizer, and a nurse must place the medications inside the pill organizer and document the date and time the pill organizer is filled. All medications, including those that are self-administered, must be administered as ordered by the physician, PA, or ARNP. Drug administration errors and adverse drug reactions must be recorded and reported immediately to the physician, PA, or ARNP. The interdisciplinary team determines if a client is capable of self-administration of medications if the physician, PA, or ARNP does not specify otherwise. The physician, PA, or ARNP must instruct the client to self-administer medication.

Assistance with Medication

The bill provides that, notwithstanding the Nurse Practice Act in part I of chapter 464, F.S., unlicensed direct care services staff who provide client services under chapter 400 or 429, F.S., may administer prescribed, prepackaged and premeasured medications under the supervision of a registered nurse. The medication administration training for unlicensed direct care services staff must be conducted by a physician, pharmacist or registered nurse.

The bill requires TLFs that allow unlicensed direct care services staff to administer medications to:

- Develop and implement policies and procedures;
- Maintain written evidence of a client's consent;
- Maintain a copy of the written prescription; and
- Maintain required training documentation.

Client Protection

The bill establishes provisions to protect TLF clients from abuse, neglect, mistreatment, and exploitation. Under the bill, the facility is responsible for developing and implementing policies and procedures for screening and training employees, protection of clients and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and exploitation. The facility is also required to identify clients whose history renders them at risk for abusing other clients. Further, the bill requires facilities to implement procedures to:

- Screen potential employees for a history of abuse, neglect or mistreatment of client;
- Train employees through orientation and on-going sessions on abuse prohibition practices;
- Implement procedures to provide clients, families and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution;
- Implement procedures to identify events such as suspicious bruising of clients that may constitute abuse to determine the direction of the investigation;
- Investigate different types of incidents and identify staff members responsible for the initial reporting and reporting of results to the proper authorities;
- Protect clients from harm during an investigation; and
- Report all alleged violations and all substantiated incidents as required under chapters 39 and 415, F.S., and to the appropriate licensing authorities.

The facility must identify, correct, and intervene in situations in which abuse, neglect, mistreatment or exploitation is likely to occur, including, the physical environment that makes abuse and/or neglect more likely to occur, such as secluded areas.
The facility is required to have a sufficient number of staff to meet the needs of the clients, and must assure that staff has knowledge of the individual client's care needs. The facility must analyze the occurrences of abuse, exploitation, mistreatment or neglect and determine what changes are needed to policies and procedures to prevent further occurrences.

Restraints and Seclusion

The bill requires physical and chemical restraints to be ordered and documented by the client's physician, PA, or ARNP with the consent of the client or client's representative. The use of chemical restraints is limited to the prescribed dosage of medications by the client's physician, PA, or ARNP and may only be used as authorized by the facility's written physical restraint and seclusion policies. Facilities are required to notify the parent or guardian within 24-hours of the use of restraint or seclusion.

The bill authorizes a physician, PA, or ARNP to issue an emergency treatment order to immediately administer rapid response psychotropic medications or other chemical restraints when a client exhibits symptoms that present an immediate risk of injury or death to themselves or others. Each emergency treatment order must be documented and maintained in the client's record and is only effective for 24-hours.

Clients receiving medications that can serve as a restraint must be evaluated by their physician, PA, or ARNP at least monthly to assess the:

- Continued need for the medication;
- Level of the medication in client's blood; and
- Need for adjustments in the prescription.

The facility is required to ensure that clients are free from unnecessary drugs and physical restraints. All interventions to manage inappropriate client behaviors must be administered with sufficient safeguards and supervision.

The bill authorizes AHCA to adopt rules for standards and procedures relating to:

- Use of restraint, restraint positioning, seclusion and emergency orders for psychotropic medications;
- Duration of restraint use;
- Staff training;
- Client observation during restraint; and
- Documentation and reporting standards.

Background Screening and Administration/Management

The bill requires all facility personnel to complete a level 2 background screening as required in s. 408.809(1)(e), F.S. The facility must maintain personnel records which contain the staff's background screening, job description, documentation of compliance with training requirements, job performance evaluations and a copy of all licenses or certifications held by staff performing services for which licensure or certification is required.

The bill requires each TLF to:

- Implement infection control policies and procedures.
- Maintain liability insurance as defined by section 624.605, F.S., at all times.
- Designate one person as administrator who is responsible for the overall management of the facility.
- Designate in writing a person responsible for the facility when the administrator is absent for 24 hours.
- Designate in writing a program director who is responsible for supervising the therapeutic and behavioral staff, determining the levels of supervision, and room placement for each client.
- Designate in writing a person to be responsible when the program director is absent from the facility for more than 24 hours.
- Obtain approval of the comprehensive emergency management plan from their local emergency management agency.
- Maintain written records in a form and system in accordance with medical and business practices and be available for submission to AHCA upon request. The records must include:
    - A daily census record;
    - A report of all accident or unusual incidents involving clients or staff members that caused or had the potential to cause injury or harm to any person or property within the facility;
    - Agreements with third party providers; and
    - Agreements with consultants employed by the facility and documentation of each consultant's visits and required written, dated reports.

Property and Personal Affairs of Clients

The bill requires TLFs to give clients options of using their own personal belongings, and to choose their own roommate whenever possible. Under the bill, the admission of a client to a facility, and their presence therein, shall not confer on a licensee, administrator, employee, or representative any authority to manage, use, or dispose of any property of the client. The licensee, administrator employee or representative may not act as the client's guardian, trustee, payee for social security or other benefits, but may act as the power of attorney for a client if the licensee has filed a surety bond with AHCA in an amount equal to twice the average monthly income of the client. When the power of attorney is granted to the licensee, administrator, staff, or representative, they must notify the client on a monthly basis of any transactions made on their behalf and a copy of such statement given to the client must be retained in the client's file and be available for inspection.

The bill requires the facility to, upon consent from the client, provide for the safekeeping of personal effects. The personal effects may not be in excess of $1,000 and funds of the client may not be in excess of $500 in cash, and the facility must keep complete and accurate records of all funds and personal effects received.

The bill provides that for any funds or other property belonging to or due to a client, such funds shall be trust funds which shall be kept separate from the funds and property of the licensee or shall be specifically credited to the client. At least once every month, unless upon order of a court of competent jurisdiction, the facility must furnish the client and the client's representative a complete and verified statement of all funds and other property, detailing the amount and items received, together with their sources and disposition.

The bill provides that any licensee, administrator, or staff, or representative thereof, who is granted power of attorney for any client of the facility and who misuses or misappropriates funds obtained through this power commits a felony of the third degree.

In the event of the death of a client, the facility must return all refunds, funds, and property held in trust to the client's personal representative. If the client has no spouse or adult next of kin or such person cannot be located, funds due the client must be placed in an interest-bearing account, and all property held in trust by the licensee shall be safeguarded until such time as the funds and property are disbursed pursuant to the Florida Probate Code.

The bill authorizes AHCA to adopt rules to clarify terms and specify procedures and documentation necessary to administer the provisions relating to the proper management of clients' funds and personal property and the execution of surety bonds.

Rules Establishing Standards

The bill authorizes AHCA to publish and enforce rules, which include criteria to ensure reasonable and consistent quality of care and client safety, with respect to the:

- Location of TLFs;
- Qualifications of all personnel having responsibility for any part of the client's care and services;
- Requirements for personnel procedures and reporting procedures;
- Services provided to clients; and the
- Preparation and annual update of a comprehensive emergency management plan.

Penalties and Violations

The bill authorizes AHCA to adopt rules to enforce penalties, and requires AHCA to classify each violation according to the nature of the violation and the gravity of its probable effect on the client. The classification of violations must be included on the written notice of the violation in the following categories:

- Class "I" violations will result in issuance of a citation regardless of correction and impose an administrative fine up to $10,000 for a widespread violation.
- Class "II" violations will result in an administrative fine up to $5,000 for a widespread violation.
- Class "III" violations will result in an administrative fine up to $1,000 for an uncorrected deficiency of a widespread violation.
- Class "IV" violations will result in an administrative fine of at least $100 but not exceeding $200 for an uncorrected deficiency.

The bill allows TLFs to avoid imposition of a fine for a class IV violation, if the deficiency is corrected within a specified period of time.

Receivership Proceedings

The bill authorizes AHCA to petition a court for the appointment of a receiver when any of the following conditions exist:

- The facility is closing or has informed AHCA that it intends to close;
- AHCA determines that conditions exist in the facility that present a danger to the health, safety or welfare of the clients; or
- The facility cannot meet its financial obligation for providing food, shelter, care and utilities.

Petitions for receivership take priority over other court business. A hearing must be conducted within five days of the petition filing. AHCA must notify the owner or administrator of the facility named in the petition and the date of the hearing. The court may grant the petition only upon a finding that the

health, safety or welfare of the client is threatened if a condition existing at the time the petition was filed is allowed to continue.

A receiver may be appointed from a list of qualified persons developed by AHCA. The receiver must make provisions for the continued health, safety and welfare of all clients and perform all duties set out by the court. The receiver must operate the facility to assure the safety and adequate health care for the clients. The receiver may use all resources and consumable goods in the provision of care services to the client and correct or eliminate any deficiency in the structure or furnishings of the facility which endangers the safety of clients and staff. The receiver may hire or contract staff to carry out the duties of the receiver. The receiver must also honor all leases and mortgages, and has the power to direct and manage, and to discharge employees of the facility.

Interagency Communication

The bill requires AHCA, DOH, APD, and DCF to develop electronic systems to ensure relevant data pertaining to the regulation of TLFs is communicated timely among the agencies for the protection of clients. Finally, the bill requires the system to include a brain and spinal cord injury registry and a client abuse registry.

Grandparents and Mental and Emotional Well-Being of Children

Petition

The new section provides that a grandparent of a minor child whose parents are deceased, missing, or in a permanent vegetative state may petition the court for visitation. Likewise, a grandparent may petition for visitation if there are two parents, one of whom is deceased, missing, or in a permanent vegetative state and the other has been convicted of a felony or an offense of violence. The petitioner must make a preliminary showing that the remaining parent is unfit or that there has been significant harm to the child. The bill specifies that if the petitioner cannot make such a showing, the court must dismiss the petition and award reasonable attorney fees and costs to be paid by the petitioner to the respondent.

The new section also directs the family to mediation, furnishes adjudication standards, and directs procedures for a petition seeking grandparent visitation with a minor child, if the court finds evidence that a parent is unfit or that there is a danger of significant harm to the child. The bill places a limit on the number of times a grandparent can file an original action for visitation, absent a real, substantial, and unanticipated change of circumstances and specifies that the venue for petition must be in the county where the minor child resides, unless otherwise governed by chapters 39, 61, or 63, F.S.. Additionally, s. 752.015, F.S., is amended to provide a cross-reference to the new statute.

Best Interest of the Child Determination

At the final hearing on whether to grant or deny grandparent visitation, the grandparent must show by clear and convincing evidence that the parent is unfit or there has been significant harm to the child. If so, then visitation may only be awarded if visitation is in the best interest of the child and if it will not harm the parent-child relationship. In determining best interest, the court is directed to consider:

- The love, affection, and other emotional ties existing between the minor child and the grandparent, including those resulting from the relationship that had been previously allowed by the child's parent;
- The length and quality of the previous relationship between the minor child and the grandparent, including the extent to which the grandparent was involved in providing regular care and support for the child;
- Whether the grandparent established ongoing personal contact with the minor child prior to the death of the parent;
- The reasons that the surviving parent cited to end contact or visitation between the minor child and the grandparent;

- Whether there has been demonstrable significant mental or emotional harm to the minor child as a result of disruption in the family unit from which the child derived support and stability from the grandparental relationship, and whether the continuation of that support and stability is likely to prevent further harm;
- The existence or threat to the minor child of mental injury as defined in s. 39.01, F.S.;
- The present mental, physical, and emotional health of the minor child;
- The present mental, physical, and emotional health of the grandparent;
- The recommendations of the minor child's guardian ad litem, if one is appointed;
- The results of any psychological evaluation of the minor child;
- The preference of the minor child if the child is determined to be of sufficient maturity to express a preference;
- A written testamentary statement by the deceased parent regarding visitation with the grandparent. The absence of such a testamentary statement does not provide evidence that the deceased parent would have objected to the requested visitation; and
- Such other factors as the court considers necessary in making its determination.

Harm

In determining material harm to the parent-child relationship, the bill specifies that the court is must consider:

- Whether there have been previous disputes between the grandparent and the parent over childrearing or other matters related to the care and upbringing of the minor child;
- Whether visitation would materially interfere with or compromise parental authority;
- Whether visitation can be arranged in a manner that does not materially detract from the parent-child relationship, including the quantity of time available for enjoyment of the parent-child relationship, and any other consideration related to disruption of the schedule and routines of the parent and the minor child;
- Whether visitation is being sought for the primary purpose of continuing or establishing a relationship with the minor child with the intent that the child benefit from the relationship;
- Whether the requested visitation would expose the minor child to conduct, moral standards, experiences, or other factors that are inconsistent with influences provided by the parent;
- The nature of the relationship between the parent and the grandparent;
- The reasons that the parent made the decision to end contact or visitation between the minor child and the grandparent which was previously allowed by the parent;
- The psychological toll of visitation disputes on the minor child; and
- Such other factors as the court considers necessary in making its determination.

Interaction with Other Statutes

The bill addresses other statutes that govern child custody and visitation. The bill specifies that article II of ch. 61, F.S., the Uniform Child Custody Jurisdiction and Enforcement Act,[128] applies to actions brought under the provisions of the bill. The bill also specifies that courts are encouraged to consolidate actions pending under s. 61.13, F.S.,[129] with those brought under s. 752.011, F.S.

Changes to Visitation Orders

The bill specifies that an order for grandparent visitation can be modified if petitioner shows that substantial change in circumstances has occurred and that modification of visitation is in the best interest of the child.

The bill specifies it does not provide for grandparent visitation with a child placed for adoption, except with respect to adoption by a stepparent or close relative. The bill specifies that after adoption of a minor child by a stepparent or close relative, the adoptive parent may petition to terminate a previous

[128] Sections 61.501 - 61.520, F.S.
[129] Section 61.13, F.S., governs child support obligations and custodial arrangements for minor children in a dissolution proceeding.

order granting grandparent visitation. The burden is on the grandparent to show satisfaction of the criteria which would satisfy an original petition for visitation.

HHA Reporting Requirements

The bill reduces the frequency for an HHA to report certain information to the AHCA from quarterly to semiannually and requires the reports to be submitted electronically. The reporting requirement is repealed for a HHA that has a controlling interest in another entity that is a Medicaid or Medicaid provider, if the HHA is not a Medicaid or Medicare provider itself. A HHA that is a Medicaid or Medicaid provider itself must continue to report.

The bill provides an effective date of July 1, 2014, except where otherwise provided.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.4574, F.S., relating to Department responsibilities for a mental health resident who resides in an assisted living facility that holds a limited mental health license.
Section 2: Amends s. 400.0074, F.S., relating to local ombudsman council onsite administrative assessments.
Section 3: Amends s. 400.0078, F.S., relating to citizen access to State Long-Term Care Ombudsman Program services.
Section 4: Amends s. 409.212, F.S., relating to optional supplementation.
Section 5: Amends s. 429.02, F.S., relating to definitions.
Section 6: Amends s. 429.07, F.S., relating to license required; fee.
Section 7: Amends s. 429.075, F.S., relating to limited mental health license.
Section 8: Amends s. 429.14, F.S., relating to administrative penalties.
Section 9: Amends s. 429.178, F.S., relating to special care for persons with Alzheimer's disease or other related disorders.
Section 10: Amends s. 429.19, F.S., relating to violations; imposition of administrative fines; grounds.
Section 11: Amends s. 429.256, F.S., relating to assistance with self-administration of medication.
Section 12: Amends s. 429.27, F.S., relating to property and personal affairs of residents.
Section 13: Amends s. 429.28, F.S., relating to resident bill of rights.
Section 14: Amends s. 429.34, F.S., relating to right of entry and inspection.
Section 15: Amends s. 429.41, F.S., relating to rules establishing standards.
Section 16: Amends s. 429.52, F.S., relating to staff training and educational programs; core educational requirement.
Section 17: Creates s. 429.55, F.S., relating to consumer information website.
Section 18: Creates s. 429.56, F.S., relating to public comment webpage; restrictions.
Section 19: Creates an unnumbered section of law requiring the Office of Program Policy Analysis and Government Accountability to conduct a study of intersurveyor reliability for assisted living facility and submit a report regarding its findings and recommendations.
Section 20: Provides an appropriation for the purposes of carrying out the regulatory activities provided in the act.
Section 21: Amends s. 395.001, F.S., relating to legislative intent.
Section 22: Amends s. 395.002, F.S., relating to definitions.
Section 23: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 24: Creates s. 395.0171, F.S., relating to recovery care center admissions; emergency and transfer protocols; discharge planning and protocols.
Section 25: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 26: Amends s. 395.10973, F.S., relating to powers and duties of the agency
Section 27: Amends s. 395.301, F.S., relating to itemized patient bill; form and consent prescribed by the agency.
Section 28: Amends s. 408.802, F.S., relating to applicability.
Section 29: Amends s. 408.820, F.S., relating to exemptions.
Section 30: Amends s. 394.4787, F.S., relating to definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.
Section 31: Amends s. 409.97, F.S., relating to state and local Medicaid partnerships.

Section 32: Amends s. 409.975, F.S., relating to managed care plan accountability.
Section 33: Creates part XI of chapter 400, F.S., relating to transitional living facilities.
Section 34: Repeals s. 400.805, F.S., relating to transitional living facilities.
Section 35: Redesignates the title of part V of chapter 400, F.S., as "intermediate care facilities."
Section 36: Amends s. 381.745, F.S., relating to definitions.
Section 37: Amends s. 381.75, F.S., relating to duties and responsibilities of the department, of transitional living facilities, and of residents.
Section 38: Amends s. 381.78, F.S., relating to advisory council on brain and spinal cord injuries.
Section 39: Amends s. 400.93, F.S., relating to licensure required; exemptions; unlawful acts; penalties.
Section 40: Amends s. 408.802, F.S., relating to applicability.
Section 41: Amends s. 408.820, F.S., relating to exemptions.
Section 42: Creates an unnumbered section of law requiring licensed transitional living facilities to be licensed under part XI of chapter 400, F.S., by a date certain.
Section 43: Creates s. 752.011, F.S., relating to petition for grandparent visitation of a minor child.
Section 44: Creates s. 752.071, F.S., relating to effect of adoption by stepparent or close relative.
Section 45: Amends s. 752.015, F.S., relating to mediation of visitation disputes.
Section 46: Repeals s. 752.01, F.S., relating to action by grandparent for right of visitation; when petition shall be granted.
Section 47: Repeals s. 752.07, F.S., relating to effect of adoption of child by stepparent on right of visitation; when right may be terminated.
Section 48: Amends s. 400.474, F.S., relating to administrative penalties.
Section 49: Provides an effective date of July 1, 2014, except as otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

ALFs

The bill amends the fines for ALFs that are cited for violations. The fines will be based on the number of licensed beds within the cited ALF. Based on the average number of citations in the last two years, the estimated fine revenue for violations would be approximately $514,243 per year.

	Violations	Current Average Fine	Proposed Fine	Difference	Additional Revenue
Class I	104	$6,585	$7,500	$915	$95,160
	11	$7,454	$11,250	$3,796	$41,756
Class II	663	$1,542	$3,000	$1,458	$966,654
	86	$1,843	$4,500	$2,657	$228,502
Class III	99	$782	$500	-$282	-$185,775
	32	$635	$750	$115	-$37,615
	28	$859	$1,000	$141	-$45,527
	47	$613	$1,125	$512	-$34,874
Class IV	13	$169	$100	-$69	-$897
	3	$166	$150	-$16	-$48
	1	$100	$225	$125	$125
	1	$100	$1,125	$1,025	$1,025
				Total Biennial Revenue	$1,028,486
				Total One Year Revenue	**$514,243**

Section 408.805, F.S., requires AHCA to set license fees that are reasonably calculated to cover the cost of regulation. The AHCA estimates that five entities may apply for licensure. These applicants will be subject to a Plans and Construction project review fee of $2,000 plus $300 per hour for building plan reviews, an application fee of at least $1,500, and a licensure inspection fee of $400.[130]

TLFs

AHCA is responsible for the licensing of TLFs. The current licensure fee is $4,588.00 with a $90 per bed fee per biennium. There are currently 13 facilities located within the state. The amount of revenue collected for licensure is expected to remain constant. Additionally, AHCA is responsible for the regulation and collection of administrative fines for TLFs. Based upon historical experience, there is expected to be minimal to no revenues associated with administrative fine collection. Finally, the bill requires that personal property funds of deceased residents that are not disbursed pursuant to Florida Probate Code within two years after death are to be deposited within AHCA's Health Care Trust Fund. The amount of funds expected to be deposited within AHCA's Health Care Trust Fund is indeterminate, but likely insignificant.

2. Expenditures:

ALFs

AHCA estimates an increase in the number of legal cases that will be generated as a result of the increased administrative penalties and fines. AHCA anticipates that an additional 143 legal cases will be created and will need two full-time equivalent Senior Attorney positions to process the additional cases. The total fiscal impact is $159,308 for Year 1 and $151,322 for each recurring year. AHCA estimates that the additional fines collected will exceed the cost of the two full-time equivalent positions.[131]

[130] Agency for Health Care Administration, Agency Bill Analysis-HB 573, dated March 20, 2014 (on file with Health and Human Services Committee staff).
[131] Id.

			FY 2014-2015	FY 2015-16
SALARIES:				
Position Title	*FTE*	*Salary Rate*	*Salary/Benefits*	*Salary/Benefits*
Senior Attorney	1.0	$51,825.50	$69,418	$69,418
Senior Attorney	1.0	$51,825.50	$69,418	$69,418
EXPENSES:				
Professional Staff			$11,778	$11,778
HUMAN RESOURCE SERVICES:				
FTE Positions			$708	$708
STANDARD EXPENSE PACKAGE:				
Professional Staff			$7,986	$0
TOTAL:			**$159,308**	**$151,322**

RCCs

The creation of the RCC license will require AHCA to regulate these facilities in accordance with chapters 395 and 408, F.S., and any rules adopted by AHCA. This will result in a minimal negative fiscal impact; however, the fees associated with the new license are anticipated to cover the expenses incurred by AHCA in enforcement and regulation of the new license.

TLFs

The bill requires AHCA, DOH, Agency for Persons with Disabilities, and DCF to develop electronic systems to share relevant information pertaining to regulation of TLFs. The cost of developing this system is estimated to be insignificant and can be absorbed within each department's existing resources. Additionally, AHCA's current staff that is responsible for the regulation of TLFs will continue to provide these functions in the future and will not require additional staff or resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

ALFs

The bill revises fines used to sanction facilities with violations, but such fines can still be challenged and settled through ch. 120, F.S. Facilities with fewer than 100 beds with class I violations will now be assessed a fine of $7,500 (current law allows the fine to be between $5,000 and $10,000). Some facilities will see a reduction in their fine, while other will see an increase. The range for fines for class II violations are replaced with an amount equal to the midpoint of the range. Fines for class III and IV violations will be based on a four-tier fixed amount. Fines for facilities with 100 beds or more will see higher fines.
Facilities would also be assessed a fine for class I violations even if they are corrected when the AHCA visits the facility. Facilities violating the background screening requirements would be levied a fine of

$500. Currently, facilities are cited for a class II or III violation for not screening the background of facility staff so the fine amount can vary. All fines are subject to challenge through an administrative hearing under ch. 120, F.S.

Facilities would be required to provide new employees that have not already gone through the ALF core training program with a 2 hour pre-service training session before they work with residents. The cost of this training is not expected to be significant and in many cases is already provided.

Facilities with specialty licenses that meet licensure standards would see fewer monitoring visits from the AHCA. This will positively impact the facilities as they will have less interruption of staff time due to such visits.

Facilities with any state supported mentally ill residents would have to meet limited mental health licensure requirements with one or more mental health residents. Facilities with one or two state supported mentally ill residents that do not meet these requirements may see increased costs to comply. Some facilities with one or two such residents however, may already meet the requirements for a limited mental health license.

RCCs

Individuals needing surgery may save money by being able to stay in an ASC for up to 24 hours or stay in an RCC for up to 72 hours rather than having to be transferred to a hospital.

Being able to keep patients longer in an ASC may have a positive fiscal impact on the ASC by being able to perform more complex procedures.

Hospitals may experience a negative fiscal impact if patients receive care in an ASC or RCC.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

The bill may implicate the provision of Article III, Section 6 of the Florida Constitution which requires every law to embrace one subject and matter properly connected to it.

Rights of Grandparents and the Mental and Emotional Well-Being of Children

The United States Supreme Court has recognized the fundamental liberty interest parents have in the 'care custody and management' of their children.[132] The Florida Supreme Court has likewise recognized that decisions relating to child rearing and education are clearly established as fundamental rights within the Fourteenth Amendment of the United States Constitution.[133] These rights may not be intruded upon absent a compelling state interest.[134]

[132] *Santosky v. Kramer*, 455 U.S. 745 (1982).
[133] *Beagle*, 678 So.2d at 1275. See also *Padgett v. Department of Health & Rehabilitative Servs.*, 577 So.2d 565, 570 (Fla. 1991).
[134] See, e.g., *Shevin v. Byron, Harless, Schaffer, Reid & Assocs., Inc.*, 379 So.2d 633, 637 (Fla. 1980); *Belair v. Drew,* 776 So.2d 1105,

According to the Florida Supreme Court, when analyzing a statute that infringes on the fundamental right of privacy, the applicable standard of review requires that the statute survive the highest level of scrutiny:

> The right of privacy is a fundamental right which we believe demands the compelling state interest standard. This test shifts the burden of proof to the state to justify an intrusion on privacy. The burden can be met by demonstrating that the challenged regulation serves a compelling state interest and accomplishes its goal through the use of the least intrusive means.[135]

The Florida Supreme Court has unequivocally announced that "the imposition, by the State, of grandparental visitation rights implicates the privacy rights of the Florida Constitution."[136] Based on Florida's constitutional privacy right, the Court then held that "the State may not intrude upon the parents' fundamental right to raise their children except in cases where the child is *threatened with harm . . .*"[137] [Emphasis in original].

Furthermore, the Florida Supreme Court has held that privacy is a fundamental right and any statute that infringes on that right is subject to the 'compelling state interest' test, the highest standard of review. . . . It concluded that section 752.01(1)(a) failed that test because the circuit court must order visitation based on the best interest of the child, "without first requiring proof of demonstrable harm to the child."[138]

B. RULE-MAKING AUTHORITY:

Where necessary, the bill provides sufficient rule-making authority to the appropriate agency or department to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 10, 2014, the Health and Human Services Committee adopted three amendments and reported the bill favorably as a committee substitute. The amendments made the following changes to the bill:

- Allowed an ALF with a LMH license to provide written evidence, in lieu of having the community living support plan and cooperative agreement on hand, that a request for the plan and agreement was sent to the Medicaid managed care plan or managing entity within 72 hours of admission of a mental health resident.
- Eliminated the requirement that the AHCA consumer website providing information about ALFs include whether or not an ALF provides mental health services and added that the website must include whether an ALF has mental health residents and, if so, the number of mental health residents.[139]
- Deleted the provision of the bill that permitted any hospital to provide cardiovascular services to an adult who was treated at the same hospital as a child for cardiac catheterization or surgery.

1107 (Fla. 5th DCA 2001).
[135] *Winfield v. Division of Pari-Mutuel Wagering, Dept. of Business Regulation*, 477 So.2d 544, 547 (Fla. 1985).
[136] See supra, FN 126.
[137] *Von Eiff,* 720 So.2d at 514.
[138] *Belair*, 776 So.2d at 1106.
[139] ALFs do not provide mental health services.

The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.